

**APPLESEED COMMUNITY MENTAL HEALTH CENTER, INC.  
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT PROGRESS NOTE**

<b>Client Name</b> (First, MI, Last)							<b>Client No.</b>				
<input type="checkbox"/> <b>Client Present</b> (if others present, please list name(s) and relationship(s) to client)											
<b>Significant Changes/Events</b> (if applicable) <input type="checkbox"/> Not applicable											
<b>Recommendation for Modifications to ISP</b> (if applicable) <input type="checkbox"/> Not applicable											
<b>CPST Rehabilitative and Environmental Support Activities</b> (check all that apply)											
<input type="checkbox"/> 1. Ongoing Assessment of Needs.				<input type="checkbox"/> 6. Coordination and/or assistance in crisis management and stabilization as needed.							
<input type="checkbox"/> 2. Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian.				<input type="checkbox"/> 7. Advocacy and outreach.							
<input type="checkbox"/> 3. Facilitation of further development of daily living skills.				<input type="checkbox"/> 8. Education and training specific to the individuals assessed needs, abilities, and readiness to learn.							
<input type="checkbox"/> 4. Coordination of the ISP.				<input type="checkbox"/> 9. Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking education and employment.							
<input type="checkbox"/> 5. Symptom monitoring.				<input type="checkbox"/> 10. Activities that increased the individual's capacity to positively impact his/her own environment.							
<b>Goal(s)/Objective(s):</b>											
<b>Brief Description of Service/s and Progress Toward Goal/s and Objectives:</b>											
<b>Provider Signature/Credentials</b>						<b>Date</b>		<b>Provider No.</b> (optional)			
<b>Client Signature</b> (optional, if clinically appropriate)						<b>Date</b>		<b>Supervisor Signature/Credentials</b> (if needed)			<b>Date</b>
<b>Supervisor Consultation</b> (if needed):											
<b>Date of Service</b>	<b>Staff ID No.</b>	<b>Loc. Code</b>	<b>Prcdr. Code</b>	<b>Mod 1</b>	<b>Mod 2</b>	<b>Mod 3</b>	<b>Mod 4</b>	<b>Start Time</b>	<b>Stop Time</b>	<b>Total Time</b>	<b>Diagnostic Code</b>

**APPLESEED COMMUNITY MENTAL HEALTH CENTER, INC.  
COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT PROGRESS NOTE**

Client Name (First, MI, Last) <b>Piglet</b>							Client No. <b>0000my</b>				
<input type="checkbox"/> Client Present (if others present, please list name(s) and relationship(s) to client)											
Significant Changes/Events (if applicable) <input checked="" type="checkbox"/> Not applicable											
Recommendation for Modifications to ISP (if applicable) <input checked="" type="checkbox"/> Not applicable											
<b>CPST Rehabilitative and Environmental Support Activities (check all that apply)</b>											
<input type="checkbox"/> 1. Ongoing Assessment of Needs.				<input type="checkbox"/> 6. Coordination and/or assistance in crisis management and stabilization as needed.							
<input type="checkbox"/> 2. Assistance in achieving personal independence in managing basic needs as identified by the individual and/or parent or guardian.				<input type="checkbox"/> 7. Advocacy and outreach.							
<input type="checkbox"/> 3. Facilitation of further development of daily living skills.				<input checked="" type="checkbox"/> 8. Education and training specific to the individuals assessed needs, abilities, and readiness to learn.							
<input checked="" type="checkbox"/> 4. Coordination of the ISP.				<input type="checkbox"/> 9. Mental health interventions that address symptoms, behaviors, thought processes, etc., that assist an individual in eliminating barriers to seeking education and employment.							
<input type="checkbox"/> 5. Symptom monitoring.				<input type="checkbox"/> 10. Activities that increased the individual's capacity to positively impact his/her own environment.							
Goal(s)/Objective(s): Goal 1, Objective 1, Intervention 3											
Brief Description of Service/s and Progress Toward Goal/s and Objectives: Piglet called reporting issues with unemployment and his fears that he was going to lose his housing due to no more money coming in and his inability to pay the rent. Discussed with Piglet what steps need to be taken as it is currently believed that he has received an extension on his unemployment. Advised that I would and did consult with employment specialist who agreed to meet with Piglet to assist in navigating the unemployment website, and to look towards an application for Social Security benefits. Piglet reports being less anxious and concerned following conversation and stated his intent to follow through with the employment specialist in the very near future.											
Provider Signature/Credentials <i>Christopher Robbins, QMHS</i>					Date <i>3/12/16</i>		Provider No. (optional)				
Client Signature (optional, if clinically appropriate)					Date		Supervisor Signature/Credentials (if needed)			Date	
Supervisor Consultation (if needed):											
<b>Date of Service</b>	<b>Staff ID No.</b>	<b>Loc. Code</b>	<b>Predr. Code</b>	<b>Mod 1</b>	<b>Mod 2</b>	<b>Mod 3</b>	<b>Mod 4</b>	<b>Start Time</b>	<b>Stop Time</b>	<b>Total Time</b>	<b>Diagnostic Code</b>
3-11-10	2b	12	41	GT				12 Noon		40	300.01

