LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

OCDD WAIVER DAILY SERVICE LOG/PROGRESS NOTE: SINGLE SHIFT FOR A SINGLE DATE OF SERVICE

Agency:_____A1 Absolute Best Care Agency, L.L.C._____ **Agency Phone Number**:__504.368.0206____

Beneficiary Name:_____ **Date of Service:** _____ **Overnight Shift:** ☐Yes ☐No

Staff Printed Name	Staff Signature	*Time in	*Time out

***If EVV is used, write "EVV" in Time in/Time Out columns. If manual entry, record the exact Time in /Time out.**

Location of Service: ☐ Home ☐ Other **(Required for Manual Entries Only)**

Check all that apply:

Relationship support/building and community connections	**Family:** ☐Call ☐ Visit ☐ Family event **Friends:** ☐Call ☐ Visit ☐ Event ☐Participated in community event ☐ Community organization meeting or activity ☐Participated independently or with family/friend ☐ Assistance or support provided by staff
Education, work, and social roles	☐Assistance getting to/from location ☐Assistance in accessing/applying for opportunities ☐Support provided to participate ☐Individual participated with assistance from another provider ☐Individual participated independently or with assistance from family/friend
Appointments	☐ Doctor Visit ☐Lab or test ☐Scheduled Procedure ☐Behavioral Health Visit ☐Therapy or home health visit ☐Any instructions provided (see notes from MD/medical provider) ☐ Any follow-up needed
Challenges today	☐ Medical symptoms ☐Critical incident ☐Behavioral incident ☐Medication error/problem ☐ Plan followed and documentation available to support ☐ Contacted supervisor or professional for assistance [Specify contact:_____]

Indicate what, if any, assistance was provided. If completed independently, provided by another person (name or role) or if assistance not provided, indicate this in the "Assistance Provided" section.	
ADL/IADL area of support	**Assistance provided:**
Eating	
Dressing or picking out clothes	
Grooming personal hygiene	
Toileting	
Bathing or showering	
Mobility, lifting, or positioning	
Shopping or purchasing	
Cleaning my home or yard	
Managing finances	
Managing time or scheduling	
Medication or medical supports	

Progress notes, descriptions, and comments. Provide additional details of items checked above AND support towards goals included in the person's CPOC.

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OCDD WAIVER DAILY SERVICE LOG/PROGRESS NOTE: ADDITIONAL NOTES PAGE

Beneficiary Name: _____ **Date of Service:** _____

Additional progress notes, descriptions, or comments	Staff printed name and signature