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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:**      |

**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#**

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| County of San DiegoHealth and Human ServicesMental Health ServicesGENERAL PROGRESS NOTEHHSA-MHSA (08/24/22) | Client: Case#: Program:  |