**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.** |