Community Habilitation
Daily Service Documentation Note

Agency: Trinity Assistance **Individual Name:** **Medicaid #:**
Staff Name: ______________________ **Title:** Com Hab Staff **Service Month:** ____________

Service Location: Home/ Various Community Locations

Date of Service	Service Start Time	Service Stop Time	Total Time	Billable Units *(15 mins=1 unit)*	***Number of Individuals Served***	***Staff Signature***
					1:1 ☐ Group ☐	

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