**Kansas Sentencing Commission**

**RAFT Diversion Program**

**Monthly Progress Report Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Offender Name:** |  | | | | | | | | **CASE #** | |  | | | | **KBI #:** | |  | | |
|  | | First Name/M/Last Name | | | | |  | | | |  | | | |  | |  | | |
|  | |  | | | | |  | | | |  | | | | |  | |  |
| **Report For Services** | | |  | | **To** |  | | | |  | | |  | | | | | |
|  | | (m/dd/yyyy) | |  | | | | (m/dd/yyyy) | | | |  | |  | | | | |

**SB 123 Provider:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Primary Provider:** | | | |  |  | | | | | | **Date of Admission:** | | |  | | | | |
|  |  | | | | | (Treatment Provider) | | | |  | | | | (m/d/yyyy) | | | | |
|  |  | | | | | | | | | | | | | | | |
|  | ***Check Service(s) Receiving and Rate Level of Participation****:* | | | | | | | | | | | | | | | |
| **Services:** | | | | | | | **Very**  **Satisfactory** | | | **Satisfactory** | | | **Needs**  **Improvement** | | | **Relapse** | |
|  | |  | Assessment | | | | |  |  | | |  | | |  | |
|  | |  | Social Detox | | | | |  |  | | |  | | |  | |
|  | |  | Therapeutic Community | | | | |  |  | | |  | | |  | |
|  | |  | Intermediate Residential | | | | |  |  | | |  | | |  | |
|  | |  | Re-Integration | | | | |  |  | | |  | | |  | |
|  | |  | Intensive-Outpatient | | | | |  |  | | |  | | |  | |
|  | |  | Out-Patient Individual | | | | |  |  | | |  | | |  | |
|  | |  | Out-Patient Group | | | | |  |  | | |  | | |  | |
|  | |  | Out-Patient Family | | | | |  |  | | |  | | |  | |
|  | |  | Peer Mentorship | | | | |  |  | | |  | | |  | |
|  | |  | Relapse Prevention | | | | |  |  | | |  | | |  | |

Comments and Recommendations Regarding Positive Progress and Areas for Improvement:

**Supervising Agency:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ISO/CSO/DA:** |  | | | | | | | |
|  |  | | | | | | | |
| **Indicate Supervision Level** | | | ***Rate Level of Performance relative to Supervision Conditions:*** | | | | |
| Level: | |  | Very Satisfactory | Satisfactory | Needs Improvement | Revoked | Other (If marked, please comment below) |

Comments and Recommendations Regarding Positive Progress and Areas for Improvement:

The SUPERVISING AGENCY and THE TREATMENT PROVIDER AGREE on the Monthly Progress Report

|  |  |  |
| --- | --- | --- |
| Authorized Treatment Provider Signature: | Date:    m/d/yyyy | Phone #:  Email: |
| Supervising Agency Signature: | Date:    m/d/yyyy | Phone #:  Email: |
| **\* A copy of this document must be retained by both Supervising Agency and Treatment Provider for auditing purposes.** | | |