Supervised IRA/CR Residential Habilitation
Daily Narrative Note

Agency Name: _____ Date of Service (mth/dy/yr) _____

Individual's Name: _____ : _____

Medicaid CIN # _____ TABS ID # (optional): _____

Primary Service Location: _____

Presence Status (P=Present, T=Therapeutic Leave, R=Retainer Day): _____
(Note: "P" is used when the person is present in the IRA, there is an emergency relocation, or services of the same scope, frequency and duration are provided 'off site')

Description of Services:

(attach additional sheets if needed)

Staff Signature:_____Date Note Written (mth/dy/yr):_____

Staff Name:_____Staff Title:_____

At least one note written during the calendar month, or a separate monthly summary note, must: summarize the implementation of the person's Residential Habilitation Plan; address the individual's response to services and; discuss any issues or concerns.