

**WEST VIRGINIA I/DD WAIVER
DIRECT SUPPORT PROGRESS NOTE**

(To be used with Traditional Service Delivery Model
and if something out of the ordinary occurs while providing services)

Name of Person Who Receives Services		Provider Agency	
Month of Service		Year of Service	

Date		Time		AM PM	Provider/Staff Initials	
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Were there any parts of the goal in which the person did especially well or poorly? Did anything out of the ordinary occur (such as illness, behaviors, etc.)? Did the person require more support than usual? How did the person respond to support and services provided?

Date		Time		AM PM	Provider/Staff Initials	
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Date		Time		AM PM	Provider/Staff Initials	
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Date		Time		AM PM	Provider/Staff Initials	
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Provider/Staff Name	Provider/Staff Signature	Provider/Staff Name	Provider/Staff Signature

