Month Of:       Member Medicaid ID:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Begin Time |  | End Time |  | Hours | Client Full Name | Type of Service | Client / Guardian Initial | Tasks, Comments & Observations |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |
|       |       | [ ] am [ ] pm |       | [ ] am [ ] pm |       |       |  |  |       |

**Note:** Client/Guardian Initials above confirm that the hours shown are a true and accurate account of the length and type of service provided.

Services not authorized by DDD, Project Insight, and client/guardian will not be paid.

**Completed** Service Logs must be received in the Tucson office **no later than 9:00 AM** every other Monday, check with office for schedule.

Staff Name: (Print)       Total Number of Hours:

Staff Signature: Client/Guardian Signature: