Southern New Hampshire Services,Inc.

Child Development Program

Termination of Social Work Intern Services

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Treatment Goals | Progress |
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| Termination of Services.  The reason(s) for discontinuation of services are as indicated below: | |
|  | Child has met goals of treatment plan and/or made significant progress |
|  | A referral for alternative support has been made |
|  | Child is no longer receiving Head Start/Early Head Start Services |
|  | Internship has come to an end |
|  | Current services in place are meeting the child’s needs |
|  | A scheduling conflict is preventing child from receiving services |

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| Additional Recommendations: |

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MSW Intern Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinical Supervisor Signature Date

I understand that I can ask any questions of the social work intern and/or Dawn Varney regarding services provided to my child.

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Guardian Signature Date