Community Mental Health for Central Michigan

SPECIALIZED RESIDENTIAL PROGRESS NOTE FORM B

DATE: _____

CONSUMER NAME: _____

CASE #: _____ **DOB:** _____

☐ **Licensed Family Home** ☐ **Licensed Group Home**

I = Independent	***M = Monitoring***	***VP = Verbal Prompts***
HOH = Hand-over-Hand	***TC = Total Care***	***R = Refusal***
LOA = Leave of Absence	***PA = Physical Assist***	***H = Hospitalization***

PERSONAL CARE SUPPORTS (hands-on & face-to-face)	**Level of Assist**		
	1st	**2nd**	**3rd**
Personal Hygiene (change clothes, wash hands/face)			
Bathing			
Dressing			
Toileting			
Medication Management/Self-Med Program			
Eating/Feeding			
Transferring (between bed, chair, wheelchair)			
Ambulating			
Meal Preparation			
Laundry/Housekeeping			

COMMUNITY LIVING SUPPORTS (monitors & prompts)	**Level of Assist**		
	1st	**2nd**	**3rd**
Medication Administration			
Grocery Shopping/Menu Planning/Meal Prep			
Laundry/Housekeeping			
Money Management			
Health Care/Dental Appointment/ER Visit			
Community Outings/Religious Services			
Symptom Management/Redirection Behaviors			
Socialization			
Transportation			
Monitoring/Protection (sleeping)			
Time Management			

1st SHIFT Start Time: _____ a.m. p.m. Stop Time: _____ a.m. p.m.

Staff Name (please print): _____

Staff Signature/Credentials: _____ **Date:** _____

2nd SHIFT Start Time: _____ a.m. p.m. Stop Time: _____ a.m. p.m.

Staff Name (please print): _____

Staff Signature/Credentials: _____ **Date:** _____

3rd SHIFT Start Time: _____ a.m. p.m. Stop Time: _____ a.m. p.m.

Staff Name (please print): _____

Staff Signature/Credentials: _____ **Date:** _____