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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:** |
|       |
|  |
| **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# |