

Music Therapy 90-Day (Quarterly) Report

CLIENT NAME		CASE MANAGER NAME	
PROVIDER NAME		PROVIDER AGENCY NAME	
DATE COMPLEMENTARY THERAPIES (FORM DSHS 27-194) WAS WRITTEN	DATE RANGE FOR THIS REPORT		PASRR CLIENT <input type="checkbox"/> Yes <input type="checkbox"/> No
Describe the goals and objectives for Music Therapy. See instructions for more detail.			
Goal 1			
Goal 2			
Goal 3			
If any new treatment goals are identified, the Music Therapy Initial Plan must be revised.			
Check corresponding boxes for types of music therapy strategies used:			
<input type="checkbox"/> Music Improvisation <input type="checkbox"/> Receptive music listening <input type="checkbox"/> Song writing <input type="checkbox"/> Lyric discussion <input type="checkbox"/> Music and imagery <input type="checkbox"/> Music performance <input type="checkbox"/> Other expressive musical forms			
Describe the treatment strategies utilized for each goal:			
Goal 1			
Goal 2			
Goal 3			
Summarize progress towards goal achievement in objective and measurable terms, including barriers to progress. Include alternate strategies planned to address barriers.			
Goal 1			Goal completion, using a scale from 1 – 10 (10 being goal is met) Goal 1: Goal 2: Goal 3:
Goal 2			
Goal 3			

List referral recommendations made if the waiver participant presents with potential underlying medical, mental health, or educational support needs:

When did you provide Music Therapy (dates / times of service in the last 90 days)?

DATE	SERVICE DELIVERY (CHECK DELIVERY METHOD)	TIME SPENT (IN 15 MINUTES)
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice	
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice	
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice	
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice	
	<input type="checkbox"/> In person <input type="checkbox"/> Teleservice	

Date of CFT meetings attended, behavioral specialist consultation, or other care coordination activities:

Date: _____ Number of Units (15 minutes): _____
 (maximum of two hours per quarter)

Describe any consultation or care coordination outcomes, if any.

Include additional visits on a separate page and attach to this report.

Total Units (15 minutes of service provided in previous 90 days:

Signatures

CLIENT SIGNATURE _____	DATE _____	LEGAL REPRESENTATIVE'S SIGNATURE _____	DATE _____
PROVIDER SIGNATURE _____	DATE _____		

Instructions for Music Therapy Quarterly Progress Report

Client Name: Add in the name of the client.

Case Manager Name: Include the name of the client's case manager.

Provider Name: Add in provider's name who is working directly with the client.

Provider Agency Name: Include the name of the agency that the clinician working with the client works for.

Date Complementary Therapies form (27.194) was written: Include the date when this form was completed.

Date range for this report: This is the date range this form is reporting on.

PASSR client: Check this box if this is a client supported by the PASSR program. The client's case manager can confirm.

Describe the client's goals and objectives for Music Therapy: Include how the goals connect to the recommended support requested by the client's behavioral health provider. Describe how each goal is intended to complement the primary behavior support plan. There should not be more than three goals per plan.

Check corresponding boxes for types of music therapy strategies used: Check the boxes that are applicable.

Describe the treatment strategies utilized for each goal: What methods and techniques have been used to support the client? Describe them here.

Summarize progress towards goal achievement in objective and measurable terms, including barriers: Include alternate strategies planned to address barriers. Include what steps the client has made in music therapy to bring them closer to their goals. How has this service assisted the client to progress with their goals? On a scale from -10 where is the client in meeting their identified goal for music therapy?

List referral recommendations: If the client presents with potential underlying medical, mental health, or educational support needs (referral may be to care coordinator, treating professional, or DDA), list in this section any referrals necessary for the client that are outside of what music therapy can provide. Consideration examples: Are there any concerns of client's mental health presentation or education needs for school? Does the client need referral to resources that they are not connected with yet?

Dates and times of service in the last 90 days: Document here when music therapy was provided, through what kind of service delivery (in-person or through teleservice), and then how much time was spent.

Date of CFT meetings attended, behavioral specialist consultation, or other care coordination activities: Document any meetings attended such as the Client and Family Team meeting for individuals on the CIIBS waiver and document any new care consultation strategies that were discussed.

Client Signature: The client must sign here.

Legal Representative Signature: When applicable, the client's legal representative needs to sign here, agreeing to this report.

Provider Signature: The equine therapy provider will sign here.