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| Client: | Case #: | | | | | | | | | | | Program: | | | | |
| Date of Service: | Unit: | | | | | | | | | | | SubUnit: | | | | |
| Server ID: | Service Time: | | | | | | | Travel Time: | | | | | | | Documentation Time: | |
| Person Contacted: | Place: | | | Outside Facility: | | | | | | | Contact Type: | | | | | Appointment Type: |
| Billing Type (Language  Provided In): | | | Intensity Type (Interpreter Utilized): | | | | | | | | | | EBP (CFT Meeting): | | | |
| Focus of session Diagnosis ICD-10 Code(s): | | | | | | | Service: | | | | | | | | | |
| Collateral Server ID: | | Service Time: | | | | | Travel Time: | | | | | | | Documentation Time: | | |
| **CHILD AND FAMILY TEAM MEETING/CFT MEETING NOTE** | | | | | | | | | | | | | | | | |
| **Traveled To/From (when applicable):** | | | | | | | | | | | | | | | | |
| **Participants** (List all participants and role; if all team members were not present, explain reason): | | | | | | | | | | | | | | | | |
| **Meeting Focus** (Permanency, stabilization of client in home, address mental health concerns, education concerns, transition, etc., *may be more than one*): | | | | | | | | | | | | | | | | |
| **Meeting Summary** (Team members identified, group agreements established, client/family goals and strengths identified, what is working well, what supports are in place, actions taken since last meeting, what are the needs of client/family): | | | | | | | | | | | | | | | | |
| **Intervention** (Writer’s unique role and contribution in meeting): | | | | | | | | | | | | | | | | |
| **Response/Observed Behavior(s)** (Current high risk behaviors that meet medical necessity; client’s response to interventions; observed mood/behavior during meeting): | | | | | | | | | | | | | | | | |
| **Progress** (include progress or barriers to progress toward meeting client plan goal): | | | | | | | | | | | | | | | | |
| **Action Plan** (What are the identified action steps agreed to in this meeting): | | | | | | | | | | | | | | | | |
| **If Wraparound CFT Meeting, Phase of Wraparound** (Engagement, Planning, Implementation, Transition): | | | | | | | | | | | | | | | | |
| **Overall Risk** (Based on current service, including mitigating factors, evaluate and determine if the client is at an elevated risk for):  Danger to Self:  Danger to Others: | | | | | | | | | | | | | | | | |
| **Additional Information** (when applicable): | | | | | | | | | | | | | | | | |
| **If CFT Meeting Facilitation Program was not utilized: CFT Summary and Action Plan Offered to Youth, Caregiver, PSW and/or Probation Officer (as applicable), and other team members** **on:** | | | | | | | | | | | | | | | | |
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| Signature/Credential | | | | |  | Date | | |  | Printed Name/Credential/Server ID# | | | | | | |
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| Signature/Credential | | | | |  | Date | | |  | Printed Name/Credential/Server ID# | | | | | | |