SUMMIT POINTE COMMUNITY LIVING SUPPORTS (H2016) and PERSONAL CARE (T1020)

Customer’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reporting Period: (Mon/Year)

Provider Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of PCP: \_\_\_\_\_\_\_\_\_\_ Start Time\_\_\_\_\_\_\_\_\_\_\_ Stop Time \_\_\_\_\_\_\_\_

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| **Goal 1:**  **Objectives:** |

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| **Community Living Supports** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
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| Please document choices given and resident’s response to activity: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Home Manager Signature and Date of Review: Support Coordinator Initials and Date of Review: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Staff Signatures/Date

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