**Mental Health Waiver Service Encounter Note**

|  |  |  |  |
| --- | --- | --- | --- |
| **Client Name: (First, Middle, Last):** |  | **Agency Name**: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Activity** | | **□ Transitional CM □ CSP □ Supported Employment □ Peer Support** | | | | | | |
| **Location: □ Office □ Home □ SNF □ CMHC □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Service: □ Individual □ Group** | | | | | | | | |
| **Goal(s) Number:** |  | | | **Objective(s) Number:** | |  | | |
| **Present at Session**  **Client Present** (If others, please identify name(s) and relationship(s) to client): | | | | | | | | |
| **Interventions Provided** |  | | | | | | | |
| **Client Response to the Intervention** |  | | | | | | | |
| **Plan and Next Steps** |  | | | | | | | |
| **\*Level of Assistance (please circle one) 5 Maximum 4 Moderate 3 Minimum 2 Standby 1 Independent 0 Unable** | | | | | | | | |
| **Signature and Credentials of Staff** | | | **Date of Signature** | **Date of Service** | **Start Time** | | **Stop Time** | **Total Minutes** |
|  | | |  |  |  | |  |  |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Activity:** | | **□ Transitional CM □ CSP □ Supported Employment □ Peer Support** | | | | | | | |
| **Location: □ Office □ Home □ SNF □ CMHC □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ Type of Service: □ Individual □ Group** | | | | | | | | | |
| **Goal(s) Number:** |  | | | | **Objective(s) Number:** | |  | | |
| **Present at Session  Client Present** (If others, please identify name(s) and relationship(s) to client): | | | | | | | | | |
| **Interventions Provided** |  | | | | | | | | |
| **Client Response to the Intervention/** |  | | | | | | | | |
| **Plan and Next Steps** |  | | | | | | | | |
| **\*Level of Assistance (please circle one) 5 Maximum 4 Moderate 3 Minimum 2 Standby 1 Independent 0 Unable** | | | | | | | | | |
| **Signature and Credentials of Staff** | | | **Date of Signature** | **Date of Service** | | **Start Time** | | **Stop Time** | **Total Minutes** |
|  | | |  |  | |  | |  |  |

|  |
| --- |
| **\*Level of Assistance**  **5 - MAXIMUM ASSISTANCE – Cues –** Step by step **physical gestures, pointing and demonstrations**. **Prompts/Coaching -** Step by step **physical demonstrations with visual and verbal directions** that prompt the participant to perform the skills and/or tasks.  **4 - MODERATE ASSISTANCE – Cues** – Step by step **verbal & written directions/hints** to help organize thoughts. **Prompts/Coaching** – Step by step **verbal directions**.  **3 - MINIMUM ASSISTANCE – Cues** - **Verbal & written hints** related to the task. **Prompts/Coaching** – **Written and/or verbal directions**.  **2 - STANDBY ASSISTANCE – Cues** – **Visual demonstrations** related to the task. **Prompts/Coaching** – **Visual and physical directions** that prompt the participant to perform the skills and/or tasks.  **1 - INDEPENDENT – No physical or cognitive assistance needed to perform activities or tasks.**  **0 - UNABLE TO ASSESS OR INDIVIDUAL REFUSES TO BE ASSESSED.** |

**7/25/2018 revised format**