**ATTACHMENT K**

**MONTHLY REPORT-VISITATION**

**Visitation – Monthly Progress Report**

**(Monthly report should be on Provider Letterhead)**

**Report Period:\_\_\_\_1\_\_\_\_\_\_\_\_\_\_\_**

**Date to Date**

|  |  |
| --- | --- |
| **Service Provide (Service Standard)** | **Visitation 2** |
| **Parent(s) Name** | **3** |
| **Child(ren)** | **4** |
| **Begin/End Date of Referral:** | **5** |
| **Referral Agency:**  **(\_\_\_\_\_County DCS or**  **\_\_\_\_\_County Probation Office)** | **6** |
| **Case Manager/Probation Officer:** | **7** |
| **Service Provider Staff** | **8** |
| **Number of Service Unit Authorized** | **9** |
| **Number of service units delivered to end of report period** | **10** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Contact Date** | **Time** | **Duration** | **Method \*** | **Location** | **Those Present** |
| **11** | **12** | **13** | **14** | **15** | **16** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**\*Method includes such things as Face to Face (ff), Phone (ph), Collateral Contacts (cc), DCS Contacts (dcs), CFTM Attendance (cftm), Court Testimony(ct).**

**Add more lines as appropriate. ‘**

|  |  |
| --- | --- |
| **Number of Appointments cancelled by Family** | **17** |
| **Number of Appointments cancelled by Provider** | **18** |
| **No Shows** | **19** |

**20 Reason for Referral and Presenting Issues:**

**21 Family Functional Strengths:**

**22 Overall recommendation and progress summary:**

**23 24**

**Signature Date:**

**Visit Documentation:**

**Complete the following table for each visit and email to FCM within 3 days of visit. If visit is cancelled send email to FCM with information about the cancelled visit.**

|  |
| --- |
| **25 Date of Visit: (include date, location, and level of supervision)** |
| **26 Attendance at Visit ( include time of arrival and departure of all parties for the visit)** |
| **27 Observation Narrative:**  **(include the following:**   * **greeting and departure interaction between parent and child(ren);** * **planned activities by the parent for visit;** * **interventions required, if any and parent’s response to direction provided with regard to interventions;** * **ability and willingness of parent to meet child’s needs as requested by child or facilitator;** * **tasks given to the parent to be completed prior to or at the next visit, etc.)** |
| **28 Observed Strengths: (include positive interactions between parent and child)** |
| **29 Observed Issues:** |
| **30 Recommendation (include recommendation regarding level of supervision of follow up visits based on on-going demonstration of ability by the parents and comfort level of the child(ren))** |

**31 32**

**Signature Date:**

**Instructions for completing the Monthly Visitation Report**

1. **Month of Reporting:** Indicates the monthly period of time in which services were provided for example July 1 to July 31, 2010
2. **Name of Service Standard**: Visitation
3. **Parent(s) Name:** Parent Name from referral
4. **Child(ren) Name:** Child(ren) name(s) from referral
5. **Begin/End Date of Referral** Dates indicated on the referral form
6. **Referral Agency** Name of local office of DCS or Probation Office
7. **FCM/Probation** Officer: Current FCM or Probation Officer
8. **Service Provider Staff:** Name of Provider Staff who provided visitation services to the family during the reporting month.
9. **Number of Service Units Authorized:** number of maximum units indicated on the referral.
10. **Number of service units delivered to end of report period:** Total number ofservice units used since the referral begin date. Include Medicaid services if Medicaid service units were in the referral.
11. **Contact Date:** Date of contact
12. **Time:** Begin and end time
13. **Duration:** Length of contact
14. **Method \***Method includes such things as Face to Face, Phone, Collateral Contacts, DCS Contacts, CFTM Attendance, Court Testimony,
15. **Location:** Location of visit**.**
16. **Those Present**: Names of the people present for the visit.
17. **Number of Appointments cancelled by Family:** Enter the number of visits cancelled by the family during the month. Explain any issues in #20 Presenting issues in the monthly report.
18. **Number of Appointments cancelled by Provider:** Enter the number of visits cancelled by the provider during the month. Explain any issues in #20 Presenting issues in the monthly report.
19. **No Shows:** Enter the number of no shows for visits during the month. Explain any issues in#20 Presenting issues in the monthly report**.**
20. **Reason for Referral and Presenting Issues:** Reason as indicated on the Referral and presenting issues determined while working with the family.
21. **Family Functional Strengths:** include strengths of the family**.**
22. **Overall recommendation and progress summary:** Summarize the families’ progress and include all recommendations.
23. **Signature:** Signature of person completing the report.
24. **Date:** Date of Signature

