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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# |