**TARP Progress Note**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Service:** |  | | | |
| **Consumer Name:** |  | | | |
| **Provider Name/Agency:** | |  | | |
| **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:** |  | | **Round Trip Mileage:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Start Time** | **End Time** | **Total Minutes** | **Notes** |
| **Service delivery:** |  |  |  | *If under or over the authorized service time, please explain:* |
| **Travel:** |  |  |  | *If not from office to place of service and return, or if there were extenuating circumstances, please explain:* |
| **Recordkeeping:** | | |  |  |

**Treatment Goal(s) or Objective(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** |  |  |