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|  |  DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA) **DDA Specialty Adult Family Home (AFH) Pilot** **Monthly Client Goal and Progress Report** |
| CLIENT’S NAME | AFH NAME AND COUNTY |
| NAME OF INDIVIDUAL COMPLETING REPORT | TELEPHONE NUMBER | REPORTING MONTH AND YEAR |
| LEGAL REPRESENTATIVE’S NAME(IF APPLICABLE) | CASE RESOURCE MANAGER’S NAME | REQUEST BEHAVIORAL CONSULTATION?[ ]  Yes [ ]  No |
|  |
| 1. Goal  of :

Describe Client’s goal: |
| List each step of the goal (e.g., shopping: making a list; following a budget, cost-comparing; transportation to / from shopping; paying for purchases; social interactions while shopping). |
| Start of the Month Skill Level (1 – 10) | Levels 1 – 4 Learning Skill (Full Support to Significant Support Needed)Levels 5 – 9 Gaining Skill (Moderate Support to Lessening Support Needed)Level 10 Mastered Skill (Minimal to No Support Needed) | End of the Month Skill Level (1 – 10) |
| **AFH Provider Reporting** |
| Describe client skills at start of month: |
| Describe specific teaching and training provided and effectiveness (modeling, prompting, step-by-step demonstration, role playing practicing, reinforcing): |
| Describe client skills at end of month: |
| Total number of days this month: Total number of hours this month: In the monthly calendar below please write in the number of hours spent with the client working on the goal: |
| **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** | **11** | **12** | **13** | **14** | **15** | **16** | **17** | **18** | **19** | **20** | **21** | **22** | **23** | **24** | **25** | **26** | **27** | **28** | **29** | **30** | **31** |
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| INDIVIDUAL’S / LEGAL REPRESENTATIVE’S SIGNATURE DATE |
| PROVIDER’S SIGNATURE DATE |
| SPECIAL NOTES |  |
| Specialist initials:  Date reviewed:   |