**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:** | | | | | |



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

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

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| **Strengths of visit:** |

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

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| **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):**    /    /