

**Children's Mental Health Bureau
Supplemental Services Program (SSP)**

Provider Monthly Report For month of: _____

Agency/Facility: _____

Person Completing form: _____

Phone # _____

Address: _____

Youth: _____

Parent/Guardian: _____

Case Manager: _____

Medicaid #: _____

DOB: _____

Admit: _____

Expected Discharge Date: _____

Describe family or guardian involvement with service/treatment, including dates, of any family therapy sessions and whether they were done in person or by other means:

Describe key indications of progress in reaching service/treatment goals, as well as unresolved concerns:

Describe discharge plan (if youth has discharged early please indicate date and explain why):

Send report by mail or fax to Regional Program Officer in region of youth's home:

Region I- Novelene Martin, 219 N. Merriam, Miles City, MT 59301;	fax # 406-234-3071
Region II- Sharon Odden, M.Ed, 201 1 st St. So., Great Falls, MT 59405	fax # 406-454-6087
Region III- Novelene Martin, 219 N. Merriam, Miles City, MT 59301	fax #: 406-234-3071
Region IV- Craig Struble, 2024 9 th Avenue, Helena, MT 59601	fax # 406-444-1681
Region V- Cynthia Erler, LCSW, 2677 Palmer, Ste 300, Missoula, MT 59808	fax # 406 523-4150