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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Client: | | | Case #: | | | | Program: | |
| Date of Service: | | Unit: | | | | | SubUnit: | |
| Server ID: | Service Time: | | | | | | Travel Time: | Documentation Time: |
| Person Contacted: | Place: | Outside Facility: | | | | | Contact Type: | Appointment Type: |
| Billing Type (Language Service  Provided In): | | | | Intensity Type (Interpreter Utilized): | | | | |
| Diagnosis At Service: ICD-10 Code(s): | | | | | | | Service: | |
| **CASE MANAGEMENT PROGRESS NOTE**  **Travel To/From:** | | | | | | | | |
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|  | | | | | | | | |
| **Service(s) Needed or Chief Complaint(s) Being Addressed:** (documentation should support why this service is necessary as it relates to current impact on client’s mental health symptoms/impairment(s) and/or progress towards goals) | | | | | | | | |
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| **Action Taken** (Describe actions or interventions taken to address the client’s current need for services and how service/intervention addresses impact to client’s mental health impairments/symptoms or progress towards goals)**:** | | | | | | | | |
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| **Response/Plan of Care/Follow Up** (Next steps and referrals given) **:** | | | | | | | | |
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| \*Signature/Title/Credential Date | | | | |  | Printed Name/Credential/Server ID# | | |
| \* I certify that the service/s shown on this sheet was provided by me personally and the service/s were medically necessary. | | | | | | | | |
|  | | | | |  |  | | |
| Co-Signature/Title/Credential Date | | | | |  | Printed Name/Credential/Server ID# | | |