BSC Name: ___________________
Client Name: __________________

Luzerne Intermediate Unit 18
368 Tioga Avenue
Kingston, Pa. 18704
(570)718-4682
Provider 50 Services: Treatment Documentation

Client: ____ Date of Birth: ___________________
BSC/MT/TSS: _________________________________ Date of Service: _________________
Start Time: __________End Time: _________________ Total Time: _____________________

TREATMENT GOAL/OBJECTIVE WITH TARGET AND REPLACEMENT BEHAVIOR:

1.

2.

3.

LOCATION: ___HOME___ SCHOOL ___ OTHER (Specify) ______________________________
Who was present: ___PARENT ___TEACHER ___CLIENT ___BSC ___OTHER (specify) ____
____

SPECIFIC INTERVENTIONS (From the Goal Treatment Plan) UTILIZED IN WORKING TOWARDS THE ABOVE GOALS:

CLIENT'S SUCCESS AND RESPONSE AS A RESULT OF THE INTERVENTIONS UTILIZED:

BSC Name: ___________________
Client Name: __________________

CAREGIVER'S/TEACHER'S INVOLVEMENT WITH PROVIDING THE INTERVENTIONS:

COMMENTS: SIGNIFICANT EVENTS, ANTECEDENTS, BEHAVIOR TRENDS, REGRESSIONS, IMPROVEMENTS

NEXT SCHEDULED DATE OF SERVICE: ____

SERVICE OVERLAP DOCUMENTATION:
DATE: _________________ START TIME: _________________ END TIME: __________________

NARRATIVE:

MA Eligibility – Date EVS contacted this week: _______________________

TSS Signature and Degree: _____________________________ Date of Note: _______________
BSC/MT Signature: ___________________________________ Date: _____________________
Reviewed by/Supervisor Signature: ______________________ Date Reviewed: _____________

Signatures on this document indicate that the above information is accurate. I understand that providing LIU#18 with false or misrepresented information may jeopardize my board approval status with P50 services. It is imperative that all services documented on this form are provided in the utmost ethical and professional manner.

CLIENT AUTHORIZATION PERIOD: ____________ TO ____________ (PLEASE REFER TO ASSIGNMENT SHEET)