**COMPLETED BY:**

1. Staff delivering services within scope of practice. Co-signature must be completed within reasonable time.

**COMPLIANCE REQUIREMENTS:**

1. A Daily Progress Note must be completed for each day of service during which the client participates in the treatment scheduled.
2. Content of each progress note must support the client participated in a minimum of 50% of the scheduled treatment hours.
3. The Daily Progress Note Template shall be used for all day treatment service activities, and all prompts must be addressed, or reason why not documented.
	1. **Specific Service(s) Provided** prompt documents all groups, activities, meetings, provided to the client. This is to document client participation or failure/refusal to participate.
	2. **Observations of Client’s Behavior** prompt is intended to document staff observations including client behavior, participation, and response during the treatment and/or in the milieu or N/A if client was not present.
	3. **Possible Side Effects of Medications** is used to document any possible side effects of medications or medication changes observed, or N/A if none are observed.
	4. **Contact with Client family, friends, natural supports, CFT, mental health team, authorized legal representatives and/or public entities involved with the client** shall document summary of any meetings(s), or interaction(s) with those listed, or N/A if none occurred.
4. Data must be entered into the Electronic Health Record (EHR).
5. Every progress note within the EHR must be completed and final approved within 3 business days (date of service is day 1).
	1. Progress notes signed by a provider needing co-signature are considered “on time” when the provider signs the note within 3 business days and the co-signer signs with a reasonable time.
	2. Notes will no longer be disallowed for being final approved late but may be marked out of compliance.

**DOCUMENTATION STANDARDS:**

1. Service entry shall be completed as a part of the progress noting process.
2. Completion and final approval of the progress note by the staff is a certification the documented service was provided personally, and the service was provided to a beneficiary meeting access criterion, or during assessment to determine if the beneficiary meets criteria.
3. When it is not completed and final approved, the note is at risk for deletion by another server.
4. Paper forms are only to be completed when the EHR is not accessible and/or when staff have not yet been trained in the EHR.
5. Progress notes are not viewed as complete until they are final approved.