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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: |
| Focus of session Diagnosis ICD-10 Code(s): | | | | | Service: | | | | | | | |
| **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): | | | | | | | | | | | | |
| **Functional Impairment** (Describe the current area(s) of client's life that are affected as a result of their mental health diagnosis; current mental health symptoms/behaviors and CANS actionable needs which impact functioning and are the focus of the CFT meeting): | | | | | | | | | | | | |
| **Meeting Summary** (Focus/purpose of meeting, natural supports/new team members identified, client/family goals and strengths identified including CANS centerpiece and well developed strengths, permanency/stabilization of client in home, progress towards goals, presenting problem(s), resources available, actions taken since last meeting, needs of client/family): | | | | | | | | | | | | |
| **Intervention** (Writer’s unique role and contribution in meeting. May include active listening time supported by what information was shared, how it can/will be used in providing, planning, or coordinating services to the client and impact on client plan): | | | | | | | | | | | | |
| **Client Response to Intervention/Observed Behavior(s) During Meeting** | | | | | | | | | | | | |
| **Progress** (Include progress or barriers to progress toward meeting client plan goal): | | | | | | | | | | | | |
| **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# | | | | |