ADVANTAGE COMMUNICTION

SUBSTITUTE CARE DAILY PROGRESS NOTES

Consumer: _____ Substitute Care Provider:
_____

(Dates and times must match billing sheet and coincide with FLP's billing sheet)

Date:	**Time of Service: (In)_____am/pm (Out)_____am/pm**

Location of Service *(must circle all that apply)*: Community / Home
Summary of activities and assistance required:

_____
_____
_____
_____
_____
_____
_____

Full Signature:_____

Dates and times must match billing sheet and coincide with FLP's billing sheet)

Date:	**Time of Service: (In)_____am/pm (Out)_____am/pm**

Location of Service *(must circle all that apply)*: Community / Home
Summary of activities and assistance required:

_____
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_____
_____
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Full Signature:_____

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Date:	**Time of Service: (In)_____am/pm (Out)_____am/pm**

Location of Service *(must circle all that apply)*: Community / Home
Summary of activities and assistance required:

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_____
_____
_____
_____
_____

Full Signature:_____