SUMMIT POINTE COMMUNITY LIVING SUPPORTS (H2015)

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

Provider Agency:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of PCP: \_\_\_\_\_\_\_\_\_\_Shared Staffing ( ) Ind ( ) Time in/Time Out/Shift:

**(Shared Staffing – Indicate Identified Hours Per Contract/Day )**

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| **Goal 1:**  **Take from current Person Centered Plan**  **Objectives: You only need to track the objectives that are not tracked elsewhere, for example “will take all medications with zero refusals”, this is documented on the medication log, so would not need to be listed here. Same with behaviors, if they are tracked on a behavior data sheet, then they do not need to be tracked here.**  **Staff initials and data go here. Depending on the obj, it could be number of prompts plus staff initials or “+” or “-“ for completion of task plus staff initials** |

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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** |
| Obj #1 here |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Obj #2 here |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Please document choices given and resident’s response to activity: Both of these questions are mandatory elements per Medicaid Manual and HCBS Rule. If both of these are answered in another document (narrative Progress notes), then this area can be skipped | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Home Managers should review data monthly prior to billing. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CSM/SC should review the data at least monthly to ensure current tx plan is being implemented and that data is being collected correctly | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Home Manager Signature and Date of Review: Support Coordinator Initials and Date of Review: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Staff Signatures/Date/Initials (these are used by auditors to match the above initials with full names)

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