HCBS/FE COMPREHENSIVE SUPPORT LOG

Provider / agency name: ____

Beneficiary name: ____

Date (MM/DD/YY)	Start time	End time	Total time	Worker initials	Beneficiary initials
	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			
	AM / PM	AM / PM			
	AM / PM	AM / PM			

Comments: ____

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I certify this information is correct and the above documented services were provided:

Personal Care Services worker name (Print) — Personal Care Services worker signature

Personal Care Services worker name (Print) — Personal Care Services worker signature

Beneficiary name (Print) — Beneficiary signature