**CLIENT NAME:** Required Field **CLIENT #:** Enter CCBH assigned number

**PROGRAM NAME:** Required Field

**SERVICE CODE 95:** Check correct program: DRF: Day Rehab Full, DRH: Day Rehab Half, DIF: Day Intensive Full, DIH: Day Intensive Half

**UNIT/SUBUNIT:** Required Field **DIAGNOSIS:**  Enter ICD-10 Code and Description

**SERVICE COMPONENTS: Only mark the corresponding boxes when client attends the services**

*Monday-Friday*: Required to include specific dates including year for each day

*Individual Therapy*: Mark the box that corresponds with the date the client attended Individual Therapy. The Individual Psychotherapy notes may be done on a separate progress note and indicate “See note dated \_/\_/\_\_”in the Significant Weekly Information section and file with the Weekly.

\*Note: if program is a Day Treatment/STRTP Hybrid, Individual Therapy may be provided on non-Day Treatment days, as well as outside of billed Day Treatment hours.

*Family Therapy:* Mark the box that corresponds with the date that client received Family Therapy if

applicable. This box is for a therapeutic service, collateral contact can be documented within

Significant Weekly Information or Other Interventions section. If a separate note is completed, can indicate “see Family Therapy note dated \_/\_/\_\_” in the Family Therapy section and file with the Weekly.

\*Note: if program is a Day Treatment/STRTP Hybrid, Family Therapy may only be billed on non-Day Treatment days.

*Group Therapy*: Mark the box that corresponds with the date that client attended Group Psychotherapy. Group Therapy may be documented in the body of the Weekly, or it can be documented on a separate Group Psychotherapy progress note and indicate “See note dated \_/\_/\_\_”in the Significant Weekly Information section and file with the Weekly.

*Therapeutic Milieu:* Mark the box that corresponds with the date that client was billable for participating in Day Program milieu. If less than 50%, this box should not be marked.

*Community Meeting*: Mark the box that corresponds with the date that client attended Community Meeting.

**ATTENDANCE TIME:** Must enter total attendance time for the each day. This time should equal the corresponding Sign In/Out sheets utilized to track attendance time and should be reflected in the billed time to Medi-cal.

**UNAVOIDABLE ABSENCES:** When a client has missed a section of allotted time for Day Treatment, you must determine if the absence was Avoidable or Unavoidable. If a client misses time to an Avoidable Absence, the State has determined that the entire day is NOT billable.

* *Avoidable Absence*: the State has determined that the entire day is NOT billable when a client misses time due to an Avoidable Absence.
* *Unavoidable Absence*: When these absences occur, mark the box that corresponds with the date the client missed time. Then in the box provide a brief reason. A more thorough description of the absence can be given in the Significant Weekly Information section or if a pattern has emerged, it can be explained in that section. The State has indicated the following to be Unavoidable Absences: family emergency, beneficiary became ill, court appearance, appointment that cannot be rescheduled (need to explain why it cannot be rescheduled), family event (ex: funeral, wedding), and transportation issues.

**ABSENCE TIME:** When a client has either of the above mentioned absences, documentation of the Absence Time In & Out must be added. These times must also correlate with the Sign In/Out Sheets used to track program attendance.

**SIGNIFICANT WEEKLY INFORMATION:** This section should provide information to obtain a clear picture of services provided throughout the week in order to justify the time billed to Medi-cal. Each day needs to be documented individually to assure that it supports time billed. Breaking out and providing examples of the different services: Process groups (groups to help clients develop the skills necessary to deal with their individual problems/issues by using the group process to provide peer interaction and feedback in developing problem-solving strategies and to assist one another in resolving behavioral and emotional problems), Skill building groups (staff help clients to identify barriers/obstacles related to their psychiatric/psychological experiences and, through the course of group interaction, become better able to identify skills that address symptoms and behaviors and to increase adaptive behaviors) and Adjunctive therapies (non-traditional therapies that utilize self-expression such as: art, dance and music; as therapeutic interventions. Clients should be able to utilize the modality to develop or enhance skills directed toward client plan goals.) are required in this section along with indicating the impairment, response and progress. Using the Program Schedule may be helpful in determining provided services for the week.

**GOALS:** List the Goals from the Client Plan in these sections.

**INTERVENTIONS AND PROGRESS TOWARDS CLIENT PLAN GOALS:** Indicate specific interventions offered to client during the week. Interventions should not include “Therapeutic Non-Specifics” such as: active listening, rapport building, unconditional positive regard. Include client’s progress towards meeting their goals for the week. This section should encompass observation throughout the week, not just one day/interaction.

**FAMILY THERAPY:** Documentation regarding the Family Therapy offered may be done in this space if a separate note is not completed. If a separate note is completed, can indicate “see Family Therapy note dated \_/\_/\_\_” and then file the note with the Weekly. \*Note: if program is a Day Treatment/STRTP Hybrid, Family Therapy may only be billed on non-Day Treatment days.

**SUMMARY OF OTHER INTERVENTIONS:** This section could provide information regarding Pathways to Well Being or other services that are not indicated in the Service Components above.

**SUMMARY OF TREATMENT TEAM REVIW:** Include information regarding updates that occurred during a Treatment Team meeting. This could include medication changes, concerns, and placement considerations.

**HAS A PATTERN OF ABSENCES EMERGED?:** Mark the appropriate box and if yes, answer what actions have been taken to mitigate.

**SIGNATURES:** If a Co-Signature is required, it must be completed by a Licensed or Licensed Waivered Staff

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| --- | --- |
| **STAFF DISCIPLINE** | **Day Rehab Weekly Summary****Co-Signature Required?** |
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| Ph.D Psy.D licensed/waivered | NO |
| Ph.D Psy.D registered | YES |
| LCSW, MFT licensed/registered/waivered | NO |
| Licensed Professional Clinical Counselor (LPCC)Professional Counselor Intern (PCI) | NO |
| Mental Health Rehab Specialist (MHRS) | YES |
| Staff not meeting minimum qualifications for MHRS (Trainee, etc) | YES |