**The above information should be completed by the provider on a monthly basis for visits. Recommend that it be completed and sent to FCM by the 10 of the month following service delivery.**

**The information below shall be completed for each visit. It should be sent to the FCM within 3 days of the visit. Cancelation and no shows should be reported to the FCM as soon as possible.**

1. **Date of Visit:** include date, location, and level of supervision
2. **Attendance at Visit:** Include all individuals who attended the visit,Include time of arrival and departure of all parties for the visit.
3. **Observation Narrative**: Include all significant observations from the visit,including the following:

* greeting and departure interaction between parent and child(ren);
* planned activities by the parent for visit;
* interventions required, if any and parent’s response to direction provided with regard to interventions;
* ability and willingness of parent to meet child’s needs as requested by child or facilitator;
* tasks given to the parent to be completed prior to or at the next visit, etc.)

1. **Observed Strengths:** include positive interactions between parent and child
2. **Observed issues:** include the needs of the parent in the interactions with their child
3. **Recommendation:** include recommendation regarding level of supervision of follow up visits based on on-going demonstration of ability by the parents and comfort level of the child(ren)
4. **Signature:** Signature of person completing the report.
5. **Date:** Date of Signature

**ATTACHMENT K**

**Monthly Progress Report**

**(Monthly report should be on Provider Letterhead)**

**Report Period:\_\_\_\_\_\_\_1\_\_\_\_\_\_\_\_**

**Date to Date**

|  |  |
| --- | --- |
| **Parent(s) Name** | **2** |
| **Child(ren)** | **3** |
| **Referral Agency:**  **(\_\_\_\_\_County DCS or \_\_\_\_\_County Probation Office)** | **4** |
| **Case Manager/Probation Officer:** | **5** |
| **List Service Standard** | **Provider Agency Staff for each Service** |
| **6** | **7** |
|  |  |
|  |  |

**8 Reason for Referral and Presenting Issues:**

**9 Family Functional Strengths:**

**10 Overall recommendation and progress summary:**

**11 Next scheduled contact with family: \_\_\_\_\_\_\_\_\_**

**12 13**

**Signature Date:**

**Individual Service Standard Monthly Report**

**Report Period:\_\_\_\_\_14\_\_\_\_\_\_to\_\_\_\_\_\_\_\_\_\_\_\_**

***Complete the following information for each DCS service standard***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Service Provide (Service Standard)** | | | | | **15** | |
| **Begin/End Date of Referral:** | | | | | **16** | |
| **Service Provider Staff** | | | | | **17** | |
| **Number of Service Unit Authorized** | | | | | **18** | |
| **Number of service units delivered to end of report period** | | | | | **19** | |
| **Contact Date** | **Time** | **Duration** | **Method** | **Location** | | **Those Present** |
| **20** | **21** | **22** | **23** | **24** | | **25** |
|  |  |  |  |  | |  |
|  |  |  |  |  | |  |
|  |  |  |  |  | |  |

**\*Method includes such things as Face to Face(ff), Phone(ph), Collateral Contacts(cc), DCS Contacts(dcs), CFTM Attendance (cftm), Court Testimony (ct), ‘**

