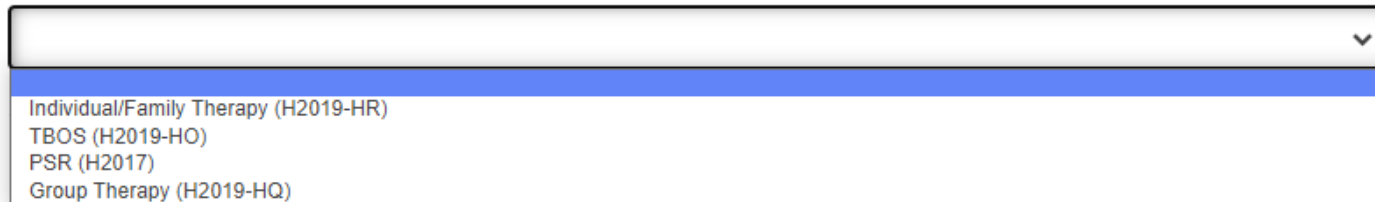


## DOCUMENTATION: THERAPY PROGRESS NOTES

When you select Progress Notes, it will prompt you to select the correct type that you want to use:

**Service \***



**Session Date \***      **Start Time \***      **End Time \***      **Duration**      **Units**

Based on your selection, the template changes to show the required items for that note.

Enter the basic information:

- Client ID
- Client's Name (make sure it's not misspelled = must match what we have on file)
- Session Date
- Start Time
- End Time
- The duration and number of units will auto-calculate
- Where the session took place
- Who participated in the session (client, parent? Someone else was there too?)
- If it was a group therapy or multiple-client PSR session, indicate the number of people in the group.

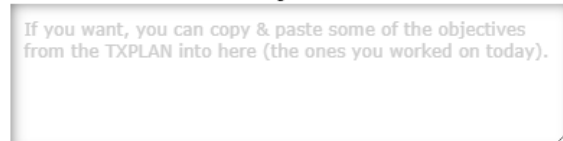
Check the appropriate problem(s) that was discussed TODAY.

- This should be something from the client's treatment plan.
- Example, if the client's problems for the treatment plan are: Defiance, Depression, and Social Skills, then at least one of these must be checked off when you write a note. You would NOT want to select Eating Disorder, for example.
- If PSR... then you have to check the PSR activity done today.

Treatment Plan Goals/Objectives Addressed

- An easy way to do this is to copy & paste some of the objectives from the TXPLAN into here (the ones you worked on today). For this, you'll need the client's treatment plan opened in another window. You should save a copy of the treatment plan so you can have it on your computer.
- Otherwise, you should write-in the specific objectives that you worked on.

**Treatment Plan Goals/Objectives Addressed \***



*TIP – you can enlarge the text boxes by clicking on the bottom-right drag-icon.*

Practitioner's interventions

- What specific techniques did you do today, to make the client improve?

- Medicaid wants to know what you did. Cognitive behavioral therapy? Role playing? Be as specific as you can be in this section.
- In a group setting, what you write here should ideally be the same for all clients in the group.

**Practitioner's Interventions \***

What specific techniques did you do today, to make the client improve?

**Client's Response**

- This is the most important part of the note, so it should be the section with the most content.
- Tell us what the client learned, what he said, include quotes if possible.
- You justify your note in this section by what you write.
- If this is a group, indicate how the client interacted with others.

**Client's Response \***

This is the heart of the note and should be the largest section... tell us what the client learned, what he said, include quotes if possible. You justify your note in this section by what you write. If this is a group, indicate how the client interacted with others.

Practitioner is improving (or not) towards his goals.

Complete the Suicidal Risk Check and indicate if the client had Homework.

The Plan for next time, should be something like "Continue therapy as scheduled, sessions scheduled for next week"

**Homework \***

If you didn't leave the CT any homework, write so in here.

**Plan \***

For example.... I will continue to work on defiance and social skills on the next session which is scheduled for next week.

Complete your name, credentials (e.g. LMHC), Sign your name, and date it.

**UPLOAD** either:

- Verification Form Signed by the client/guardian
- Screenshot of session or of Time Log
- Scanned Verification Form for In-Person sessions

Upload any files if necessary (e.g. drawings, client reports, etc.). >>>> Press Submit Note.