|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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:** | | | | |

**PROGRESS NOTE**

**Travel To/From:**

**Intervention** (How does the service address the beneficiary’s behavioral health need(s) – symptoms, condition, diagnosis, and/or risk factors):

**Client Response** (How did the client respond to the above intervention):

**Next Steps** (Planned action steps by provider or beneficiary, collaboration with beneficiary, collaboration with other provider[s]):

     

**Update to Problem List** (Include any changes or updates to client Problem List):

\***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#**

|  |  |
| --- | --- |
| County of San Diego  Health and Human Services  Mental Health Services  GENERAL PROGRESS NOTE  HHSA-MHSA (08/24/22) | Client:  Case#:  Program: |