**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 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **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 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

1. **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:
	1. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. 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)