



Supported Community Living (SCL) Service Documentation

Mileage: _____
Expenses: _____

Consumer's Legal Name: _____ **Medicaid #:** _____
(include nicknames used in summary)

Date of Service: __/__/__ **Start Time*:** __:__:__ **End Time*:** __:__:__ **Date of Birth:** __/__/__
 * Use military time to document

Location of Service (check all that apply – if visiting more than one location, document when and where in summary):

Consumer's Home BASICS OASIS Community (i.e. Lindale Mall): _____

The following are types of interventions and acronyms that DSP(s) can use when working on skills with consumer(s):

I = Independent **VP = Verbal** **D = Demonstration** **G = Gesture** **PP = Partial Physical Assistance** **FP = Full Physical Assistance** **VC = Visual Cues**

Goal: _____

Objective # ____ : _____

List the intervention(s) staff used (include specific mechanisms, # and type): _____

Explain consumer's response to the intervention(s): _____

How effective was the intervention(s)? (circle one) Not effective Somewhat effective Very effective

Explain: _____

What would/should staff do the same or differently next session? _____

What type of progress was noticed? (circle one) Progress Made None Noted Regression of Progress

Explain: _____

Were there any concerns for health, safety and/or welfare for this objective? (circle one) Yes No

Explain: _____

Consumer Name: _____ Medicaid #: _____ Date of Birth: __/__/__
(include nicknames used in summary)

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Objective # ____: _____

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Explain consumer's response to the intervention(s): _____

How effective was the intervention(s)? (circle one) Not effective Somewhat effective Very effective

Explain: _____

What would/should staff do the same or differently next session? _____

What type of progress was noticed? (circle one) Progress Made None Noted Regression of Progress

Explain: _____

Were there any concerns for health, safety and/or welfare for this objective? (circle one) Yes No

Explain: _____

Direct Service Provider (DSP) Verification: *Did the DSP have access to Care & SCL Plan (i.e. ELP):* Yes No*

*If no, explain: _____

Full Legal Name (Print): _____ DSP ID # _____

Full Legal Name (Signature): _____ Date _____

Primary Caregiver/Person Responsible for Consumer:

Did the DSP complete documentation and provide a summary of the service? (check one) Yes No

Is the DSP responsible for dispensing/observing medications/procedures? (check one) Yes** No

** if yes, complete a medication log

Signature of Person Responsible for Consumer _____ Date _____

Completed service notes must be turned in on the 1st & 16th each month to the Arc at:

680 2nd Street SE, Suite 200 • Cedar Rapids, IA 52401

Phone: 319-365-0487 • Fax: 319-365-9938

The Arc of East Central Iowa: SCL Service Documentation Back Page (Revised 1/9/08)

Office Use Only

Lead/Dir QA by: _____ Date: _____

Office QA by: _____ Date: _____

See Discussion Log: Consumer DSP