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

Employee: _____ *Print Full Name*

Consumer: _____ *Print Full Name*

Case: _____

Support Coordinator/Agency: _____

Phone #: _____

FI Name: _____

Pay Period: _____/_____/_____ to _____/_____/_____

Please identify only one authorized code per page to document service provided :

CLS				
H2015	1:1 ☐	2:1 ☐	3:1 ☐	
H0043	1-3 ☐	E TF	TT ☐	
	4-7 ☐	E TG	TT ☐	
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:*