

## Specialized Habilitation 90-Day (Quarterly) Report

CLIENT NAME		CASE MANAGER NAME	
PROVIDER NAME		PROVIDER AGENCY NAME	
DATE INITIAL PLAN WAS WRITTEN OR REVISED		DATE RANGE FOR THIS REPORT	
TARGETED CATEGORIES OF SPECIALIZED HABILITATION (AS IDENTIFIED IN THE INITIAL PLAN FORM, DSHS 10-657) <input type="checkbox"/> Self-Empowerment <input type="checkbox"/> Safety Awareness and Self-Advocacy <input type="checkbox"/> Interpersonal Effectiveness and Effective Social Communication <input type="checkbox"/> Coping Strategies regarding Everyday Life Challenges <input type="checkbox"/> Managing Daily Tasks and Acquiring Adaptive Skills			
Goals and objectives address as they appear in Policy 4.20. No more than three per plan.			
Goal 1			
Goal 2			
Goal 3			
If any new treatment goals are identified, Specialized Habilitations Initial Plan must be revised.			
Treatment strategies utilized for each goal above			
Goal 1			
Goal 2			
Goal 3			
Summarize progress towards goal achievement in objective and measurable terms.			Goal completion, using a scale from 1 – 10 (10 being goal is met)  Goal 1:  Goal 2:  Goal 3:
If progress has not been made, include alternate strategies planned.			
Goal 1			
Goal 2			
Goal 3			
List referral recommendations if the waiver participant presents with potential underlying medical, mental health, or educational support needs:			
When did you provide Staff and Family Consultation (dates / times of service in the last 90 days)?			
DATE	SERVICE DELIVERY (CHECK DELIVERY METHOD)		TIME SPENT (IN 15 MINUTES)
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice		
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice		
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice		
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice		
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice		



## Instructions for Specialized Habilitation Quarterly Progress Report

**Client Name:** Add in the name of the client.

**Case Manager Name:** Include the name of the client's case manager.

**Provider Name:** Add in provider's name who is working directly with the client.

**Provider Agency Name:** Include the name of the agency that the clinician working with the client works for.

**Date plan as written or revised:** Include when this plan was completed.

**Today's Date:** This is the date this form is being written.

**Targeted categories of Specialized Habilitation:** Check the box according to the category of Specialized Habilitation that the client would like to work with. Do not check more boxes than goals. Example: If the client has three (3) goals (which is the maximum at any time), there must only be three (3) or less boxes checked. There may be multiple goals that fit under one category, so it is possible to have three (3) goals, but only two (2) boxes checked in this area.

**Treatment strategies utilized for each goal:** What methods and techniques have been used to support the client? Describe them here.

**What is the expected frequency and duration of the service?** Describe how long the service of Specialized Habilitation is expected to last until the client is able to reach their goal. How often will the client need to work with the provider in order for them to reach their goal? Example: Once per week for two (2) hours, for the next three (3) months.

**List referral recommendations:** If the client presents with potential underlying medical, mental health, or educational support needs (referral may be to Care Coordinator, treating professional, or DDA), list in this section any referrals necessary for the client that are outside of what Specialize Habilitation can provide. Consideration examples: Are there any concerns of client's mental health presentation or education needs for school aged client? Does the client need referral to resources that they are not connected with yet?

**Dates and Times of service in the last 90 days:** Document here when Specialized Habilitation was provided, through what kind of service delivery (in-person or through telehealth), and then how much time was spent.

**Client Signature:** The client must sign here.

**Legal Representative Signature:** When applicable, the client's legal representative needs to sign here, agreeing to this initial plan.

**Provider Signature:** The Specialized Habilitation provider will sign here.