

**OFFICE OF SUBSTANCE ABUSE
OUTPATIENT SERVICE DELIVERY FORM
SFY' 11**

This form should be completed for each ambulatory service setting the agency is contracted for. Please remember that DSAT clients should be reported separately on their own Outpatient Service Delivery Form.

Contract Number: _____ **Contract Month:** _____

Please circle one: **Non-Intensive Outpatient** **Adolescent Non-Intensive Outpatient**
 Intensive Outpatient **Adolescent Intensive Outpatient**
 Women's Case Management Services

Are these DSAT clients: **Yes** **No**

Agency Name: _____

Telephone #: _____

Prepared by: _____

Total Program Units Delivered
 (Please use 1/4 hour units to report outpatient services
 and daily units for intensive outpatient services)

		Primary Month	Affected Month
Individual			
Group			
Use as Appropriate for: Family, Assessment or Case Management			

If you have questions regarding this form, please call the Helpdesk at 287-6337 or email it at TDS.Helpdesk@maine.gov

Please return one copy to:

Date received by OSA:

Mary Beaudoin
 Office of Substance Abuse
 11 SHS
 41 Anthony Ave
 Augusta, ME 04333-0011
 Fax: (207) 287-8910
 or email: Johanna.Buzzell@maine.gov