ADULT DAY SUPPORT/VOCATIONAL HABILITATION GOAL SHEET

INDIVIDUAL NAME: ______________________ PROVIDER NAME / # ______________________ SITE LOCATION: ______________________

SPAN DATES: ____________ EFFECTIVE DATE: ________ MEDICAID # ____________ SUPPORT ADMINISTRATOR: ____________

FREQUENCY OF IMPLEMENTATION: __________ DURATION: ____________ GROUP SIZE / ACUITY: ____ SUPERVISOR: ____________

MONTH/YEAR: ________________

Date	Initials	Comments

Mandatory monthly summary:

____
Signature / Date

Rev. 9/2012

INDIVIDUAL NAME: ______________________ MONTH/YEAR: ______________________

Goal Area: ______________________

Baseline:

Goal:

Procedures:

DOCUMENT TYPE OF PROMPT NECESSARY TO PERFORM STEP: **I**=Independent, **V**=Verbal, **G**=Gestural, **P**=Physical, **R**=Refused (comment required), **T**=Total Assistance, **HH**=Hand Over Hand, **ND**=Not Delivered, **A**=Absence, **C**=Closed, **H**=Holiday

Indication of Service Delivery: + Individual met goal as stated in plan - Individual did not meet goal as indicated in plan

		GOAL	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
*If additional trials are required, use additional Individual Plan documentation sheet *All goals will continue to the first of the month following annual meeting date for ICFMR	Trial 1	+/-																															
		Type of Prompt(s)																															
		# of Prompt(s)																															
		Initials																															
	Trial 2	+/-																															
		Type of Prompt(s)																															
		# of Prompt(s)																															
		Initials																															
	Trial 3	+/-																															
		Type of Prompt(s)																															
		# of Prompt(s)																															
		Initials																															

STAFF SIGNATURE ______________________ INITIALS ________ STAFF SIGNATURE ______________________ INITIALS ________

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