**Credentialed Provider Documentation Form**

**Therapeutic Support and Support Staff Service**

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| --- | --- |
|  | **Invoice:**       |
| **Agency Name:**           |
| **Agency Address:**       | **City:**       | **State:**    | **Zip:**       |
| **Agency Phone:** (   )    **-**      |
| **\*\* Complete form for each visit \*\*** |
| **Child's Name:**      | **DOB:**    /    /     | **Case ID:**       |
| **Other Info:**       |
| **Referring Office:**         | **Child ID:**       | **Case Name:**       |
| DCF Worker:       | Phone: (   )    **-**      | Email:       |
| DCF Supervisor:       | Phone: (   )    **-**      | Email:      |
| Service Type (Name):        | Date of service:    /    /     |
| Staff Name:        |
| Proposal Approval Period:       | Total Number of Hours:       |
| **Location where service occurred**:       |
| **Goals as identified by the DCF Social Worker:** |

1.
2.

|  |
| --- |
| **What was the activity on this date?** |

|  |
| --- |
| How does this activity connect with the **goal(s)** listed above: |

|  |
| --- |
| **Strengths of visit:** |

|  |
| --- |
| **Describe the area(s) that require more support:** |

|  |
| --- |
| **Based on today’s visit, what is the plan for the next visit to address unmet goals to build on success:** |

**Submitted by (Name and signature):**

**Submitted on (date):**    /    /