**Rehabilitative Services Monthly Contact Report**

This form must be completed and entered into the PCC tracking module by the 4th 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:

MONTHLY FACE-TO-FACE CONTACT INFORMATION:

1. Date of contact: \_\_\_\_/ \_\_/20\_\_\_
2. Location of contact **(check only one)**:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Child/Youth Placement Location |  | Hospital/CSU – Mental Health |
|  | Community Outpatient Treatment |  | Jail/Detention |
|  | ER/Hospital - Medical |  | Other |

1. Service activity conducted **(check all that apply)**:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Child/Youth Evaluation |  | Independent and Transitional Living |  | Placement |
|  | Counseling Services |  | Ongoing Services |  | Transportation |
|  | Family Team Meeting |  | Parent, Child/Youth, Sibling Visitation |  |  |

1. Description of service activity including but not limited to verification of Lifebook development, review of treatment plan (including supervision plan), review of medical passport, review of educational or developmental progress, and review of visitation agreement or permanency plan.

Document specific information regarding the following components of the treatment plan:

1. Mental health/treatment plan:
2. Attachment issues:
3. Education:
4. Permanency:
5. Medical/physical health:
6. Independent living skills:
7. Compliance with court orders (if applicable):
8. Safety and supervision:

NAME AND TITLE OF PERSON COMPLETING FORM:   
  
 \_\_\_\_\_\_\_\_\_\_

(PLEASE PRINT)

SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SUPERVISOR’S NAME AND SIGNATURE (IF REQUIRED): \_\_\_\_\_

DISTRIBUTION: Original—Facility/Provider File (if applicable)