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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:**       |
|  |  |       |  |       |
| Signature/Credential  |  | Date |  | Printed Name/Credential/Server ID# |
|  |  |       |  |       |
| Signature/Credential |  | Date |  | Printed Name/Credential/Server ID# |