



2008 MONTHLY PROVIDER REPORT TO TEAM / SUPPORTING LHCP

Child's Name:	Month:	Sessions Attended (e.g. 3/4):
Srvc Coord:	DOB:	IFSP Authorization Dates:
Date referral received:		Date Service Began this authorization:
Date of Most Current HELP Strands:		Supporting LHCP for ITDS:
Reason for any missed sessions:		Medicaid #:

Outcomes, criteria, timelines	Met / Not Met	Description of Progress
IFSP Outcome / Family Concerns		
IFSP Criteria for Progress / Goals		
3 Months		
6 months		

IFSP Strategies Used	Plan for Next Month

Questions or Comments to Team

Team review request yes/no Reason:

Provider Signature _____ **Date** _____
 (Type your name and credentials here)

To the best of my knowledge the above information is true. I understand this form will become part of the child's permanent file, and the family has the right to view its contents.