**BELLEFAIRE JCB: CPST PROGRESS NOTE**

**Client Name:** (Last, First) \_\_\_\_\_ **Client ID:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Staff ID/Name:** \_\_\_\_\_ **Program RU:** \_\_\_\_\_

Client Start Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Client End Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Billable Time	UNITS
Staff Start Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Staff End Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Total Staff Time	UNITS

**LOCATION**

<input type="checkbox"/> 03 School	<input type="checkbox"/> 04 Shelter	<input type="checkbox"/> 09 Correctional Fac.	<input type="checkbox"/> 11 Office	<input type="checkbox"/> 12 Home
<input type="checkbox"/> 21 Inpatient Med Hosp	<input type="checkbox"/> 23 Emer Room	<input type="checkbox"/> 51 Inpatient Psych Hosp	<input type="checkbox"/> 56 Psych Residential Tx.	<input type="checkbox"/> 99 Other _____

**MODIFIER**

<input type="checkbox"/> F0 Face/Face with client	<input type="checkbox"/> F1 Face/Face with client/family/signif other	<input type="checkbox"/> F2 Face/Face with Family/Sig Other: no client
<input type="checkbox"/> F3 Face/Face with other professional	<input type="checkbox"/> F4 Face/Face with client, penal system	<input type="checkbox"/> F5 F/F with Fam/Sig Other: no client—penal sys
<input type="checkbox"/> T0 Telephone with client	<input type="checkbox"/> T1 Tele w/client & family/Significant other	<input type="checkbox"/> T2 Tele with family/sign other—no client
<input type="checkbox"/> T3 Telephone with other professional	<input type="checkbox"/> T4 Tele with client, penal system	<input type="checkbox"/> T5 Tele with Fam/Sig Other: no client-penal sys
<input type="checkbox"/> 0000 Non-Billable	<input type="checkbox"/> 0010 No Show	<input type="checkbox"/> 0020 Cancellation

**ISP GOAL(S) ADDRESSED:**  #1 \_\_\_\_\_  #2 \_\_\_\_\_  
 #3 \_\_\_\_\_  #4 \_\_\_\_\_

**SERVICE ACTIVITY RENDERED**

<input type="checkbox"/> Ongoing Assessment of needs <input type="checkbox"/> Assist in achieving personal independence in managing basic needs <input type="checkbox"/> Facilitate further development of daily living skills <input type="checkbox"/> Coordination of the ISP <input type="checkbox"/> Assistance with accessing natural support systems in the community <input type="checkbox"/> Linkage to formal community services/systems	<input type="checkbox"/> Symptom monitoring <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization <input type="checkbox"/> Advocacy and outreach <input type="checkbox"/> Education and Training specific to assessed needs <input type="checkbox"/> Activities that increase the individual's capacity to positively impact own environment <input type="checkbox"/> MH intervention to address symptoms, behaviors, thought process that assist in eliminating barriers to seek or maintain education and employment
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**Briefly Describe:** \_\_\_\_\_

