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CASE MANAGEMENT MONTHLY TREATMENT REPORT		This from must be completed and submitted with each Monthly Billing Additional sheets may be used.
1. PROGRAM NAME:	1a. USPO/USPSO NAME:	2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS)
3. CLIENT NAME:	3a. PACTS NO.	4. FOR PERIOD COVERING
5. PRETRIAL CLIENT: ☐ Yes ☐ No	6. CLIENT EMPLOYED: ☐ Yes ☐ No ☐ Student ☐ Other	7.CLIENT BENEFITS RECEIVED ☐ SSI ☐ SSDI ☐ Medi-Cal ☐ Medicare ☐ Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Services (Name and No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)

9. COMMENTS REGARDING PROGRESS

a. List case management goals of achieving benefits or linkage to County Services addressed this month (☐ Met ☐ Not Met):

b, Describe steps taken toward achieving these goals this month:

c. Describe status of each goal:

d. If goals are not yet achieved and continued case management is recommended, discus the plan for next month (☐ Recommended ☐ Not Recommended)

SIGNATURE OF COUNSELOR:	DATE:

DISTRIBUTION: ORIGINAL CONTRACTOR

PROB 46
(Rev. 06/10)

MONTHLY TREATMENT REPORT

This form must be completed and submitted with each monthly billing. Additional sheets may be used.

1. PROGRAM NAME:	USPO/USPSO NAME:	2. DATE OF CURRENT TX PLAN (ATTACH REVISIONS):
3. CLIENT NAME:	3a. PACTS NO.	4. FOR PERIOD COVERING:

5. PHASE NO.	5a. TIME IN PHASE:	6. PRETRIAL CLIENT:	7. CLIENT EMPLOYED:
		☐ Yes ☐ No	☐ Yes ☐ No ☐ Student ☐ Other

8. CONTACTS SINCE LAST REPORT

a. Date	b. Service (Name & No.)	c. Length of Contact	d. Comments (No Shows, Tardiness, Issues Addressed)	e. Copay (amount collected)

9. URINE TESTING RECORD

DATE COLLECTED	Scheduled		Sample Not Tested		Drug Use Admitted		COLLECTED BY	SPECIFIC GRAVITY	TEST RESULTS (Positive/Negative)	Copay (amount collected)
	Yes	No	Insuf. Qty.	Stall	No	Yes (specify drug)				

10. COMMENTS REGARDING CLIENT'S TREATMENT PROGRESS

a. Describe the treatment goals addressed this month (☐ Met ☐ Not Met):

b. Describe any steps taken by the client this month toward these goals (☐ Positive ☐ Negative):

c. Describe any obstacles or setbacks the client encountered this month:

d. Describe one unique way the PO/PSO can assist/support the client in treatment over the next month:

e. If continued treatment is recommended, discuss the plan for next month (☐ Recommended ☐ Not Recommended):

f. Discuss your observations of the client's behavior and commitment to treatment (☐ Positive ☐ Negative):

g. Comments:

h. Overall Progress: ☐ Acceptable ☐ Unacceptable

SIGNATURE OF COUNSELOR	DATE

DISTRIBUTION: ORIGINAL CONTRACTOR

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CASE MANAGEMENT SERVICES (MENTAL HEALTH) * 6000

The Vendor shall:

Complete the attached Case Management Monthly Treatment Report (Attachment J.4) in addition to the Prob 46 Monthly Treatment Report (MTR) and provide them both to officers bythe 10th of the month.

On a quarterly basis, provide the Mental Health Coordinator with data on number of referrals to the vendor, number of offenders successfully obtaining benefits, number of offenders successfully placed in County resources, and data demonstrating success linking offenders to any other resources such as Department of Rehabilitation or Employment Resources.

Information regarding applications pending should also be included. The option to renew BPAs for option years may be based on successful achievement of benefits and county/non contract resources.