Progress Notes

REQUIRED FORM:

This form is a required document in the client file to document progress toward achieving the client's recovery or treatment plan goals.

WHEN:

This form must be completed within the following guidelines (Title 22):

- Progress notes shall be legible
- Outpatient programs (except IOT) must document a progress note for each client's individual or group session attended within 7 calendar days from the date of service (use Form 601a).
    - Progress notes documented after 7 calendar days will be disallowed.
- IOT programs must document at least one progress note per calendar week for each client participating in structured activities (use Form 601b).
    - The individual narrative summaries must include:
        - Description of progress on treatment plan
        - Record of attendance at each counseling session, including the date, start and end times, and the topic
    - The note must be completed within the following week.
- Residential programs shall document each client's progress on a weekly basis and complete the note within the following week (use Form 601b).

COMPLETED BY:

Each progress note is written by the counselor who provided the service.

REQUIRED ELEMENTS:

- **Client Name:** Complete client's full name.
- **Counselor Name:** Complete primary counselor's name.
- **Client ID:** Complete the client ID number as determined by agency guidelines.
- **Week of:** Complete the beginning date **through** the ending date of the service week (optional)
- **Date:** Complete date of the service.
- **Time:** Complete beginning and ending time of the service.
- **Minutes:** Complete service minutes elapsed.
- **Problem Area:** Address problem areas from Recovery/Treatment plan.
- **Activity Code:** Complete activity code consistent with the service provided from the list of activity codes from the bottom of page.
- **Progress Note Comments Section:** A complete progress note addresses:
    1. Include topic of session in body of progress note.

2. Client's progress towards one or more goals in the client's recovery or treatment or plan, action steps, and/or referrals.
3. New issues or problems that affect the client's recovery or treatment plan.
4. Types of supports provided by the program or other appropriate health care providers.
5. All entries must include the printed name, signature and date of the staff completing the progress note.

NOTE:

Per Title 22 (CCR 51490.1 and 51341.1), if a DMC client must return on the same day for a second service at the same provider, then the Multiple Billing Override Certification (DHCS MC 6700 form) must be completed and maintained in the client file:
http://www.dhcs.ca.gov/formsandpubs/forms/Documents/MC_6700_Form_Override.pdf

For ODF programs, the second service can be a crisis or collateral service, and the progress note must document the return visit did not create a hardship on the client and was unavoidable. For IOT programs, the second service must be a crisis service and must be documented in a progress note.