

# Self Determination Progress Note

Consumer Name: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Time In: \_\_\_\_\_  AM  PM Time Out: \_\_\_\_\_  AM  PM

CLS (H2015):  Respite (T1005):  Overnight (T2027):  Location of Service: \_\_\_\_\_

Documentation:

---

---

---

---

---

---

---

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Time In: \_\_\_\_\_  AM  PM Time Out: \_\_\_\_\_  AM  PM

CLS (H2015):  Respite (T1005):  Overnight (T2027):  Location of Service: \_\_\_\_\_

Documentation:

---

---

---

---

---

---

---

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Service: \_\_\_\_\_ Time In: \_\_\_\_\_  AM  PM Time Out: \_\_\_\_\_  AM  PM

CLS (H2015):  Respite (T1005):  Overnight (T2027):  Location of Service: \_\_\_\_\_

Documentation:

---

---

---

---

---

---

---

Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_