

Contact Record Form
The Institute for Behavior Change, Inc

CLIENT'S NAME: _____ **CURRENT DSM IV Axis I diagnosis code:** _____

TSS Started:	BS Started:	MT Started:	PSY Started:
TSS Expires:	BS Expires:	MT Expires:	PSY Expires:

County: _____

BSC NAME: _____

<i>DO NOT USE THIS FORM AFTER</i>												
Service Date	Start Time	Stop Time	EVAL						Transportation TO		Recipient Signature	
				TS1	TS2	TS3	BS	MT	START	STOP		
TOTAL HOURS				T1	T2	T3	BS	MT	*Reminder: Only travel time of 1 hour or more is payable and only travel time TO your client is paid, NOT travel home.			

If all assigned hours were not utilized, please provide a reason as to why and a plan to make up the lost hours

- 1 Family wants NO services 2 Child unavailable 3 Family will wait for a particular provider 4 Staff unavailable, substitute NOT wanted (up to 2 weeks)
 8 Unsafe setting 9 Staff unavailable; substitute WANTED 10 Staff unavailable, substitute NOT wanted (more than 2 weeks) 11 Alternative services provided

Notes	Office Use Only
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I certify that I have delivered the services listed above. I understand that payment for these services will be from federal and state funds, and that any false claims, statements, documents, or concealment of material *is illegal* may be prosecuted under applicable federal and state laws.

Provider's Signature: _____

Phone: _____