IDD SERVICE NOTE **Community Counseling Services** Rev 01/17

Name: _____ Medicaid #: _____

Service: Agency:

Date: Begin Time: End Time: Total Time: Location(s):

Person's Activities	Staff's Activities
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	

Date: Begin Time: End Time: Total Time: Location(s):

Person's Activities	Staff's Activities
(Who, What, When, Where, How, Why)	
Staff Signature/ Credentials	