

ASSERTIVE COMMUNITY TREATMENT TEAM (ACTT) PROGRESS NOTE

PIE CLINICAL FORMAT • TRAINING & PRESENTATION TEMPLATE

Name:	John "Jack" Doe (Sample)	DOB:	05/14/1994
Age:	32	Medicaid ID #:	987654321A
MCO:	TRILLIUM	MCO Record #:	TRL-8842109
Procedure Code:	H0040 (Assert comm tx pgm per diem, 1.00 Unit)	Date of Service:	09/18/2026
Primary Diagnosis:	F25.0 — Schizoaffective disorder, bipolar type	Service Type:	ACTT Community Service

Face-to-Face Time Slot:	Start: _10:00 am_ End: _11:00 am	Total F2F Time / Units:	_60_ Minutes / 1.00 Unit
Travel Time Slot:	Start: _9:45am_ End: _10:00 am_	Total Travel Time:	_15_ Minutes

PERSON-CENTERED PLAN (PCP) REFERENCE & ACTIVE GOALS

PCP Plan Date: 03/18/2026 | Last Review Date: 04/01/2026 | Next Review Date: 03/17/2027 | Status: 04/01/2026 (Active)

Short Term Goal (Vocational / Meaningful Community Engagement): John will explore areas of meaningful community engagement and college programs online or in person as evidenced by at least one community outing per week, reviewing college courses twice per month, and maintaining sobriety through at least 2 ACTT Vocational and Co-Occurring related interventions per month over the next 12 months. [Date Started: 04/01/2026]

- **Planned Intervention:** Teach and practice with John positive and effective coping skills to offset triggers and identified barriers to engaging in positive community activities including school or employment in the community.

Short Term Goal (Substance Use Recovery & Relapse Prevention): John will maintain harm-reduction and sobriety practices in the community as evidenced by identifying high-risk triggers, establishing a weekly recovery-oriented routine, and participating in peer support or recovery groups through at least 2 ACTT Co-Occurring / Peer Support interventions per month over the next 12 months. [Date Started: 04/01/2026]

- **Planned Intervention:** Provide individualized relapse prevention counseling, identify personal recovery triggers, and practice refusal skills to support ongoing sobriety and healthy lifestyle choices.

P — PROBLEM / PRESENTING SITUATION

Document John's current mood, behavioral presentation, reported symptoms related to F25.0, current triggers/barriers, and the specific goal (Goal 1 or 2) targeted today.

CPSS met client at local library for weekly scheduled check in. Client stated, "I feel like I'm falling back into old habits and can't stay on track". Noted low energy and visible anxiety when discussing upcoming routine changes. Client also expressed feeling overwhelmed and isolated over the past week.

I — INTERVENTION

Document ACTT clinician/specialist actions: specific coping strategies modeled, psychoeducation delivered, community navigation/housing search performed, or self-advocacy skills practiced.

CPSS utilized active listening and reflective dialogue to validate client's feelings without judgment. CPSS shared lived experience regarding managing routine disruptions and navigating self-doubt in early recovery. Explored existing natural supports and reviewed client's daily coping toolbox. Focused on boundary setting and small, manageable daily goals.

E — EVALUATION / CLIENT RESPONSE & FUTURE PLAN

Document John's engagement, receptivity, ability to demonstrate skills taught, response to intervention, safety assessment, action steps before next session, and next contact date/time.

Client's posture was relaxed and affect shifted from tense to engaged. Client identified two concrete steps to take before the next session: reach out to support friend twice this week and taking a daily 15-minute walk. Agreed to reconnect next Tuesday at 10:00 am to review his progress.

Staff Signature, Title & Credentials:	Date / Time Signed:
<i>Buffy L. Cooper</i> , CPSS, CADCR	9/18/2026 12:43 pm