

OCDD WAIVER DAILY SERVICE LOG/PROGRESS NOTE:
MULTIPLE SHIFTS FOR A SINGLE DATE OF SERVICE

Agency: _____ Agency Phone Number: _____

Beneficiary Name: _____ Date of Service: _____

Staff	Printed Name	Signature	Initials	Time in*	Time out*
Shift 1:					
Shift 2:					
Shift 3:					

*If EVV is used, write "EVV" in Time in/Time Out columns. If manual entry, record the exact Time in /Time out. If manual entry, also identify location on page 2 (Home or Other).

Relationship support/building and community connections	Family: <input type="checkbox"/> Call <input type="checkbox"/> Visit <input type="checkbox"/> Family event Friends: <input type="checkbox"/> Call <input type="checkbox"/> Visit <input type="checkbox"/> Event <input type="checkbox"/> Participated in community event <input type="checkbox"/> Community organization meeting or activity <input type="checkbox"/> Participated independently or with family/friend <input type="checkbox"/> Assistance or support provided by staff
Education, work, and social roles	<input type="checkbox"/> Assistance getting to/from location <input type="checkbox"/> Assistance in accessing/applying for opportunities <input type="checkbox"/> Support provided to participate <input type="checkbox"/> Individual participated with assistance from another provider <input type="checkbox"/> Individual participated independently or with assistance from family/friend
Appointments	<input type="checkbox"/> Doctor Visit <input type="checkbox"/> Lab or test <input type="checkbox"/> Scheduled Procedure <input type="checkbox"/> Behavioral Health Visit <input type="checkbox"/> Therapy or home health visit <input type="checkbox"/> Any instructions provided (see notes from MD/medical provider) <input type="checkbox"/> Any follow-up needed
Problems or challenges today	<input type="checkbox"/> Medical symptoms <input type="checkbox"/> Critical incident <input type="checkbox"/> Behavioral incident <input type="checkbox"/> Medication error/problem <input type="checkbox"/> Plan followed and documentation available to support <input type="checkbox"/> Contacted supervisor or professional for assistance [Specify contact: _____]

Indicate all that apply and note time that task completed with initials:						
ADL/IADL area of support	Time(s) Shift 1	Initials	Time(s) Shift 2	Initials	Time(s) Shift 3	Initials
Eating						
Dressing or picking out clothes						
Grooming personal hygiene						
Toileting						
Bathing or showering						
Mobility, lifting, or positioning						
Shopping or purchasing						
Cleaning my home or yard						
Managing finances						
Managing time or scheduling						
Medication or medical supports						

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Progress notes, descriptions, and comments. Provide narrative of items checked and initialed on page 1 AND support towards goals included in the person's CPOC. This section must be completed for each shift.		Staff printed name and signature
<p align="center">Shift 1</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Other</p>		
<p align="center">Shift 2</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Other</p>		
<p align="center">Shift 3</p> <p><input type="checkbox"/> Home</p> <p><input type="checkbox"/> Other</p>		