



TURNING POINT FAMILY CARE
PO BOX 789, WASHINGTON, UT. 84780
VOX: 435.674.7421 FAX: 435.674.3175

MONTHLY SKILLS DEVELOPMENT REPORT

Date: _____ Number of Pages to this Report: _____

Client: _____ Case Number: _____

Medicaid Number: _____ Case manager: _____

Therapist: _____ Therapist Signature: _____

Last Day of Month Served: _____

NUMBER OF GOALS LISTED OF CLIENTS TREATMENT PLAN: _____

NUMBER OF GOALS YOU RECOMMEND TO BE CLOSED THIS MONTH: _____

GOALS RECOMMENDED TO BE ADDED TO THE TREATMENT PLAN:

SDS Provider Signature



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GOAL SHEET

Client's Name: _____ Date: _____

1. **GOAL NUMBER:** _____
2. **GOAL HEADING:** _____
3. **SIGNIFICANT ACTIVITIES:** (Will client remember this activity? Did you teach it? How often?)

A. _____

B. _____

C. _____

4. **PROGRESS/LACK OF GOAL:** (Must be measurable and obtainable and related to activities)

A. _____

B. _____

C. _____

5. **CONTINUED NEED FOR SKILL:** (In your opinion, why does client still need your help on this goal)

