Socially Necessary Services Monthly Report

Provider Name		Service Month	
FACTS # of all clients receiving services		Date of Report	
Staff name completing report		Client Name	
Client # of all clients receiving services		DHHR Worker & County	
Client Address and Contact Information			

Referral Information/Services Requested:

Click or tap here to enter text.

Treatment Goals as outlined by DHHR, MDT, Terms/Conditions of Period of Improvement:

Click or tap here to enter text.

Dates of service completed, contacts, and cancelled appointments:

Date	Service	Time start and stop	Individuals present for service or reason for cancellation	Mileage

Summary of Services Provided:

Service	Staff member who provided services	Lesson provided & curriculum used	Observations	How did the service address issues?

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Progress towards treatment goals and increase of safety/decrease of risk:

Click or tap here to enter text.

Additional presenting problems, barriers, and unmet needs:

Click or tap here to enter text.

Community referrals and linkage to other services and support:

Click or tap here to enter text.

Recommendations:

Click or tap here to enter text.

I certify, on behalf of the provider listed herein, the services described in this report have been provided to the family.

Authorized Agency Representative (print)	
Signature	
Title	

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Date	
Contact Information	