IOWA | Department of Inspections, Appeals, & Licensing

IOWA PROFESSIONAL HEALTH PROGRAMS

Quarterly Report - Aftercare Provider

Participant Name:	Aftercare Provider Name and Credentials:
	Contact Information:

Indicate which quarter this report covers:

☐ 1st Quarter ☐ 2nd Quarter ☐ 3rd Quarter ☐ 4th Quarter

Dates of Group Sessions:

Dates of Individual Sessions:

Current Treatment Goals:

	Yes	No
Has progress been demonstrated toward their treatment goals?	☐	☐
Does the participant actively participate in group discussion?	☐	☐
Does the participant give and receive feedback appropriately?	☐	☐
Does the participant appear motivated and ask for help?	☐	☐
Does the participant have insight into their condition?	☐	☐
Does the participant attend self-help meetings weekly?	☐	☐
Did the participant experience a return to use during this quarter?	☐	☐

Please provide an explanation for your responses above:

Which meetings does the participant attend? AA, NA, Celebrate Recovery, SMART or other? How often?		
	Yes	No
Do you recommend a change in the frequency of sessions? If yes, please provide recommendation.	☐	☐
Do you recommend any changes to the participant's individual and/or group requirements, including frequency of self-help meetings, need for re-evaluation, etc? If yes, please explain.	☐	☐
Are the proper supports/requirements in place for monitoring and treatment to promote success? Please explain.	☐	☐
Have you communicated with the participant's monitoring healthcare provider this quarter?	☐	☐
Based on your knowledge, is the participant adherent with their IPHP contract?	☐	☐
Would you like the IPHP staff to contact you?	☐	☐
Any further Comments, Questions or Concerns?		
Aftercare Provider's Signature: Date:		

PROGRAM CONTACTS:

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