MSDP

CBFS Note
Revision Date: 06/12/09

Community Based Flexible Support Service Note

Person's Name (First, MI, Last)**:**	**Record #:**	**DOB:**
Organization Name:		

Contact Type	☐ In Person Meeting ☐ Telephone ☐ Collateral (please describe): ☐ Other (please describe):
List All Persons Present	☐ Person Present ☐ No Show ☐ Person Cancelled ☐ Provider Cancelled Explanation: ☐ Others Present (please identify name(s) and relationship(s) to person):

Functioning - Observed or Reported (May include mood, affect, behavior, cognitive functioning, etc.):

New Issue(s) Presented Today: ☐ **None Reported** ☐ **New Issue resolved, no CA Update required** ☐ **CA Update Required**

Refer to Shift/Daily Note of

Goal(s)/Objective(s) Addressed as Per Individualized Action Plan:

☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective___	☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective___	☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective___	☐ Goal ___ ☐ Objective 1 ___ ☐ Objective 2 ___ ☐ Objective 3 ___ ☐ Objective___

Therapeutic Interventions Provided:

☐ Advocacy	☐ Eliminating Barriers	☐ Monitoring
☐ Assessment of Needs	☐ Employment Supports	☐ Outreach
☐ Coordinating Services	☐ Empowerment/Skills Building	☐ Wellness
☐ Crisis Management	☐ Housing Advocacy	☐ Other:
☐ Education/Training	☐ Medication Training/Administration	

Describe the interventions provided:

Person's Response to Intervention/ Progress Toward Goals and Objectives:

Plan / Additional Information (*Indicate action plan between sessions***):**

Provider – (Print Name/Credential) **:**		**Supervisor - Print Name/Credential** (if needed):	
Provider Signature:	**Date:**	**Supervisor Signature** (if needed):	**Date:**
Person's Signature (Optional):	**Date:**	**Next Appointment:** **Date: / / - Time:** ☐ **am** ☐ **pm**	

Date of Service	Provider Number	Loc. Code	Prcdr. Code	Mod 1	Mod 2	Mod 3	Mod 4	Start Time	Stop Time	Total Time	Diagnostic Code