**Add more lines as appropriate.**

|  |  |
| --- | --- |
| **Number of Appointments cancelled by Family** | **26** |
| **Number of Appointments cancelled by Provider** | **27** |
| **No Shows** | **28** |

***Complete the following for each Goal: (Duplicate as needed)***

|  |
| --- |
| **29 DCS Service Goal:** |
| **30 Narrative Discussion of Services provided for this goal during month:** |
| **31 Progress Summary toward goal:** |
| **32 Family cooperativeness:** |
| **33 Recommendation regarding services for goal**  **(Continue: Reason or End: Reason)** |

**34 35**

**Signature Date:**

**Instructions for completing the Monthly Report**

1. **Report Period:** Indicates the monthly period of time in which services were provided for example**,** July 1 to July 31, 2010
2. **Parent(s) Name:** Parent Name from referral
3. **Child(ren) Name:** Child(ren) name(s) from referral
4. **Referral Agency** Name of local office of DCS or Probation Office
5. **FCM/Probation Officer**: Current FCM or Probation Officer
6. **List Service Standard:** List the DCS Service Standard as indicated on the referral.
7. **List Provider Staff:** List the name of the staff member who provided the services for the family for the corresponding service standard.
8. **Reason for Referral and Presenting Issues:** Reason as indicated on the Referral and presenting issues determined while working with the family.
9. **Family Functional Strengths:** Include strengths of the family**.**
10. **Overall recommendation and progress summary:** Summarize the families’ progress and include all recommendations.
11. **Next Scheduled Contact with Family:** Indicates the date of the next scheduled meeting with the referred family.
12. **Signature:** Signature of person completing the report.
13. **Date:** Date of Signature

**The above information should be completed by the provider on a monthly basis as a summary for all services provided. Recommend that it be completed and sent to FCM by the 10 of the month following service delivery.**

**The information below shall be completed for each service (per service standard) It should be attached to the above sheet. Cancelation and no shows should be reported to the FCM as soon as possible by phone or email.**

1. **Report Period:** Indicates the monthly period of time in which services were provided per report for example July 1 to July 31, 2010
2. **Service Provided (Service Standard):** Name of DCS Service Standard as indicated on the referral.
3. **Begin/End Date of Referral:** Dates as indicated on the referral.
4. **Service Provider Staff:** List the staff that provided service under the service standard during the reporting month.
5. **Number of Service Units Authorized:** Number of maximum units indicated on the referral.
6. **Number of service units delivered to end of report period** Total number ofservice units used since the referral begin date. Include Medicaid services if Medicaid service units were in the referral.
7. **Contact Date:** Date of contact.
8. **Time:** Begin and end time
9. **Duration:** Length of contact
10. **Method \***Method includes such things as Face to Face (ff), Phone (ph), Collateral Contacts (cc), DCS Contacts (dcs), CFTM Attendance (cftm), Court Testimony (ct),
11. **Location:** Location of service**.**
12. **Those Present**: indicates all individuals present for services.
13. **Number of Appointments cancelled by Family:** Enter the number of visits cancelled by the family during the month. Explain any issues in #8 Presenting issues in the monthly report.
14. **Number of Appointments cancelled by Provider:** Enter the number of visits cancelled by the provider during the month. Explain any issues in #8 Presenting issues in the monthly report.
15. **No Shows:** Enter the number of no shows for visits during the month. Explain any issues in#8 Presenting issues in the monthly report**.**

**Complete the following for each goal, duplicate as needed.**

1. **Service Goal:** Enter the DCS goal for the service
2. **Narrative Discussion of Services provided for this goal during month:** A monthly narrative of services should be included for each corresponding goal.
3. **Progress Summary toward goal:** enter progress toward goal
4. **Family Cooperativeness:** enter the willingness of the family to accept services
5. **Recommendation regarding services for goal (Continue: Reason or End Reason):** A recommendation should be provided for each corresponding goal.
6. **Signature:** Signature of person completing the report.
7. **Date:** Date of Signature