HALO NETWORK OF SERVICES

Monthly Summary Note

Individual's Name: **Month:** **Year:**

Last name First Name

Individual's Medicaid CIN: **Fiscal Intermediary (FI) Agency:** HALO NETWORK INC.

This form is completed monthly **by you** with help, as needed, from your designee or staff. The Monthly Summary Note includes:

1. **Service** – check the service(s) you participated in this month. This service should relate to your valued outcomes.
2. **Progress** – describe what progress you made towards your personal goals and valued outcomes.
3. **Follow-up** – state whether you would like any changes to your services and supports or whether you have any service-related concerns.
4. Sign and date the form once it's complete.
5. Send the complete form to your Fiscal Intermediary by the date agreed upon within your FI Memorandum of Understanding (MOU).

Progress

These services and supports helped me:

☐ Improve my independence at home and in my community
☐ Live safely at home
☐ Be more involved in my community
☐ Improve my health
☐ Engage in meaningful activities such as:
☐ Work towards the following goals/valued outcomes:

Brief summary of implementation of the Habilitation Plan(s) (if applicable):

Was a Circle Meeting held this month? ☐ No ☐ Yes

This month I used the following items that are included in my SD Plan/Budget. Check all that apply:

Don't forget to sign at the bottom of every page!

◻ Advertising for staff ◻Staff activity costs ◻Mileage – service related ◻ Household supports (including rent, utilities, repairs & maintenance, food, household supplies, insurance, etc.) ◻Personal Use Transportation ◻ Gym/health club membership ◻Equine therapy ◻Massage therapy ◻Music therapy ◻Classes
◻ Other therapy (specify):
◻ Other costs (specify):

Follow-up

Would you like to change anything about your services and supports?

☐ No ☐ Yes If yes, please describe here:

Do you have any service-related concerns that need to be addressed?

☐ No ☐ Yes
If yes, please describe here:

My Community Habilitation Staff are:

1.
2.
3.

Of the selections above, are there any new staff for this month:

☐ No ☐ Yes
If yes, Please write which staff:

Signing and submitting false information may lead to a charge of Medicaid fraud.

I received my budget tracker for the prior month (Example: You are filling out October's MSN, did you receive September's Budget Tracker?" ☐ No ☐ Yes

By signing this document, I confirm that I received the services and supports described above and that statements made about them are true:

Signature of Individual **Date (Mo/Day/Yr)**

Print name

The person identified below helped me to complete this form:

Signature of Individual **Date (Mo/Day/Yr)**

Print name **Title**