Clinical Service Monthly Review
Month of Service: XX/XX/XX

Service Recipient:	
Behavior Service Provider:	
ISC:	
Residential Provider:	
Day Service Provider:	

SERVICE STATUS

Service Phase:	☐ Assessment ☐ Treatment ☐ Maintenance ☐ Discharge
Service Documents Currently in Use:	☐ BSP: Unrestricted Procedures/ Implementation date: _____/_____/_____ ☐ BSP: Restricted Procedures / Implementation date: _____/_____/_____ ☐ With programmatic restraint ☐ With protective equipment ☐ With other restricted interventions or rights restrictions related to behavior (specify): _____ ☐ BMP: Behavior Maintenance /Implementation date: _____/_____/_____
Documented Frequency of Application of Restricted Interventions	_____ # Documented Applications of Emergency Manual _____ # Documented Applications of Emergency Mechanical _____ # Documented Applications of Emergency Protective Equipment _____ # Documented Applications of Emergency Psychotropic Medication (Chemical Restraint) _____ # Documented Applications of Programmatic Manual Restraint _____ # Documented Applications of Programmatic Mechanical Restraint _____ # Documented Applications of Mechanical Restraint _____ # Documented Applications of Other Restricted Interventions _____ # Documented Applications of Other Rights Restrictions Linked to Behavior (specify) _____ _____

BEHAVIOR SERVICE OBJECTIVES REVIEWED THIS MONTH	**PROGRESS** *Check one for each objective*
	☐ No progress ☐ Progress ☐ Objective attained
	☐ No progress ☐ Progress ☐ Objective attained
	☐ No progress ☐ Progress ☐ Objective attained

SERVICE IMPLEMENTATION

Implementation reliability:	☐ 80% or greater	☐ 79% or less*

* Describe recommendation or plan to restore to 80% or greater in Recommendations and Planning Section

PROGRESS TOWARD THE ISP OUTCOME (Specify Outcome)

_____

Graphical Display

Clinical Interpretation*

* Include an indication regarding whether the current behavior service plan is meeting the service recipient's needs. Include events (e.g., health-related; staffing issues) that may have impacted progress this month or presented a barrier to effectiveness.

BEHAVIOR SERVICES PROVIDED: MONTHLY SUMMARY

#Planned Visits _____ #Visits That Occurred _____	Explanation of difference:
#Additional Visits (e.g. on-site response to crisis calls) _____	Explanation as needed:
#Total Service Units Approved: _____	Explanation of difference:

#Total Service Units Used: _____	
# Service Units for Staff Training _____	Explanation:

RECOMMENDATIONS AND PLANNING

Behavior services and behavior plan are meeting needs. Continue behavior services as currently authorized.	☐ Yes ☐ No*	*Describe the recommended changes, including any need to change to a different behavior intervention, and why:
Initiate communication to consider revision, modification, or amendment to ISP and Plan of Care.	☐ Yes ☐ N/A	Describe recommended changes and why: If recommended change involves amending cost plan service authorization, specify changes and why:
Recommendation(s) to address identified barriers to effective service:	☐ Yes ☐ N/A	Describe recommendations and why:
Recommendation(s) to address identified reliability of 79% or less:	☐ Yes ☐ N/A	Describe recommendations and why:
Other recommendations (as needed):		

_____

Signature
Title/Credentials
Date of Review Completion

Distribution of CSMR:

___ISC or Case Manager
___Regional Office Behavior Analyst Director
___Others (Specify)_____