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| New Jersey Department of Children and Families  **Division of Children’s System of Care** |  | **CONFIDENTIAL**  **Service Delivery Encounter Documentation Form** |

**Service Encounter 01 Type of Service Delivery Site Service Deliver Site Phone Address of Service Delivery Site (if other than home)**

**(if other than home)**

**Encounter Date**

**Street**

Mo. – Day - Year **Services Delivered Guardian or Responsible Party’s Name** IIC Masters Level IIC Licensed Level City State **Encounter Time**  IIH Masters Level IIH Licensed Level Respite Other

Individual Group **Guardian or Responsible Party’s Address**

Start Finish County Zip

**Guardian or Responsible Party’s Relationship to child**

**Street**

**Guardian or Responsible Party’s Certification**

My signature below certifies that services were delivered as indicated. City State

Signature

County Zip

Date Signed

**Service Encounter 02 Type of Service Delivery Site Service Deliver Site Phone Address of Service Delivery Site (if other than home)**

**(if other than home)**

**Encounter Date**

**Street**

Mo. – Day - Year **Services Delivered Guardian or Responsible Party’s Name** IIC Masters Level IIC Licensed Level City State **Encounter Time**  IIH Masters Level IIH Licensed Level Respite Other

Individual Group **Guardian or Responsible Party’s Address**

Start Finish County Zip

**Guardian or Responsible Party’s Relationship to child**

**Street**

**Guardian or Responsible Party’s Certification**

My signature below certifies that services were delivered as indicated. City State

Signature

County Zip

Date Signed

**Service Encounter 03 Type of Service Delivery Site Service Deliver Site Phone Address of Service Delivery Site (if other than home)**

**(if other than home)**

**Encounter Date**

**Street**

Mo. – Day - Year **Services Delivered Guardian or Responsible Party’s Name** IIC Masters Level IIC Licensed Level City State **Encounter Time**  IIH Masters Level IIH Licensed Level Respite Other

Individual Group **Guardian or Responsible Party’s Address**

Start Finish County Zip **Guardian or Responsible Party’s Relationship to child**

**Street**

**Guardian or Responsible Party’s Certification**

My signature below certifies that services were delivered as indicated. City State

Signature

County Zip

Date Signed

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 the parent or legal guardian and I certify that the child received services as documented on this form. – **OR** –

5. I am fourteen years old or older and certify that I have received services as documented on this form

**Signature Date Signed**