ATTACHMENT J

Monthly Progress Report
(Monthly report should be on Provider Letterhead)
Report Period:_____1_____
Date to Date
See www.in.gov/dcs/3395.htm for attachment

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.

14 **Report Period:** Indicates the monthly period of time in which services were provided per report for example July 1 to July 31, 2010
15 **Service Provided (Service Standard):** Name of DCS Service Standard as indicated on the referral.
16 **Begin/End Date of Referral:** Dates as indicated on the referral.
17 **Service Provider Staff:** List the staff that provided service under the service standard during the reporting month.
18 **Number of Service Units Authorized:** Number of maximum units indicated on the referral.

19 **Number of service units delivered to end of report period** Total number of service units used since the referral begin date. Include Medicaid services if Medicaid service units were in the referral.
20 **Contact Date:** Date of contact.
21 **Time:** Begin and end time
22 **Duration:** Length of contact
23 **Method** *Method includes such things as Face to Face (ff), Phone (ph), Collateral Contacts (cc), DCS Contacts (dcs), CFTM Attendance (cftm), Court Testimony (ct),
24 **Location:** Location of service**.**
25 **Those Present**: indicates all individuals present for services.
26 **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.
27 **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.
28 **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.

29 **Service Goal:** Enter the DCS goal for the service
30 **Narrative Discussion of Services provided for this goal during month:** A monthly narrative of services should be included for each corresponding goal.
31 **Progress Summary toward goal:** enter progress toward goal
32 **Family Cooperativeness:** enter the willingness of the family to accept services
33 **Recommendation regarding services for goal (Continue: Reason or End Reason):** A recommendation should be provided for each corresponding goal.
34 **Signature:** Signature of person completing the report.
35 **Date:** Date of Signature