

TREATMENT PROGRESS/TERMINATION REPORT

COVERAGE PERIOD: _____

CLIENT: _____ LEVEL OF CARE: Option 2 Outpt Counseling (Juv Sub Abuse)
Last Name First Name

INITIAL DATE OF THIS LEVEL OF CARE: _____

AGENCY: _____ CLINICIAN: _____

PHONE: _____ REPORT DATE: _____

OFFICER: _____ *Note* Monthly reports should be received by 7th of each month

TREATMENT PROGRESS

Attendance: Attended all scheduled groups/appts. this month

*Dates Not Attended: _____ Dates Excused : _____

Batterers Group Attendance: # _____ of _____ weeks

	Problematic				Fully Compliant	
	1	2	3	4	5	n/a
Progress in knowledge learned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Actively participates - self disclosure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progress in skill level – practicing skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Progress related to treatment goals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

REPORT NARRATIVE *(required)*:

Is the client demonstrating financial responsibility with the provider? Yes No

If no, what is client's plan to get current?

Present balance: \$ _____ Payment plan: \$ _____ per month/session

TERMINATION

As the provider, I confirm the client is terminated with the following *(mark all that apply)*:

- 1 - met minimum requirements
- 2 - successful
- 3 - unsuccessful*
- 4 - legal consequences recommended for further violations

* If unsuccessful, due to:

Recommendation(s) for other programming: