**TARP Progress Note**

|  |  |
| --- | --- |
| **Date of Service:** |       |
| **Consumer Name:** |       |  |  |
| **Type of Contact:** | [ ] Face to face[ ] Phone with consumer [ ] Collateral contact[ ] Other (specify):       |
| **Place of Service:** |       |
| **Contact Time:** |       *If you went under or over your authorized service time, please note the reason in the “Activity” section*  |
| **Travel time** *(billable time to and from office to place of service)* |       | **Mileage:** |       |
| **Recordkeeping Time:** |       |
| **Provider Name/Agency:** |       |

**Treatment Goal(s) Addressed:** *(must match current Recovery Plan)*

|  |
| --- |
|       |

**Activity / Assessment:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Please select the service/activity category**

|  |  |
| --- | --- |
| **[ ]**  | Screening and Assessment |
| **[ ]**  | Service Planning |
| **[ ]**  | Service Facilitation |
| **[ ]**  | Diagnostic Evaluations |
| **[ ]**  | Medication Management |
| **[ ]**  | Physical Health Monitoring |
| **[ ]**  | Peer Support |
| **[ ]**  | Individual Skill Development and Enhancement |
| **[ ]**  | Employment Related Skill Training |
| **[ ]**  | Individual and/or Family Psychoeducation |
| **[ ]**  | Wellness Management and Recovery/Recovery Support Services |
| **[ ]**  | Psychotherapy |
| **[ ]**  | Substance Abuse treatment |
| **[ ]**  | Non-Traditional or Other Approved Services |

|  |
| --- |
| **Description:** *Include mental status observations, what the service/activity was, how it related to the goal, how you supported the consumer with the activity.*      |

 |

**Response / Progress:** *(describe the consumer’s response to/participation in the service/activity)*

|  |
| --- |
|       |

**Plan:** *(describe the plan for the next meeting or next step in services/the intervention)*

|  |
| --- |
|       |

|  |  |  |
| --- | --- | --- |
|       |  |       |
| **Provider’s Name** |  | **Provider’s Credentials** |
|  |  |  |
| **Provider’s Signature** |  |  |