

**Commonwealth of Kentucky
Cabinet for Health and Family Services
Department of Community Based Services
Division of Protection and Permanency**

Rehabilitative Services Monthly Progress Report

This form must be completed and sent to the DCBS worker by the 15th of each month.

MONTH ENDING _____
DCBS CASE MANAGER _____
CHILD NAME: _____ DOB: _____
SSN NUMBER: _____ PROVIDER/FACILITY: _____

Date of Current DPP-1293 Approval: _____
Date of Next Six-Month Review: _____

TREATMENT SUMMARY:

OVERALL GOALS/OBJECTIVES OF REHABILITATIVE SERVICES PLAN:

- DPP-1293 in development
- Remains the same as described in the rehabilitative services plan of care, DPP-1293
- Have been changed as indicated on the attached revised DPP-1293

PROGRESS NOTES:

1. **TREATMENT PLANNING AND SUPPORT-** Describe representative treatment planning and support activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

DATE	PROVIDER	ACTIVITY DESCRIPTION

2. **LIVING SKILLS DEVELOPMENT -** Describe representative skills training and development activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

DATE	PROVIDER	ACTIVITY DESCRIPTION

3. **THERAPY, EVALUATION, AND ASSESSMENT-** Describe counseling, therapy, evaluation, and assessment activities performed over the last month in support of the goals and objectives of the rehabilitative services plan of care:

DATE	PROVIDER	ACTIVITY DESCRIPTION

CASE STATUS SUMMARY

1. SUMMARIZE CHILD'S/YOUTH'S ADJUSTMENT TO FACILITY:

2. SERVICES PROVIDED TO CHILD/YOUTH AND CHILD'S/YOUTH'S FAMILY:

3. PROGRESS TOWARD RETURN OF CHILD/YOUTH TO THE HOME OR COMMUNITY (IF APPLICABLE):

4. PERMANENCY GOAL FOR CHILD/YOUTH:

5. YOUTH ON EXTENDED COMMITMENT:
 - A. Please check all that apply and include verification documentation (class schedule, unofficial transcript, paycheck stubs, documentation of medical condition, etc.)
 - Employed full-time (working at least 30 hours per week);
 - Enrolled full-time in an educational program;
 - Employed part-time and enrolled in part-time in an educational program;
 - Attending high school or a program leading to a high school diploma or a high school equivalency certificate (GED);
 - Attending college or vocational program;
 - Participating in a program or activity that promotes or removes barriers to employment;
 - Is incapable of doing any of the above due to a documented medical condition; or
 - Did not meet state requirements for extended commitment and provided a probation contract.

Total hours of employment this month: _____

B. PROGRESS TOWARD ACHIEVING INDEPENDENT LIVING MILESTONES:

NAME AND TITLE OF PERSON COMPLETING FORM: _____

(PLEASE PRINT)

SIGNATURE: _____

SUPERVISOR'S NAME AND SIGNATURE (IF REQUIRED): _____

DISTRIBUTION: Original—Child's Social Services Worker (case record), *may be emailed*
Copy—Facility/Provider File (if applicable)