

**NYS OFFICE OF MENTAL HEALTH  
MONTHLY SERVICE DELIVERY REPORT  
MHOTRS/CCBHC Clinics**

Provider and Site ID:  
Staff Name and Contact:  
Reporting Month:

<b>Capacity &amp; Access</b>		<b>Total</b>	<b>0-17 yrs</b>	<b>18 yrs +</b>
1	In your best estimate, will you have availability to see routine community referrals: (select from dropdown options) a) Same day or within 1 day b) 7 calendar days c) 14 days d) 30 days e) 60 days f) More than 60 days g) Placed on waitlist or intake closed or ask client to call back later h) N/A this program site does not conduct intake assessments i) N/A this program site is a school satellite j) N/A this program site is in NYC and reporting in NYC MH Connect			
<b>Services This Past Month</b>				
2	Total number of services provided in the past month			
3	Number of group services provided in the past month			
<b>Client Census Activity This Past Month</b>				
4	Number of individuals in Treatment - as of End of Month			
5	Number of individuals who received any service this past month			
6	Number of individuals admitted to this program this past month			
7	Number of individuals discharged from this program this past month			