St. Clair County Community Mental Health

Direct Service Activity Review

Date: _____

Supervisor Name: _____

Program: _____

I have reviewed direct service percentages with staff who have not met their Direct Service goals.

Attached: ☐ Supervision Notes ☐ Direct Service Reports

_____ _____

Supervisor Signature Date

* Please attach individual supervision notes, emails, etc., that detail how this was addressed with staff – ONLY necessary for staff who did not meet their target.

** This form is due to your supervisor within 10 days of disbursement of Face-to-Face Direct Service Reports.

*** Director – return this form to the Chief Clinical Officer within 14 days.