

Outpatient Therapy

Family Therapy

Date of service *

Member Name *

Start Time & Duration *

Location of the service (Home, Community, or Office) **

Goal of service, which must coincide with a current treatment plan *

Summary of the intervention/service *

List the relationship of all family participants **

Member progress and/or response to intervention *

Plan for the next session ***

Signature & Credentials of the person providing the service. Electronic Signature & Title is acceptable. *

Key:

* Medicaid Requirement - KMAP General Benefits 8/1/2008; KMAP non-PAHP Manual 8/1/2008; KMAP SED 8/1/2008

** KHS Requirement - Effective January 1, 2009

*** KHS Suggestion - Effective January 1, 2009