

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)
**Staff and Family Consultation (SFC) 90-Day (Quarterly)
 Progress Report**

CLIENT NAME	CASE MANAGER NAME
PROVIDER NAME	PROVIDER AGENCY NAME
DATE OF INITIAL PLAN	DATE RANGE FOR THIS REPORT

Staff or Family (S/F) member consultation goal and summary of their progress in the last 90 days:

Needed support to assist S/F in working toward their goal: check all that apply.

Observation of S/F member actions
 Modeling appropriate techniques to S/F
 Phone consultation
 Referral to family support group or advocacy organization

Describe:

If the client has a current therapeutic plan in which the consultation is being provided on, are there new needs the family or staff member is reporting that should be communicated to the therapist? Yes No

If yes, please briefly explain:

Barriers to the staff or family member meeting their goal(s) / recommended changes to the Initial Plan:

Referrals provided since the last report, in the last 90 days, or significant change in client presentation observed in the last 90 days (include date of referral, if applicable):

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)
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Signatures

CLIENT SIGNATURE	DATE	LEGAL REPRESENTATIVE SIGNATURE	DATE
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PROVIDER SIGNATURE	DATE
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Instructions for Staff and Family Consultation Progress Report Form
(To be completed by the provider.)

Client: Add in client's name.

Provider: Add in the name of the Staff and Family Consultation provider

Case Manager: Add in the name of the client's current case resource manager.

Waiver: Add in what waiver the client is enrolled on.

Report Date Range: What date range is this progress report reporting on? Identify the months that the provider has delivered Specialized Habilitation for which this report is discussing. Example: January, February, March.

Staff or Family (S/F) member consultation goal and summary: Document what the goal of the staff or family member. This goal should match what was identified in the Staff and Family Initial plan. Document the staff or family's progress in the last 90 days.

Needed support: Document what the provider will be doing with the family or staff to help them reach their goals for Staff and Family Consultation.

Is there a current therapeutic plan? Document if the client has a current therapeutic plan in which the consultation is being provided on, and if there are any new needs that should be communicated to the professional writing the treatment plan?

Barriers to meeting goal(s): Document any barriers or challenges experienced in helping the staff or family member and any recommended changes to the Initial Plan.

Referrals: Document any barriers, challenges, or changes to the staff and family consultation in the last 90 days. (Include date of referral, if applicable).

When did you provide Staff and Family Consultation? Document dates that Staff and Family Consultation was provided. In-person service delivery and teleservice delivery need to be identified. In the last column, identify how long you worked with the client each day (example: one (1) hour).

Client Signature: Sign your name here. This means you agree with this form, and you agree with it.

Legal Representative Signature: Legal representatives sign here, when applicable. This means they agree with this form and agree with it.

Provider Signature: Sign your name here.