DPP-1294B
R. 5/21

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 faxed, mailed, or e-mailed*
Copy—Facility/Provider File (if applicable)