

**County of El Dorado
Health and Human Services Agency
Monthly Client Progress Report**

Provider's Name: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Client's Name: _____

Social Worker's Name: _____

Dates of sessions since last report (please indicate no shows by writing "N/A" next to the date):

Assessment, goals, and treatment plan:

Progress since last report:

Please complete a progress report on each client referred by the County of El Dorado Health and Human Services Agency- Social Services Division on a monthly basis and send the report to the appropriate office listed below:

West Slope Vendors, send report to:	East Slope Vendors, send report to:
County of El Dorado Health and Human Services ATTN: Accounting Unit 3057 Briw Road Placerville, CA 95667	County of El Dorado Health and Human Services ATTN: Accounting Unit 3368 Lake Tahoe Blvd., #100 South Lake Tahoe, CA 96150

 Provider's Signature

 Date