



DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)  
**Companion Home Quarterly Report**

DATE PREPARED
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CLIENT NAME	COMPANION HOME PROVIDER NAME
QUARTER (SELECT ONE) <input type="checkbox"/> January / February / March 20____ <input type="checkbox"/> April / May / June 20____ <input type="checkbox"/> July / August / September 20____ <input type="checkbox"/> October / November / December 20____	

Describe the recreational, leisure, and community activities the client participated in during the quarter and how often the activities occurred.

List the client's **habilitation** goal and their progress toward the goal. What have you done with the client during the quarter to assist them to reach their habilitation goal?

Describe the client's progress toward gaining independence in the support needs and goals identified in their PCSP and assigned to the companion home provider.

Describe any Employment or Community Inclusion services the client is receiving (i.e., any Employment or Community Inclusion activities they are participating in, program name, frequency of service, and overview of progress).

Describe any healthcare or treatments the client has received during the quarter (i.e., healthcare provider's name, frequency of visits, and general overview of progress). Were there any refusals to participate in monthly evacuation drills or health care support?

Describe any illnesses, injuries, or other concerns with the client's overall health and well-being. Were incident reports completed and submitted as necessary?

SIGNATURE (OR TYPED NAME IF SUBMITTING ELECTRONICALLY)	DATE SENT TO DDA
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