New Jersey Department of Children and Families

# 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<br>☐ IIC – Bachelors level<br>☐ IIC – Masters level<br>☐ IIC – Licensed | | Mo. - Day - Yr. | Mo. - Day - Yr. | |
| ☐ Behavioral Assistance<br>☐ IIC – Bachelors level<br>☐ IIC – Masters level<br>☐ IIC – Licensed | | Mo. - Day - Yr. | Mo. - Day - Yr. | |
| ☐ Behavioral Assistance<br>☐ IIC – Bachelors level<br>☐ IIC – Masters level<br>☐ IIC – Licensed | | Mo. - Day - Yr. | Mo. - Day - Yr. | |

**13. For Provider Use**

## 14. Behavioral Assistant Certification

14a. Name and Medicaid Provider Number↓ — Last Name | First Name | M.I. | Medicaid Provider Number

14b. Business Address↓ — Street | City | State | Zip

14c. Business Phone↓ ( ) - — 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

15b. Business Address↓ — Street | City | State | Zip

15c. Business Phone↓ ( ) - — 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

16b. Business Address↓ — Street | City | State | Zip

16c. Business Phone↓ ( ) - — 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

17b. Business Address↓ — Street | City | State | Zip

17c. Business Phone↓ ( ) - — 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

18b. Business Address↓ — Street | City | State | Zip

18c. Signatory's Phone↓ ( ) - — Area Code

18d. Agency Name↓

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**

New Jersey Department of Children and Families
**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