**TARP Progress Note**

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| **Date of Service:** |  | | | | | | |
| **Consumer Name:** |  | |  | |  | | |
| **Type of Contact:** | Face to facePhone 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)*

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**Activity / Assessment:**

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| **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)*

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

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