**TARP Progress Note**

|  |  |
| --- | --- |
| **Date of Service:** |       |
| **Consumer Name:** |       |  |  |
| **Type of Contact:** | [ ] Face to face[ ] Phone with consumer *(billable only by Service Facilitator)*[ ] Collateral contact *(billable only by Service Facilitator)*[ ] Other (specify):       |
| **Place of Service:** |       |
| **Contact Time:** |       *Include only face-to-face service delivery 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 | **[ ]**  | Individual Skill Development and Enhancement |
| **[ ]**  | Service Planning | **[ ]**  | Employment Related Skill Training |
| **[ ]**  | Service Facilitation | **[ ]**  | Individual and/or Family Psychoeducation |
| **[ ]**  | Diagnostic Evaluations | **[ ]**  | Wellness Management and Recovery/Recovery Support Services |
| **[ ]**  | Medication Management | **[ ]**  | Psychotherapy |
| **[ ]**  | Physical Health Monitoring | **[ ]**  | Substance Abuse treatment |
| **[ ]**  | Peer Support |  |  |

|  |
| --- |
| **Description:** *(Include mental status observations, details of the service/activity you provided, 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)*

|  |
| --- |
|       |
| **Activities not Included in “Contact Time” above:** *(Activities not billable on an interim basis such as in-person or phone collateral contacts and phone contact with consumer)* |
|       |

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