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| --- | --- | --- |
| **Client:**       | **Case#:**       | **Program:**      |
| **Date of Service:**  Date | **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/PEER SUPPORT CLIENT PLAN NOTE**

**Goal of Service:** (***Specifies the measurable goals of treatment, service activities, and assistance to address the negotiated objectives of the plan and the medical social, educational and other services needed by the beneficiary.)***

**Intervention: (*A narrative describing the service, including how the service addressed the beneficiary’s behavioral health need goals [e.g., symptom, condition, diagnosis, and/or risk factors]).***

**Response to Intervention(s):**

**Action Plan: (*Identifies a course of action to respond to the assessed needs of the beneficiary next steps including, but not limited to planned action steps by the provider or by the beneficiary, collaboration with the beneficiary, collaboration with other provider(s) and any update to the problem list as appropriate.)***

**Transition Plan: *(To be completed when a beneficiary has achieved the goals of the care plan.)***

**Client agreed to plan of care: *Yes\_\_\_\_ No\_\_\_\_ If “no”, document reason why not:***

\***Signature/Title/Credential** **Date**  **Printed Name/Credential/Server ID#**

\*I certify that the service/s shown on this sheet were provided by me personally and the services were medically necessary.

**Co-Signature/Title/Credential Date Printed Name/Credential/Server ID#**

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| County of San DiegoHealth and Human Services AgencyMental Health ServicesCASE MGMT/PSS CLIENT PLAN PROGRESS NOTEHHSA-MHS (08/24/22) | Client: John DoeCase #: 123456789Program: ABC Therapy |