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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**