CHRONOLOGICAL NARRATIVE

State Form 46014 (R3 / 7-01) / HCBS 0008

Annual redetermination date *(month, day, year)*

☐ Aged and Disabled ☐ Autism ☐ ICF / MR ☐ Medically Fragile Children ☐ TBI ☐ AL ☐ AFC

INSTRUCTIONS: ***All remarks must be dated, signed with credentials and reflect the units of service provided. One unit of service = 1/4 hour.***

Name	Medicaid number
Address *(number and street)*	Telephone number
City, state, ZIP code	Waiver effective date *(month, day, year)*

DATE	UNITS OF SERVICE	REMARKS