

**SUMMIT POINTE
COMMUNITY LIVING SUPPORTS (H2015)**

Customer's Name: _____ **Reporting Period:** _____ (Mon/Year)
Provider Agency: _____ **Date of PCP:** _____ **Shared Staffing () Ind () Time in/Time Out/Shift:** _____
(Shared Staffing – Indicate Identified Hours Per Contract/Day _____)

Goal 1:
Objectives:

Personal Care	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Please document choices given and resident's response to activity:

