



HABILITATIVE TIMESHEET PROGRESS REPORT

Client Name: _____ **Sunday that started your work week:** ____ / ____ / ____

Service Type	Support Codes		
DH = Day Habilitation	I = Independent/no assistance required	PC = Physical cues*	V = Verbal cues*
IH = In-Home Support	M = Modeling*	PS = Protective supervision	Other:
SL = Supported Living	N/A = Not attempted/unable to attempt	R = Refused/non-compliant	Other:
	P = Physical assistance	U = Attempted but unable to complete	* = Requires frequency (for example: V3)

Objective #	Reference the objective cue sheet(s).	Service Type One service type per objective. DH may only be provided in a community setting.				Enter the date of service under each day's letter below.						
						S	M	T	W	T	F	S
						For each day of service, enter a support code, as well as the number of times each objective was addressed. Example: V3/4						
		DH	IH	SL	/	/	/	/	/	/	/	/
		DH	IH	SL	/	/	/	/	/	/	/	/
		DH	IH	SL	/	/	/	/	/	/	/	/
		DH	IH	SL	/	/	/	/	/	/	/	/
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		DH	IH	SL	/	/	/	/	/	/	/	/
		DH	IH	SL	/	/	/	/	/	/	/	/

Any objective not noted above will be assumed to be marked N/A. Routine failure to address an objective is not acceptable and will be questioned by the agency. Unusual service circumstances leading to an objective not being addressed **MUST** be directly reported to the agency!

Employee Name: _____	Signature: _____	Date: _____
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Employee signature confirms that any day habilitation services were provided in an appropriate community setting, or as otherwise authorized by the State of Alaska and CDCN.



HABILITATIVE TIMESHEET DAILY CASE NOTES

Client Name: _____ Sunday that started your work week: ____/____/____

Check all support and teaching strategies used this week:

- Administered Coached Coordinated Encouraged Explored Followed Up Instructed Participated
- Practiced Praised Pre-Taught Redirected Role Played Used Visual Learning Aids
- Used Adaptive Equipment Other: _____ Other: _____ Other: _____

SUNDAY: _____

Note:

MONDAY: _____

Note:

TUESDAY: _____

Note:

WEDNESDAY: _____

Note:

THURSDAY: _____

Note:

FRIDAY: _____

Note:

SATURDAY: _____

Note:

Employee Name: _____	Signature: _____	Date: _____
<input type="checkbox"/> CHECK HERE IF THESE CASE NOTES REQUIRE IMMEDIATE REVIEW BY CDCN STAFF.		CDCN Use Only: <input type="checkbox"/> Case notes sent to Hab Coordinator