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| --- | --- |
| **Youth:** Name | **CRN:** 123456 |
|  |
| **Service Provider:** Name | **Provider Agency:** select |
| **Service Date:** select | **Start Time:** 9:00 am | **End Time:** 10:00 am | **Units:** # |
| **In-Home Service:** select | **Credential:** select |
| **Out-of-Home Service:** select |
| **Service Format:** select | **Service Setting:** select |
| [ ]  *This service overlaps with another – do not bill Medicaid.* |
| [ ]  *This was a telehealth service.* |
| [ ]  *Contents of this note are sensitive.* (reason if checked) |
| **DAP Note** |
| **D:** Data |
| **A:** Assessment of progress on goals |
| **P:** Plan |
| **Treatment Targets Addressed this Session (up to 3)** |
| *Treatment Target (select 1)* | *Treatment Target Progress Rating* |
| Externalizing BehaviorsInternalizing BehaviorsPositive BehaviorsMore TargetsOther | select |
| *Practice Elements Used (select 1 practice element per column – up to 3 total)* |
| Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther | Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther | Behavior ManagementCoping/Self-ControlCore PracticesMore PracticesOther |
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| **Additional Information:** Describe |
| *Submitted by:* |
| **Provider:** Name | **Signature:** |  | **Date:** select |
| *(If provider is not a QMHP, supervisor must complete next section)* |

*Supervisor Review & Approval* [ ]  *Not Applicable*

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| --- |
| *Select one (1):* |
| [ ]  I discussed the case with Name on select. I have reviewed this note and agree with the documented findings and plan of care.  |
| [ ]  I saw the youth and performed evaluation and direct services with Name on select. See note dated select for additional history and recommendations. I have reviewed this note and agree with the documented findings and plan of care.  |
| **Additional Comments / Recommendations:** Describe |
| **Supervisor:** Name | **Signature:** |  | **Date:** select |