□ Substitute care I □ Respite I□ Customized Community Supports I□ Customized In Home Supports

Individual's Name:	Month: Year:
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Therapy Visits-(Please	list therapy (BT, PT, OT, SLP) received, date and time.)	Documentation	1	
		Doctor Visits		
		Incident Reports		
		VTA (Work) Completed		
		, 111 (Holl) Completed		
Thank You!				
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House Manager Signature: D		ate:		
Service Coordinator Signature :		 ate:		