CONTRA COSTA HEALTH
MENTAL HEALTH SERVICES

Progress Note / Service Entry

NAME/MRN

Facility Name: ______________________ ID: _______ Program Name: ________________________ ID: _________

Provider: ____________________ ID: _______ Service Date: ______________

Service Category:

☐ CPT/HCPC Service Provided ☐ Lockout - CPT/HCPC Service Provided

☐ Other Nonbillable Service Provided:

☐ Money Management ☐ Providing transportation ☐ Leaving voicemails

☐ Coordination of logistics ☐ Clerical work ☐ Other ____________________________________

Direct Service Time (Min): ________ Documentation Time (Min): ________ Travel Time (Min): ________

Number in Group: ________ CPT/HCPC Code: _____________

Location of Service (Please check one)

☐ Age-Specific Community Center
☐ Client's Job Site
☐ Correctional Facility
☐ Faith-Based
☐ Field
☐ Health Care/Primary Care
☐ Home
☐ Homeless/Emergency Shelter
☐ Inpatient
☐ Mobile Service
☐ Non-Traditional service location
☐ Office
☐ Other Community Location
☐ Phone–provided in client's home
☐ Phone–provided other than in client's home
☐ Residential Care - Adults
☐ Residential Care - Children
☐ School
☐ Telehealth/Video-provided in client's home
☐ Telehealth/Video-provided other than in Client's home
☐ Unknown/Not Reported

☐ Nontraditional Location ☐ Other ______________________________ ☐ Unknown

Did this service involve interactive complexity? ☐ **Yes** ☐ **No**

Did this service include the interpretation of results and explanation to the client/family? ☐ **Yes** ☐ **No**

For Clients Under 21 only:

Is this an ICC Service? ☐ **Yes** ☐ **No** Is this service linked to a Child and Family Team? ☐ **Yes** ☐ **No**

COUNTY STAFF ONLY: Does this service fall under FFPSA (Qualified Individual? ☐ **Yes** ☐ **No**

Was an Interpreter used? ☐ **Yes** ☐ **No** Name of Interpreter: ________________________________

Language

Language service provided in other than English: ☐ Spanish ☐ Other ____

Is the client pregnant? ☐ **Yes** ☐ **No (If yes, please document how service was pregnancy-related)**

EBP/Service Strategies:

☐ Assertive Community Treatment
☐ Supportive Employment
☐ Supportive Housing
☐ Family Psychoeducation
☐ Integrated Dual Diagnosis Treatment
☐ Illness Management and Recovery
☐ Medication Management
☐ New Generation Medications
☐ Therapeutic Foster Care
☐ Multisystemic Therapy
☐ Functional Family Therapy
☐ Peer/Family Delivered Services
☐ Psychoeducation
☐ Family Support
☐ Supportive Education
☐ In Partnership w/ Law Enforcement
☐ In Partnership w/ Health Care
☐ In Partnership w/ Social Services
☐ In Partnership w/ SA Services
☐ Integrated Services for MH/Aging
☐ Integrated Services for MH/DD
☐ Ethnic-Specific Service Strategy
☐ Age-Specific Service Strategy
☐ Unknown Service Strategy

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Evidence-based practice/tracking program? ☐ **Yes** ☐ **No** **Program** ____________________________________

This service was provided via telehealth with the consent of the client or authorized representative. ☐

Diagnosis:

Primary
ICD-10 Code: _____________ DSM-5 Narrative: ____

Secondary
ICD-10 Code: _____________ DSM-5 Narrative: ____

Problem/Behavioral Health Need Addressed. Describe problem/need, reason for contact, status update, clinical impression.

Focus of Activity. Describe type of service rendered, how the service addressed client's behavioral health need, how the client responded – symptoms, condition, diagnosis, and/or risk factors.

Plan. Describe next steps – action steps by provider or client, collaboration with the client or other providers, updates to the problem list as appropriate.

NAME/MRN

Form MHC-016, Targeted Case Management Plan and Level of Care Determination, was completed in conjunction with this progress note. ☐

Is this late documentation? ☐ Yes ☐ No

The problem list/Care Plan has been updated as needed: ☐ **Yes** ☐ **No**

Signature/License/Designation	Printed Name	Date
Co-Signature/license (if applicable)	Printed Name	Date

Data Entry Clerk Initials ______________