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| --- | --- | --- | --- |
| New Jersey Department of Children and Families**Division of Children’s System of Care** |  | **CONFIDENTIAL** **Service Delivery Encounter Documentation Form** |  |

**1. Service Recipient’s Name 8. Service(s) 9. Authorization No. 10. Start Date 11. End Date 12. Units Authorized**

 **IIC/IH-Master**

 **IIC/IIH-Licensed**

 **Last Name First Name Middle Initial Respite** - - - -

 **Other**

**2. Recipient DOB 3. Recipient Gender 4. Recipient CYBER ID Number**  **Mo. – Day – Year Mo. – Day – Year**

 **Male Female IIC/IH-Master**

 **IIC/IIH Licensed**

**Mo. – Day – Yr. Respite** - - - -

 **5. Recipient Medicaid Number Other Mo. – Day – Year Mo. – Day – Year**

 **IIC/IIH Masters**

 **IIC/IIH Licensed** - - - -

 **6. Recipient Home Address Respite**

 **Other Mo. – Day – Year Mo. – Day – Year**

 **Street**

 **City State Zip**

**7. Recipient Telephone Number & Area Code ( ) - -**

**13. IIC/IIH Masters Level Certification**

**13a. Name and Medicaid Provider Number 13b. Business Address 13c. Business Phone 13e. Progress Notes on File 13f. IIC/IIH Masters Level Certification I certify that I possess at least the minimum credentials ( ) - - Yes No required to provide IIC/IIH Masters services and I delivered**

 **those services as indicated on this form.**

 **Last Name First Name Street**

 **13d. Clinical Supervisor’s Name and Licenses Number IIC IIH**

 **Medicaid Provider ID**

 **City State Zip**

 **Name License Number Signature**

**14. IIC/IIH Licensed Level Certification City State Zip**

**14a. Name and Medicaid Provider Number 14b. Business Address 14c. Business Phone 14e. Progress Notes on File 14f. IIC/IIH Licensed Level Certification I certify that I possess at least the minimum credentials ( ) - - Yes No required to provide IIC/IIH Licensed services and I delivered**

 **Street those services as indicated on this form.**

 **14d. Clinical Supervisor’s Name and Licenses Number IIC IIH**

 **Medicaid Provider ID**

 **City State Zip**

 **Name License Number Signature**

**17. Respite Worker**

**17a. Name and Medicaid Provider Number 17b. Business Address 17c. Business Phone 17e. Progress Notes on File 17f. Respite Worker I certify that I possess at least the minimum credentials ( ) - - Yes No required to provide respite services and I delivered**

 **Street those services as indicated on this form.**

 **17d. Clinical Supervisor’s Name and Licenses Number**

 **Medicaid Provider ID**

 **Name License Number Signature**

**18. Other**

**18a. Name and Medicaid Provider Number 18b. Business Address 18c. Business Phone 18e. Progress Notes on File 18f.Other I certify that I possess at least the minimum credentials Yes No required to provide services and I delivered**

 **Street ( ) - - those services as indicated on this form.**

 **18d. Clinical Supervisor’s Name and Licenses Number**

 **Medicaid Provider ID**

 **Name License Number Signature**

**19. For Provider Use Only**