Barry Mental Health Authority - Independent CLS Staff Documentation

Consumer Name _____ Start Time _____ Case Number _____

Date of Service _____ Stop Time _____ CSM/SC _____

Level of Support (Choose at least one for each Goal / Objective area below):

4 – Full Physical Assist **3** – Light/Partial Physical Assist **2** – Guiding-Verbal/Gesture **1** – Monitoring/Observing/Reminding **0** – Independent **R** - Refused

Please write in the Objective above in the space provided below:

Objective			
Level of Support Required		Location	
Staff Intervention:			
Progress towards achieving the Objective:			
Objective			
Level of Support Required		Location	
Staff Intervention:			
Progress towards achieving the Objective:			
Objective			
Level of Support Required		Location	
Staff Intervention:			
Progress towards achieving the Objective:			
Overall Satisfaction - 'In their own words'			

Staff Signature_____ **Date** _____