Client Start Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Client End Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Billable Time	UNITS
Staff Start Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Staff End Time	<input type="checkbox"/> AM <input type="checkbox"/> PM	Total Staff Time	UNITS

**LOCATION**

<input type="checkbox"/> 03 School	<input type="checkbox"/> 04 Shelter	<input type="checkbox"/> 09 Correctional Fac.	<input type="checkbox"/> 11 Office	<input type="checkbox"/> 12 Home
<input type="checkbox"/> 21 Inpatient Med Hosp	<input type="checkbox"/> 23 Emer Room	<input type="checkbox"/> 51 Inpatient Psych Hosp	<input type="checkbox"/> 56 Psych Residential Tx.	<input type="checkbox"/> 99 Other _____

**MODIFIER**

<input type="checkbox"/> F0 Face/Face with client	<input type="checkbox"/> F1 Face/Face with client/family/signif other	<input type="checkbox"/> F2 Face/Face with Family/Sig Other: no client
<input type="checkbox"/> F3 Face/Face with other professional	<input type="checkbox"/> F4 Face/Face with client, penal system	<input type="checkbox"/> F5 F/F with Fam/Sig Other: no client—penal sys
<input type="checkbox"/> T0 Telephone with client	<input type="checkbox"/> T1 Tele w/client & family/Significant other	<input type="checkbox"/> T2 Tele with family/sign other—no client
<input type="checkbox"/> T3 Telephone with other professional	<input type="checkbox"/> T4 Tele with client, penal system	<input type="checkbox"/> T5 Tele with Fam/Sig Other: no client-penal sys
<input type="checkbox"/> 0000 Non-Billable	<input type="checkbox"/> 0010 No Show	<input type="checkbox"/> 0020 Cancellation

**ISP GOAL(S) ADDRESSED:**  #1 \_\_\_\_\_  #2 \_\_\_\_\_  
 #3 \_\_\_\_\_  #4 \_\_\_\_\_

**SERVICE ACTIVITY RENDERED**

<input type="checkbox"/> Ongoing Assessment of needs <input type="checkbox"/> Assist in achieving personal independence in managing basic needs <input type="checkbox"/> Facilitate further development of daily living skills <input type="checkbox"/> Coordination of the ISP <input type="checkbox"/> Assistance with accessing natural support systems in the community <input type="checkbox"/> Linkage to formal community services/systems	<input type="checkbox"/> Symptom monitoring <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization <input type="checkbox"/> Advocacy and outreach <input type="checkbox"/> Education and Training specific to assessed needs <input type="checkbox"/> Activities that increase the individual's capacity to positively impact own environment <input type="checkbox"/> MH intervention to address symptoms, behaviors, thought process that assist in eliminating barriers to seek or maintain education and employment
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**Briefly Describe:** \_\_\_\_\_

**Progress:**  N/A  No Change  Deterioration  Improvement: If Deterioration or Improvement Noted, Briefly Describe \_\_\_\_\_

**Significant Life Changes/Events:**  N/A  Yes, Explain: \_\_\_\_\_

**Recommend Modification to ISP:**  No  Yes, refer to MHA Update \_\_\_\_\_

**Change in Risk to Self or Others:**  No  Yes, refer to  MHA update;  Suicide Assessment;  Duty to Protect \_\_\_\_\_

My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire JCB to bill for the time documented as "billable" above.

STAFF SIGNATURE _____	CREDENTIAL _____	DATE _____
SUPERVISOR SIGNATURE (If Applicable) _____	CREDENTIAL _____	DATE _____

<b>Min</b>	<b>6</b>	<b>9</b>	<b>10</b>	<b>12</b>	<b>15</b>	<b>18</b>	<b>20</b>	<b>21</b>	<b>24</b>	<b>25</b>	<b>27</b>	<b>30</b>	<b>33</b>	<b>35</b>	<b>36</b>	<b>39</b>	<b>40</b>	<b>42</b>	<b>45</b>	<b>48</b>	<b>50</b>	<b>51</b>	<b>54</b>	<b>55</b>	<b>57</b>	<b>60</b>
<b>Unit</b>	.10	.15	.17	.20	.25	.30	.33	.35	.40	.42	.45	.50	.55	.58	.60	.65	.67	.70	.75	.80	.83	.85	.90	.92	.95	1.00

Bellefaire Jewish Children's Bureau: CPST Progress Note

Client Name: (Last, First) [REDACTED]		Client #: [REDACTED]		Date of service: 3/12/10	
Staff ID, Name: [REDACTED]					
Client Start Time	10:43 AM	Client End Time	11:07 AM	Billable Time	0.40 UNITS
Staff Start Time	10:43 AM	Staff End Time	11:07 AM	Total Time	0.40 UNITS
Program RU 212 PACT CPST		Location 11 Office Other:		Modifier T3 Telephone w/other professional, no client	
ISP GOAL(S) ADDRESSED: <input checked="" type="checkbox"/> #1 IP will display a marked reduction in the intensity, frequency, and duration of negative behaviors and increase compliance with adult directives and requests as evidenced by caregiver report.; <input type="checkbox"/> #2 IP will reach level of reduced tension, increased satisfaction, and improved communication with sister and mother as evidenced by client and parent report.; <input type="checkbox"/> #3 ; <input type="checkbox"/> #4 ; <input type="checkbox"/> #5					
SERVICE ACTIVITY RENDERED			SERVICE ACTIVITY RENDERED		
<input checked="" type="checkbox"/> Ongoing Assessment of needs <input type="checkbox"/> Assist in achieving personal independence in managing basic needs <input type="checkbox"/> Facilitate further development of daily living skills <input type="checkbox"/> Coordination of the ISP <input type="checkbox"/> Assistance with accessing natural support systems in the community <input type="checkbox"/> Linkage to formal community services/systems			<input checked="" type="checkbox"/> Symptom monitoring <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization <input type="checkbox"/> Advocacy and outreach <input checked="" type="checkbox"/> Education and Training specific to assessed needs <input type="checkbox"/> Activities that increase the individual's capacity to positively impact own environment <input type="checkbox"/> MH intervention to address symptoms, behaviors, thought process that assist in eliminating barriers to seek or maintain education and employment		
Briefly Describe: Explored teacher's concerns re: IP's negative behaviors in classroom, including specific behaviors observed, time of day IP demonstrates behaviors, triggers, and approaches teacher has taken to manage behaviors. Provided information re: behavior modification approach of using rewards for positive behaviors and consequences for negative behaviors.					
Client Start Time	01:10 PM	Client End Time	02:04 PM	Billable Time	0.90 UNITS
Staff Start Time	01:10 PM	Staff End Time	02:04 PM	Total Time	0.90 UNITS
Program RU 212 PACT CPST		Location 12 Client's Home Other:		Modifier F2 F:P w/family/signif other no client	
ISP GOAL(S) ADDRESSED: <input checked="" type="checkbox"/> #1 ; <input checked="" type="checkbox"/> #2 ; <input type="checkbox"/> #3 ; <input type="checkbox"/> #4 ; <input type="checkbox"/> #5					
SERVICE ACTIVITY RENDERED			SERVICE ACTIVITY RENDERED		
<input type="checkbox"/> Ongoing Assessment of needs <input type="checkbox"/> Assist in achieving personal independence in managing basic needs <input type="checkbox"/> Facilitate further development of daily living skills <input type="checkbox"/> Coordination of the ISP <input type="checkbox"/> Assistance with accessing natural support systems in the community <input type="checkbox"/> Linkage to formal community services/systems			<input checked="" type="checkbox"/> Symptom monitoring <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization <input type="checkbox"/> Advocacy and outreach <input checked="" type="checkbox"/> Education and Training specific to assessed needs <input type="checkbox"/> Activities that increase the individual's capacity to positively impact own environment <input type="checkbox"/> MH intervention to address symptoms, behaviors, thought process that assist in eliminating barriers to seek or maintain education and employment		
Briefly Describe: Explored mother's concerns re: IP's behaviors at home and negative school behaviors and discussed possibility that IP may be tired or hungry which may increase irritability that may lead to increase in negative behaviors. Provided information re: framing problems as small and big to give IP better framework and understanding of magnitude of problems and actions that would be appropriate for each type of problem.					
Client Start Time	02:05 PM	Client End Time	03:22 PM	Billable Time	1.29 UNITS
Staff Start Time	02:05 PM	Staff End Time	03:22 PM	Total Time	1.29 UNITS
Program RU 212 PACT CPST		Location 99 Other other: Public library		Modifier F1 F:F w/Client Family Significant other	
ISP GOAL(S) ADDRESSED: <input checked="" type="checkbox"/> #1 ; <input checked="" type="checkbox"/> #2 ; <input type="checkbox"/> #3 ; <input type="checkbox"/> #4 ; <input type="checkbox"/> #5					
SERVICE ACTIVITY RENDERED			SERVICE ACTIVITY RENDERED		
<input type="checkbox"/> Ongoing Assessment of needs <input type="checkbox"/> Assist in achieving personal independence in managing basic needs <input type="checkbox"/> Facilitate further development of daily living skills <input type="checkbox"/> Coordination of the ISP <input type="checkbox"/> Assistance with accessing natural support systems in the community <input type="checkbox"/> Linkage to formal community services/systems			<input type="checkbox"/> Symptom monitoring <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization <input type="checkbox"/> Advocacy and outreach <input checked="" type="checkbox"/> Education and Training specific to assessed needs <input checked="" type="checkbox"/> Activities that increase the individual's capacity to positively impact own environment <input type="checkbox"/> MH intervention to address symptoms, behaviors, thought process that assist in eliminating barriers to seek or maintain education and employment		
Briefly Describe: Used therapeutic activity to improve IP's ability to positively interact with others, take turns, and share appropriately and reduce negative interactions between IP and IP's sister. Provided information re: self-esteem, self-talk, and impact these have on one's feelings and actions. Assisted IP in identifying and practicing use of coping skills to use when sad or angry.					
Progress: <input type="checkbox"/> N/A <input checked="" type="checkbox"/> No Change <input type="checkbox"/> Deterioration <input type="checkbox"/> Improvement: If Deterioration or Improvement Noted, Briefly Describe					
Significant Life Changes/Events: <input checked="" type="checkbox"/> N/A <input type="checkbox"/> Yes, Explain:					
Recommend Modification to ISP: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, refer to MHA Update					
Change in Risk to Self or Others: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes, refer to <input type="checkbox"/> MHA update; <input type="checkbox"/> Suicide Assessment <input type="checkbox"/> Duty to Protect					
My signature verifies that service occurred as documented on this progress note. I authorize Bellefaire/JCB to bill for the time documented as "billable" above.					
[REDACTED SIGNATURE]			PC		3/15/10

**Greater Cincinnati Behavioral Health Services  
Progress Note-CPST**

Affix **CLIENT** label

Affix **STAFF** label above

Date of Service

M	M	/	D	D	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

**Service Codes:** H0036 – CPST M3149 – CoTx-safety H0031 - MH Assess no bill  
**Location Codes:** 53-GCB 12-Cit Home 99-Community 51-Summit 09-Jail  
**Mod 1:** HE-face-to- face GT-phone HQ-group **Mod 2:** UK-Client Not Present

Start Time	End Time	Service Code	Mod 1	Mod 2	Location
<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input type="checkbox"/> HE <input type="checkbox"/> GT <input type="checkbox"/> HQ	<input type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09
<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input type="checkbox"/> HE <input type="checkbox"/> GT <input type="checkbox"/> HQ	<input type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09
<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> am <input type="checkbox"/> pm	<input type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input type="checkbox"/> HE <input type="checkbox"/> GT <input type="checkbox"/> HQ	<input type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09
<b>Program:</b> <input type="checkbox"/> Case Management <input type="checkbox"/> CU <input type="checkbox"/> TSS <input type="checkbox"/> Homelink <input type="checkbox"/> CLS <input type="checkbox"/> Welcome Center			<b>Team:</b>		<b>Date entered:</b>

**Treatment Outcome(s) from the ISP addressed by this intervention(s)**

- |  |   |
|--|---|
| <input type="checkbox"/> Psychiatric Improvement                         | <input type="checkbox"/> Barriers to Employment, Education, Meaningful Activities |
| <input type="checkbox"/> Improved Management of SAMI Issues              | <input type="checkbox"/> Independent Living Skills                                |
| <input type="checkbox"/> Medical and Health Wellness and Personal Safety | <input type="checkbox"/> Personal and Social Skills/Empowerment                   |
| <input type="checkbox"/> Housing Stability                               |   |

**CPST Activity** *Directions: Check the box(es) that best describe the CPST activity(s).*

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ongoing assessment of needs   | <input type="checkbox"/> Coordination of the ISP  | <input type="checkbox"/> Education and training specific to the individual's assessed needs, abilities and readiness to learn                                  |
| <input type="checkbox"/> Assistance in achieving personal independence in managing basic needs | <input type="checkbox"/> Facilitation of further development further development of daily living skills | <input type="checkbox"/> Address symptoms, behaviors, thought processes, that assist in eliminating barriers to seeking or maintaining education or employment |
| <input type="checkbox"/> Coordination and/or assistance in crisis management and stabilization |   | <input type="checkbox"/> Activities that increase the individual's capacity to positively impact his/her own environment                                       |
|  |   | <input type="checkbox"/> Symptom monitoring <input type="checkbox"/> Advocacy and outreach   |

**Describe Staff Intervention(s):** *(taught, trained, practiced, reviewed, role-modeled, coached, prompted etc.)*

**Significant changes or events in the life of the client:**  None reported/observed

**Observations of living environment, appearance, behaviors and barriers to progress:**

**Recommended Revision to ISP:**  None  Revise ISP

**Assessment of progress toward treatment outcomes:**  No Progress  If Progress, specify:

<b>Staff Signature:</b>	<input type="checkbox"/> QMHS <input type="checkbox"/> PC <input type="checkbox"/> PCC <input type="checkbox"/> SW <input type="checkbox"/> ISW	<b>Signature/Documentation Date</b> -- --
<b>Client Signature:</b>		

**Greater Cincinnati Behavioral Health Services  
Progress Note-CPST**

Affix CLIENT label

Affix STAFF label above

Date of Service

03 / 01 / 2010  
M M D D Y Y Y Y

Service Codes: H0036 - CPST M3149 - CoTx-safety H0031 - MH Assess no bill  
 Location Codes: 53-GCB 12-Clt Home 99-Community 51-Summit 09-Jail  
 Mod 1: HE-face-to-face GT-phone HQ-group Mod 2: UK-Client Not Present

