CCBH Folders and Progress Notes TIP SHEET

Progress Note Folder Types

Service Type Family Interim Folder (IF) is available to be opened and used for up to 30 days, when providing pre-client plan billable services to a new client until a client plan is written. Electronically sign and Final Approve the Family **IF** for the type of service you provide before entering progress notes. The **IF** must be ended before a client plan folder can be opened. **IF** and a client plan folder dates cannot overlap. There is no need for an **IF** once a client plan folder is opened. If a client plan is written at client's admission, then an **IF** would not be opened or used, as a client plan folder is used instead. ~ ***See Interim Folder section of CP Training Manual***

Service Type Family Client Plan Folder (CP) is required to be written, signed, Final Approved within 30 days of client's admit date. **CP**s are active for up to one year for Adult programs and for CYF programs until all sessions are completed and a UM request is submitted or up to one year, whichever comes first. Complete the **CP** Tiers and narrations before signing the **CP**. Clinician must have client agreement documented within the first 30 days or have client/guardian signature of approval, be electronically signed and be Final Approved within timeline requirements for **CP** to be valid. ~ ***See Client Plan section of CP Training Manual***

Modify Dates option is for modifying or changing the begin and/or end date of an open **IF** or **CP**. This occurs when ending an **IF** and beginning a **CP** or modifying a **CP** end date for UM or for starting a completely new **CP** when a current plan exists. ~ ***See Client Plan: Modifying Dates section of CP Training Manual***

Revise option is for making changes to a current **CP**. **Revise option is <u>NOT</u> used for CYF UM**. When you **Revise** the system will not change the **CP** begin or end dates. Clinician must have client/guardian signature of approval, complete electronic signatures in the EHR and Final Approve **CP**. ~ ***See Client Plan: Revising section of CP Training Manual***

Review option is used when the current **CP** is expiring, or when CYF programs UM for additional sessions requiring an updated **CP**. The system will add new timelines (begin and end dates). Clinician must have client/guardian signature of approval, complete electronic signatures in the EHR and Final Approve within required timelines for **CP** to be valid. ~ ***See Client Plan: Reviewing section of CP Training Manual***

Progress Notes Types

Informational Progress Note is used for entering information into a client chart that is Never Billable information. <u>Begin with Unit/Subunit in narration</u>. Template is not used. All staff with access to sign can Final Approve. Co-signature is <u>not</u> required. ~ ***See Informational Progress Note section of PN Training Manual***

Individual Progress Note is used to document and bill for individual MH services. Templates can be used, particularly for Rehabilitation or Psychotherapy services and Med. notes. Enter the narrative first, signatures second. Enter the service billing information after the signature lines are properly completed, including Co-signature if needed, within timelines, and then Final Approved. ~ ***See Individual Progress Note section of PN Training Manual***

Group Progress Note is used when providing services to multiple individuals in a group setting. All clients must have open folders in the system to Final Approve the progress notes. Enter Documentation Time after progress notes are Final Approved. In general, each step must be saved before moving to the next step, including each client narration. The note must be Final Approved within timelines. ~ ***See Group Progress Note section of PN Training Manual***

DISCLAIMER

This tip sheet is only a brief description and not a replacement for the Client Plans and Progress Notes Resource Packet!