

Community Psychiatric Support Treatment Program Progress Note (EXAMPLE)

Client Name _____ Client Number _____ Date _____

Start Time _____ AM PM End Time _____ AM PM Billable time _____ Location Code: _____ Type of Contact Code: _____
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Location: Code: C = **Community** A = **Agency** CH = **Client's Home** O = **Other (Fill in above)**

Contact Code: FC = **F-t-F w/ Client** TC = **Phone w/ Client** FEO = **F-t-F with Essential Other** TEO = **Phone w/ Essential Other**

Non-Billable Time: No show Cancellation Other non-billable activity

1. **Additional Notes (Optional)** _____

2. **GOAL:** _____

3. Description of CPST Rehabilitative and Environmental Support Activities Provided (Check all that apply)

(Note: Agency should individualize the activity section according to need based on client population, diagnosis and service provided)

- | | |
|--|---|
| <input type="checkbox"/> 1. ISP development, review or revision | <input type="checkbox"/> 9. Crisis support and/or development of a crisis management and contingency plan, and/or crisis stabilization |
| <input type="checkbox"/> 2. Teaching to develop the skills to access needed services, support systems & resources for him/herself | <input type="checkbox"/> 10. Teaching interventions to address deficits in socialization skills, including communication, interpersonal relationships and conflict resolution |
| <input type="checkbox"/> 3. Restorative interventions to improve independent living skills | <input type="checkbox"/> 11. Teaching methods to acquire psychiatric self-monitoring and symptom management skills |
| <input type="checkbox"/> 4. Assessment of psychiatric, physical health, housing, income support & vocational needs | <input type="checkbox"/> 12. Teaching to develop stress and anger management skills |
| <input type="checkbox"/> 5. Teaching consumer how to advocate for him/herself | <input type="checkbox"/> 13. Mental illness, recovery and wellness management education and training to client and/or family |
| <input type="checkbox"/> 6. Rehabilitative interventions to address psychiatric, physical health, housing, income & vocational needs | <input type="checkbox"/> 14. Employment readiness interventions to address identified psychiatric deficits which impact employment |
| <input type="checkbox"/> 7. Education & training to manage impact of psychiatric symptoms on school/home/work functioning | <input type="checkbox"/> 15. Other (specify) _____ |
| <input type="checkbox"/> 8. Teaching/providing assistance in skill-building to develop psychiatric support systems | |

4. Yes No Activity/Service Provided is Medically Necessary as Documented in Mental Health Assessment & Authorized by ISP

Brief Description of service(s) provided: _____

5. **Assessment of Progress:**

No Progress If Progress, specify: _____

6. **Significant Changes or Events in the Life of the Client, if applicable:**

7. **Recommend Modification to ISP, if applicable (Explain):**

8. **No Change Noted in Client's Behavior, Actions or Statements as it Relates to Harming Self or Others OR**

Yes, Change Noted in Risk of Harm to **Self** **Others (Check one, Complete Below & Explain any "Yes" Answers) OR**

Yes, Change Noted in Risk of Harm to **Self** **Others (Check one, See "Duty to Protect" Form)**

Thoughts to harm self/others No Yes, specify: _____ Intention to harm self/others No Yes, specify: _____

Past attempts to harm self or others? No Yes, specify: _____ Plan No Yes, specify: _____

Access to planned method? No Yes, specify: _____

What is the action plan to ensure safety? _____

Plan agreed to by client? Yes No, specify: _____

STAFF SIGNATURE (Name and Credentials) or Initials (Signature/Credential Sheet must be Present in ICR)

DATE