# INTEGRATION DOCUMENTATION

| Name: | Month & Year: | Type of Service: |
|---|---|---|
| Medicaid #: | Provider: | Provider #: |

| Outcome: | Action Steps & Frequency/Duration |
|---|---|
| | |

| Date | Location | What did you do and who did you meet? | Integration value | Initials |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| Barriers or Recommendations**:** | Next Steps: |
|---|---|
| | |

| Staff Signature &Initials | Date & Supervisor Initial |
|---|---|
| | |

Additional Notes:

# INTEGRATION DOCUMENTATION

**Name_____**
**Date_____**

| |
|---|
| **Where did you go?** |
| **Who did you go with?** |
| **What did you do?** |
| **Who did you meet?** |
| **What did you talk about?** |
| **Did you like what you did?** |
| **Did your staff help you? What did they do?** |
| **Do you want to do it again?** |
| **What would you like to do next?** |
| **When do you want to do it?** |

Additional Notes: