# MONTHLY SUMMARY NOTE - COMMUNITY HABILITATION

**AGENCY**: Person Centered Care Services, Inc. **MONTH / YR OF SERV. DELIVERY**: ___________________

**SD Participant Name**: ______________________________________ **TABS ID**: ______________ **MEDICAID #**: ____________________________

*Provide a narrative that summarizes the implementation of the Community Habilitation Services Plan, and addresses the SD Participant's response to the services provided and any issues or concerns.*

_____________________________________________ SIGNATURE OF STAFF PERSON WRITING THE NOTE (REQUIRED)

______________________________________ TITLE

____________________ DATE (MM/DD/YYYY)

______________________________________________ SIGNATURE OF SD PARTICIPANT/DESIGNEE

______________________________________ SD PARTICIPANT/DESIGNEE

____________________ DATE (MM/DD/YYYY)