



WRAP Progress Note/ Billing Form

NAME / MRN _____

Service Date: _____ **RU:** _____
Staff #: _____ **Hours*** _____ **Mins** _____ **# in Group:** _____
Co-Staff #: _____ **Hours*** _____ **Mins** _____ **Total Travel Time: Hours** _____ **Mins** _____

* Service duration must include travel time, if applicable

Services: (Check one)

<input type="checkbox"/> 300 No Show	<input type="checkbox"/> 313 Evaluation	<input type="checkbox"/> 351 Group Therapy	<input type="checkbox"/> 561 Case Mgmt – Linkage
<input type="checkbox"/> 400 Client Cancel	<input type="checkbox"/> 315 Plan Developmt	<input type="checkbox"/> 355 Group Rehab	<input type="checkbox"/> 564 ICC
<input type="checkbox"/> 700 Staff Cancel	<input type="checkbox"/> 317 Rehab	<input type="checkbox"/> 357 Group Collateral	<input type="checkbox"/> 571 Case Mgmt - Plan Developmt
<input type="checkbox"/> 371 Crisis Int.	<input type="checkbox"/> 331 Assessment	<input type="checkbox"/> 358 IHBS	<input type="checkbox"/> 540 Non-Billable Services
<input type="checkbox"/> 311 Collateral	<input type="checkbox"/> 341 Indiv Therapy	<input type="checkbox"/> 541 Case Mgmt - Placement	<input type="checkbox"/> 580 Non-Billable - Lock-outs

Location of Services: (Check one)

<input type="checkbox"/> 1 Office	<input type="checkbox"/> 5 School	<input type="checkbox"/> 11 Faith-based	<input type="checkbox"/> 15 Licensed Care Fac. (Adult)	<input type="checkbox"/> 19 Residential Tx Center (Child)
<input type="checkbox"/> 2 Field	<input type="checkbox"/> 8 Correctional Facility	<input type="checkbox"/> 12 Healthcare	<input type="checkbox"/> 16 Mobile Service	
<input type="checkbox"/> 3 Phone	<input type="checkbox"/> 9 Inpatient	<input type="checkbox"/> 13 Age-Specific Center	<input type="checkbox"/> 17 Non-Traditional Location	<input type="checkbox"/> 20 Telehealth
<input type="checkbox"/> 4 Home	<input type="checkbox"/> 10 Homeless/Shelter	<input type="checkbox"/> 14 Client's Job-site	<input type="checkbox"/> 18 Other	<input type="checkbox"/> 21 Unknown

Service Strategies: (Check up to three, if applicable)

<input type="checkbox"/> 50 Peer/Family Services	<input type="checkbox"/> 53 Supportive Education	<input type="checkbox"/> 56 With Social Services	<input type="checkbox"/> 59 With Developmt Disabled
<input type="checkbox"/> 51 Psycho-Education	<input type="checkbox"/> 54 With Law Enforcement	<input type="checkbox"/> 57 With Substance Abuse	<input type="checkbox"/> 60 Ethnic-specific Services
<input type="checkbox"/> 52 Family Support	<input type="checkbox"/> 55 With Health Care	<input type="checkbox"/> 58 With Aging Providers	<input type="checkbox"/> 61 Age-specific Services
			<input type="checkbox"/> 99 Unknown

Is the client pregnant? Yes No (If yes, please document how service was pregnancy-related)

Interpreter Name of Interpreter: _____
 Language service provided in other than English: Spanish Other _____

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

1b. Description of Current Situation/Reason for Contact: (Status update, needs, clinical impressions) **DSM-5 Code** _____ **ICD-10 Code** _____

Name: _____ MRN: _____

2. **Focus of Activity:** (Intervention and Response to Intervention, what did you do? What is the consumer's response?)

3. **Plan** (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the consumer/family/providers are to do.*

Signature/License/Job Title

Printed Name

Date

Co-Signature/License (if applicable)

Date

**Data Entry
Clerk Initials**