Start Time	End Time	Service Code	Mod 1	Mod 2	Location
10.9.13 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	11.0.21 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	<input checked="" type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input checked="" type="checkbox"/> HE <input type="checkbox"/> GT <input type="checkbox"/> HQ	<input type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09
11.0.24 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	11.0.31 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	<input checked="" type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input checked="" type="checkbox"/> HE <input checked="" type="checkbox"/> GT <input type="checkbox"/> HQ	<input checked="" type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09
11.1.07 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	11.1.20 <input checked="" type="checkbox"/> am <input type="checkbox"/> pm	<input checked="" type="checkbox"/> H0036 <input type="checkbox"/> M3149 <input type="checkbox"/> H0031 <input type="checkbox"/> no bill	<input checked="" type="checkbox"/> HE <input checked="" type="checkbox"/> GT <input type="checkbox"/> HQ	<input checked="" type="checkbox"/> UK	<input type="checkbox"/> 53 <input type="checkbox"/> 12 <input type="checkbox"/> 99- <input type="checkbox"/> 51 <input type="checkbox"/> 09

Program:  Case Management  CU  TSS  
 Homelink  CLS  Welcome Center

Team: 1000 Date entered:

**Observations of living environment, appearance, behaviors and barriers to progress:**

Met clt. @ his apt. He reported that he doesn't think his new meds are working b/c his "mind is messing w/me," and he is "seeing things." Stopped all meds "a few days ago." Unable to report list of meds. Reported that he has not contacted Dr. b/c he didn't want to bother him. Thinks he may have missed some work shifts b/c he has "bad feelings." Clt was unshowered, in dirty clothes, pills strewn on counter + coffee table.

Significant changes or events in the life of the client:  None reported/observed

clt may be experiencing problems related to new medications.  
 Clt may be missing work, has had good attendance for several mos.

**Treatment Outcome(s) from the ISP addressed by this intervention(s)**

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> Psychiatric Improvement              | <input checked="" type="checkbox"/> Barriers to Employment, Education, Meaningful Activities |
| <input type="checkbox"/> Improved Management of SAMI Issues              | <input type="checkbox"/> Independent Living Skills   |
| <input type="checkbox"/> Medical and Health Wellness and Personal Safety | <input checked="" type="checkbox"/> Personal and Social Skills/Empowerment                   |
| <input type="checkbox"/> Housing Stability                               |  |

**CPST Activity** Directions: Check the box(es) that best describe the CPST activity(s).

- |   |   |   |
|---|---|---|
| <input checked="" type="checkbox"/> Ongoing assessment of needs   | <input type="checkbox"/> Coordination of the ISP  | <input type="checkbox"/> Education and training specific to the individual's assessed needs, abilities and readiness to learn |
| <input checked="" type="checkbox"/> Assistance in achieving personal independence in managing basic needs | <input checked="" type="checkbox"/> Address symptoms, behaviors, thought processes, that assist in eliminating barriers to seeking or maintaining education or employment | <input type="checkbox"/> Activities that increase the individual's capacity to positively impact his/her own environment      |
| <input type="checkbox"/> Facilitation of further development further development of daily living skills   | <input checked="" type="checkbox"/> Symptom monitoring  | <input checked="" type="checkbox"/> Advocacy and outreach   |
| <input checked="" type="checkbox"/> Coordination and/or assistance in crisis management and stabilization |   |   |

**Describe Staff Intervention(s):** (taught, trained, practiced, reviewed, role-modeled, coached, prompted etc.)

Prompted clt to call Dr. + work. Practiced how to appropriately communicate concerns to Dr. Reviewed sx recognition plan + coping strategies to manage "bad feelings." Reviewed "Start the Day" checklist re: hygiene issues. Called Dr. and Job coach to coordinate.

Recommended Revision to ISP:  None  Revise ISP

Assessment of progress toward treatment outcomes:  No Progress  If Progress, specify:

clt is experiencing some setbacks, but is scheduled to see Dr. in am. Job coach will contact employer.

Staff Signature: Casey Manag...	<input checked="" type="checkbox"/> QMHS <input type="checkbox"/> PC <input type="checkbox"/> PCC <input type="checkbox"/> SW <input type="checkbox"/> ISW	Signature/Documentation Date 3 - 1 - 10
Client Signature:		