Macomb County Community Mental Health - Self Determination/Choice Voucher Program
Payroll/Service Note

Employee: ______________________ ______________________
Print Full Name *Employee ID number*

Consumer: ______________________
Print Full Name

Case: ______________________

Support Coordinator/Agency: ______________________

Phone #: ______________________

FI Name: **Community Living Network (CLN)**

Pay Period: _______/_______/_______ to _______/_______/_______

Please identify only one authorized code per page to document service provided :	CLS		
	H2015 1:1 ☐	2:1 ☐	3:1 ☐
	[redacted]		
	RESPITE		
	T1005 1:1 ☐	2:1 ☐	3:1 ☐

*Write Legibly using blue or black ink

*Narrative of services must support time billed (use as many lines as necessary)

* Services must not overlap with other State Plan services (e.g. Home Help or medical appointments)

Use this GOAL / OBJ. PROGRESS KEY to document progress of the IPOS goal/Objective worked on per shift.	
DECREASE	D
SAME	S
INCREASE	I

Date	Start Time	Stop Time	Hours/Units	Service Note - Narrative Statement of Supports Provided	GOAL / OBJ. from IPOS	PROGRESS (D, S, I)
	am / pm	am / pm			___/___ ___/___ ___/___	___ ___ ___
	am / pm	am / pm			___/___ ___/___ ___/___	___ ___ ___
	am / pm	am / pm			___/___ ___/___ ___/___	___ ___ ___
	am / pm	am / pm			___/___ ___/___ ___/___	___ ___ ___
	am / pm	am / pm			___/___ ___/___ ___/___	___ ___ ___

Totals: ______ *Hours/Units*

My signature below certifies that I have reviewed this information and to the best of my knowledge it is true and complete. It also certifies that I, the Consumer or Consumer Representative, knowingly provide service note information to my Fiscal Intermediary, waiving any confidentiality claims.

Consumer Representative or Consumer Signature: ______________________ **Date:** __________

Employee Signature: ______________________, **Aide** **Date:** __________

For Primary Case Holder Use Only:	*Indicate quality of notes by checking, as applicable:*	*Satisfactory* ☐ *Needs Improvement* ☐ *Unsatisfactory* ☐	*Follow-up Requested (explain):* *Date of Review:* *Initial:*

IMPORTANT: CHILDREN'S WAIVER PLEASE ATTACH CORRESPONDING DATA SHEETS PRIOR TO SUBMISSION TO FISCAL INTERMEDIARY