

TREATMENT PROVIDER PROGRESS REPORT

Treatment Provider Name:
Address:

Date:
Case Name:
Case Number:
File Number:

(DPH CASC NAME/ADDRESS OF ASSESSMENT PROVIDER)

Our records indicate that _____, General Relief (GR) participant is receiving treatment in our Program. Verification of his/her progress is needed to continue the participant's eligibility to GR. Please complete this form and return it to the above DPH CASC address within five (5) workdays. If you have any questions, please contact your DPH CASC liaison.

PROGRESS DETERMINATION TO BE COMPLETED BY THE TREATMENT PROVIDER		
The above-referenced GR participant:		
<input type="checkbox"/> Is satisfactorily participating _____ hours per week		
<input type="checkbox"/> Failed to cooperate effective _____		
<input type="checkbox"/> Dropped out of treatment on _____		
<input type="checkbox"/> Successfully completed treatment on _____		
Signature of Person Completing Form:	Position:	Date:
Print Name:		

Thank you for your assistance