New Jersey Department of Human Services • Office of Children's Services

Division of Child Behavioral Health Services

CONFIDENTIAL

Intensive In-Community Service Delivery Encounter Documentation Form

1. Service Recipient's Name

Last Name | First Name | Middle Initial

2. Recipient DOB Mo. - Day - Yr.

3. Recipient Gender ☐ Male ☐ Female

4. Recipient ABSolute Number

5. Recipient Medicaid Number

6. Recipient Home Address

Street | City | State | Zip

7. Recipient Telephone Number & Area Code ( ) - Area Code

8. Service(s)	9. Authorization No.	10. Start Date	11. End Date	12. Units Authorized
☐ Behavioral Assistance ☐ IIC – Bachelors level ☐ IIC – Masters level ☐ IIC – Licensed		Mo. - Day - Yr.	Mo. - Day - Yr.	
☐ Behavioral Assistance ☐ IIC – Bachelors level ☐ IIC – Masters level ☐ IIC – Licensed		Mo. - Day - Yr.	Mo. - Day - Yr.	
☐ Behavioral Assistance ☐ IIC – Bachelors level ☐ IIC – Masters level ☐ IIC – Licensed		Mo. - Day - Yr.	Mo. - Day - Yr.	

13. For Provider Use

Service Code: ____________________ Hours per week: __

14. Behavioral Assistant Certification

14a. Name and Medicaid Provider Number: Last Name | First Name | M.I.
Medicaid Provider Number: 0023671

14b. Business Address: Street: 950 E Haverford Avenue Suite 301; City: Bryn Mawr; State: PA; Zip: 19010

14c. Business Phone: (877) 384 - 1729 (Area Code)

14d. Clinical Supervisor's Name and License Number: Name | License Number

14e. Progress Notes on File? ☒ Yes ☐ No

14f. Behavioral Assistant Certification: I certify that I possess at least the minimum credentials required to provide Behavioral Assistance services and I delivered those services as indicated on this form.

Signature

15. IIC – Bachelors Level Certification

15a. Name and Medicaid Provider Number: Last Name | First Name | M.I.
Medicaid Provider Number: 0023671

15b. Business Address: Street: 950 E Haverford Avenue Suite 301; City: Bryn Mawr; State: PA; Zip: 19010

15c. Business Phone: (877) 384 - 1729 (Area Code)

15d. Clinical Supervisor's Name and License Number: Name | License Number

15e. Progress Notes on File? ☒ Yes ☐ No

15f. IIC-Bachelors Level Certification: I certify that I possess at least the minimum credentials required to provide IIC-Bachelors services and I delivered those services as indicated on this form.

Signature

16. IIC – Masters Level Certification

16a. Name and Medicaid Provider Number: Last Name | First Name | M.I.
Medicaid Provider Number: 0023671

16b. Business Address: Street: 950 E Haverford Avenue Suite 301; City: Bryn Mawr; State: PA; Zip: 19010

16c. Business Phone: (877) 384 - 1729 (Area Code)

16d. Clinical Supervisor's Name and License Number: Name | License Number

16e. Progress Notes on File? ☒ Yes ☐ No

16f. IIC-Masters Level Certification: I certify that I possess at least the minimum credentials required to provide IIC-Masters services and I delivered those services as indicated on this form.

Signature

17. IIC – Licensed Certification

17a. Name and Medicaid Provider Number: Last Name | First Name | M.I.
Medicaid Provider Number: 0023671

17b. Business Address: Street: 950 E Haverford Avenue Suite 301; City: Bryn Mawr; State: PA; Zip: 19010

17c. Business Phone: (877) 384 - 1729 (Area Code)

17d. Progress Notes on File? ☒ Yes ☐ No

17e. Certification and License No.: I certify that I possess at least the minimum credentials required to provide IIC-Licensed services and I delivered those services as indicated on this form.

Signature | License Number

18. Agency Signatory's Certification

18a. Name and Medicaid Provider Number: Last Name | First Name | M.I.
Medicaid Provider Number: 0023671

18b. Business Address: Street: 950 E Haverford Avenue Suite 301; City: Bryn Mawr; State: PA; Zip: 19010

18c. Signatory's Phone: (877) 384 - 1729 (Area Code)

18d. Agency Name: Kaleidoscope Family Solutions, Inc.

18e. Agency Signatory's Certification: I certify that I am the authorized signatory for the agency identified at left and that services were delivered by that agency as indicated on this form.

Signature

19. For Provider Use

Job Order #: ____________ Date of Referral: ____________ Date Accepted: ____________ Taker: ____________ Filled by: ____________

Provider: ________________________ Type: ____________ Amount: ____________ Case Manager: ____________

Referral Agency: VO CMO YCM MRRS County: ____________ Client ID: ____________ Needs: ADHD Aggression Social Skills ODD ____________

NJ Department of Human Services ▪ Office of Children's Services
Division of Child Behavioral Health Services

C O N F I D E N T I A L
IIC Service Delivery Encounter Documentation Form

Service Encounter 01

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC - Licensed
☐ Individual __ Group

☒ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Encounter 02

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC - Licensed
☐ Individual __ Group

☐ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Encounter 03

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC - Licensed
☐ Individual __ Group

☐ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Encounter 04

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC - Licensed
☐ Individual __ Group

☐ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Encounter 05

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC – Licensed
☐ Individual __ Group

☐ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Encounter 06

Encounter Date ↓
__ - __ - __
Month Day Year
Encounter Time↓
Start Finish

Type of Service Delivery Site (if other than home)↓
Address of Service Delivery Site (if other than home)↓
Street
City
State Zip County

Service Delivery Site Phone↓
( ) -
Area
Services Delivered ↓
☐ Behavioral Assistance
☐ IIC – Bachelors level
☐ IIC – Masters level
☐ IIC - Licensed
☐ Individual __ Group

☐ Guardian or ☐ Responsible Party's Name↓
Guardian or Responsible Party's Address↓
Street
City
State Zip County

Guardian or Responsible Party's Certification↓
Relationship to child
My signature below certifies that services were delivered as indicated at left.
Signature
Date Signed

Service Recipient's or Guardian's Signature

1. I authorize the release of any medical or other information necessary to process claims associated with services delivered as documented on this form.
2. I request payment of government benefits either to myself or to the party who accepts assignment.
3. I authorize payment of medical benefits to the supplier(s) identified at numbers 13 through 17 on this form for services described on this form.
4. I am fourteen years old or older and certify that I have received services as documented on this form – OR –
5. I am the parent or legal guardian of a child under the age of fourteen and I certify that the child received services as documented on this form.

Signature Date Signed