**COMPLETED BY:**

1. Staff delivering services within scope of practice.

**COMPLIANCE REQUIREMENTS:**

1. A Progress Note must be completed after every service contact with the client.
2. The contents of the progress note shall support the service code(s) selected, medical necessity and effective clinical care/ coordination among providers.
3. The General Progress Note Template shall be used for all individual and family services.
4. All prompts must be addressed. (Effective 01/01/2024 per [BHIN 23-068](https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf)):
	1. **Type of Service**
	2. **Date of Service**
	3. **Duration** of direct patient care for the service
	4. **Location/Place** **of Service**
	5. **Intervention** – Describe how the service provided addressed the beneficiary’s behavioral health need(s) (e.g., symptom, condition, diagnosis, and/or risk factors).
	6. **Client Response**- Document the beneficiary’s response to the intervention.
	7. **Next Steps** - May include planned action steps by the provider or by the member; collaboration with the member; collaboration with other provider(s); goals and actions to address health, social, educational, and other services needed by the member; referrals; and discharge and continuing care planning.
	8. **Update to Problem** **List**- Document any updates/ changes to the Problem List (if applicable).
	9. **Name/ Signature**/ **Date of signature-** Must be legible.
5. Please note that travel time [Travel To/From] is no longer billable, however providers should continue to document this information as it will be used to inform future rates/ productivity.
6. Every progress note within the EHR must be completed and final approved within 3 business days with the exception of crisis services, which shall be completed within 1 calendar day. (Date of service is day 0).
	1. Progress notes signed by a provider needing co-signature are considered “on time” when the provider signs the note within 3 business days and the co-signer signs with a reasonable time.
	2. Notes will no longer be disallowed for being final approved late but may be marked out of compliance.

**DOCUMENTATION STANDARDS:**

1. Service entry shall be completed as a part of the progress noting process.
2. Notes shall include the minimum elements described above, but the nature and extent of the information included may vary based on the service type and the member’s clinical needs. Some notes may appropriately contain less descriptive detail than others. If information is located elsewhere in the clinical record (for example, a treatment plan template), it does not need to be duplicated in the progress notes.
3. Completion and final approval of the progress note by the staff is a certification the documented service was provided personally, and the service was provided to a beneficiary meeting access criterion, or during assessment to determine if the beneficiary meets criteria.
4. Data must be entered into the Electronic Health Record (EHR). Paper forms are only to be completed when the EHR is not accessible and/or when staff have not yet been trained in the EHR.
5. Progress notes are not viewed as complete until they are final approved. When it is not completed and final approved, the note is at risk for deletion by another server.