



## Staff and Family Consultation (SFC) 90-Day (Quarterly) Progress Report

WAIVER PARTICIPANT'S NAME		PROVIDER'S NAME	
CASE MANAGER'S NAME		REPORT DATE RANGE	
CURRENT WAIVER			
DATE OF SERVICE	HOURS WORKED	FAMILY OR STAFF NAME	
Staff or Family (S/F) member consultation goal:			
<p>Needed support to assist S/F in working toward their goal: check all that apply.</p> <p><input type="checkbox"/> Observation of S/F member actions</p> <p><input type="checkbox"/> Modeling appropriate techniques to S/F</p> <p><input type="checkbox"/> Phone consultation</p> <p><input type="checkbox"/> Referral to family support group or advocacy organization</p> <p>Describe:</p>			
<p>If the client has a current therapeutic plan, are there new needs the family or staff member is reporting that should be communicated to the therapist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please briefly explain:</p>			
Summary of the progress towards achievement of SFC goal(s):			

Barriers to meeting 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:

<b>Signatures</b>			
PROVIDER'S SIGNATURE	DATE	LEGAL REPRESENTATIVE'S SIGNATURE	DATE
WAIVER PARTICIPANT'S SIGNATURE	DATE	DDA CASE / RESOURCE MANAGER'S SIGNATURE	DATE