

The Institute for Behavior Change, Inc

CLIENT'S NAME:

TSS Home Started:	BS Started:	MT Started:	PSY Started:
TSS Home Expires:	BS Expires:	MT Expires:	PSY Expires:

County:

BSC NAME:

TSS Home:	BSC:	MT:	TSS School Auth #					Units	Start:	Stop:	
Service Date	Start Time	Stop Time	EVAL						Transportation TO		Recipient Signature
				TS1	TS2	TS3	BS	MT	START	STOP	
										Home	
										Home	
										Home	
										Home	
										Home	
										Home	
										Home	
										School	
										School	
										School	
										School	
										School	
										School	
										School	
TOTAL HOURS				T1	T2	T3	BS	MT	For TSS, only travel time of 1 hour or more is payable and only travel time <u>TO</u> your client is paid, NOT travel home.		

Target Behavior Domain	Frequency	Severity	Average

If all assigned hours were not utilized, please provide a reason as to why and a plan to make up the lost hours

Notes	Office Use Only

I certify that I have delivered the services listed above. I understand that payment for these services will be from federal and state funds, and that any false claims, statements, documents, or concealment of material *is illegal* may be prosecuted under applicable federal and state laws

Provider's Signature: _____ Phone: _____

Print Name if signature legibility is questionable: _____