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| **Credentialed Provider Documentation Form****Supervised Visitation Service** | **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:        |
| Name of Individual providing Transportation (if different):       |
| Proposal Approval Period:       | Total Number of Hours:       |
| **Location where service occurred**:       |
| **Name of Individual(s) attending today’s visit:** |
| 1.       |
| 2.        |
| 3.       |
| **Please describe your observation of:** |

**PARENT:**

**CHILD:**

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| **Please describe your observation of the parent child interaction (including strengths and challenges)** |

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| **Was there a need to intervene for safety reason? If yes, please describe.** |

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| **Describe the feedback provided to the family following the visit.** |

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

**Submitted on (date):**    /    /