LOUISIANA DEPARTMENT OF HEALTH
Office for Citizens with Developmental Disabilities

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

Agency: _____ **Agency Phone Number:** _____

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

Staff	Printed Name	Signature	Initials	Time in*	Time out*
Shift 1:					
Shift 2:					
Shift 3:					

***If EVV is used, write "EVV" in Time in/Time Out columns. If manual entry, record the exact Time in /Time out. If manual entry, also identify location on page 2 (Home or Other).**

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
Problems or 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 all that apply and note time that task completed with initials:						
ADL/IADL area of support	**Time(s) Shift 1**	**Initials**	**Time(s) Shift 2**	**Initials**	**Time(s) Shift 3**	**Initials**
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						

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Issued 2/12/2025
Replaces all prior issues

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Progress notes, descriptions, and comments. Provide narrative of items checked and initialed on page 1 AND support towards goals included in the person's CPOC. **This section must be completed for each shift.**		Staff printed name and signature
Shift 1 ☐ Home ☐ Other		
Shift 2 ☐ Home ☐ Other		
Shift 3 ☐ Home ☐ Other		