

**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

**2. Recipient**

M -  Da -  Yr.  
 o            y

**3. Recipient Gender**

Male     Female

**4. Recipient ABSolute Number**

**5. Recipient Medicaid Number**

**6. Recipient Home Address**

Street   
  City   
  Stat   
  Zip

**7. Recipient Telephone Number & Area Code**

(  )  -   
 Area Code

**8.**

Behavioral Assistance  
 IIC - Bachelors level  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Behavioral Assistance  
 IIC - Bachelors level

**9.**

**10. Start Date**

M -  D -  Y  
 M -  D -  Y  
 o            a            r.  
 -            y  
 M -  D -  Y

**11. End Date**

M -  D -  Y  
 M -  D -  Y  
 o            a            r.  
 -            y  
 M -  D -  Y

**12. Units**

**13. For Provider Use**

**14. Behavioral Assistant Certification**

**14a. Name and Medicaid Provider**  
 Last Name     First Name     M  
 Medicaid Provider Number

**14b. Business Address**

200 Federal Street Ste. 227  
 Camden     NJ     08103  
 City                                  Stat                                  Zip

**14c. Business Phone**

(  86 )  98 -  266  
Area Code

**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**

**15a. Name and Medicaid Provider**  
 Last Name     First Name     M  
 Medicaid Provider Number

**15b. Business Address**

200 Federal Street Ste. 227  
 Camden     NJ     08103  
 City                                  Stat                                  Zip

**15c. Business Phone**

(  86 )  98 -  266  
Area Code

**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**  
 Last Name     First Name     M  
 Medicaid Provider Number

**16b. Business Address**

200 Federal Street Ste. 227  
 Camden     NJ     08103  
 City                                  Stat                                  Zip

**16c. Business Phone**

(  86 )  98 -  266  
Area Code

**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**  
 Last Name     First Name     M  
 Medicaid Provider Number

**17b. Business Address**

200 Federal Street Ste. 227  
 Camden     NJ     08103  
 City                                  Stat                                  Zip

**17c. Business Phone**

(  86 )  98 -  266  
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

**18. Agency Signatory's Certification**

**18a. Name and Medicaid Provider**  
 LaSorsa     Theresa  
 Last Name     First Name     M  
 Medicaid Provider Number

**18b. Business Address**

200 Federal Street Ste. 227  
 Camden     NJ     08103  
 City                                  Stat                                  Zip

**18c. Signatory's Phone**

(  86 )  98 -  266  
Area Code

**18d. Agency Name**

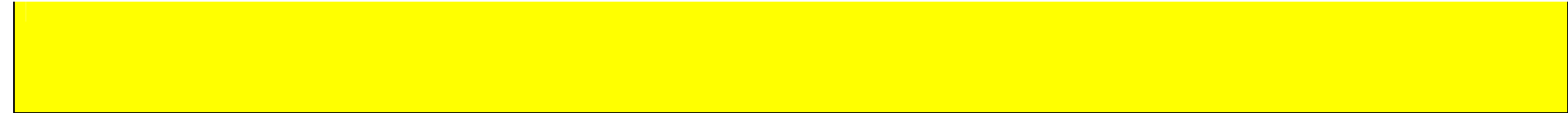
The Hammond Group Inc

**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**



**Service Encounter 01**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 Signature  
 Date Signed

**Service Encounter 02**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 Signature  
 Date Signed

**Service Encounter 03**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 Signature  
 Date Signed

**Service Encounter 04**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 Signature  
 Date Signed

**Service Encounter 05**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 Signature  
 Date Signed

**Service Encounter 06**

Encounter Date ↓  
 M - D - Y  
 Encounter Time ↓  
 Start Finish

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

Service Delivery Site Phone ↓  
 ( ) - -  
 A  
 Services Delivered ↓  
 Behavioral Assistance  
 IIC - Bachelors level  
 IIC - Masters level  
 IIC - Licensed  
 Individual Gro

Guardian  Responsible Party's  
 Guardian or Responsible Party's Address ↓  
 Street  
 City  
 St Zip County

Guardian or Responsible Party's Certification ↓  
 Relationship  
 My signature below certifies that services were delivered as  
 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

