CONTRA COSTA HEALTH

Network Provider Progress Note

Beneficiary: _____ **MRN:** _____
Last Name, First Name (Please print.)

Service Begin Date: _____ Begin Time: _____ Total Minutes: _____

Type of MH Service:

- ☐ Assessment (90791)
- ☐ Assessment (90792)
- ☐ Individual (90832)
- ☐ Individual (90834)
- ☐ Individual (90837)
- ☐ Family w/client (90847)
- ☐ Group (90853)
- ☐ Psychotherapy for Crisis, first hour (90839)
- ☐ Psychotherapy for Crisis, each addtl 30 min (90840)
- ☐ MH Plan Dev (H0032)
- ☐ Collateral (H2021)
- ☐ Other: _____
- ☐ Not a billable service

Location Group:

- ☐ Office (11)
- ☐ Telehealth other than clt home (02)
- ☐ Telehealth clt home (10)
- ☐ Phone other than clt home (02)
- ☐ Phone clt home (10)
- ☐ School

Telehealth only: Client understands their right to in-person services and consents to Telehealth: ☐ Yes ☐ No

Interpreter Services Provided: ☐ Yes ☐ No

Name of Interpreter: _____ Language: _____

☐ Service provided in another language by clinician: ☐ Spanish ☐ Other: _____

Does client have restricted pregnancy-only Medi-Cal? ☐ Yes ☐ No

If yes, please document either: a) how the pregnancy affects the client's mental health issues OR
b) how the client's mental health issues affect the pregnancy

Chart to: goals/strategies on Partnership Plan, impairment related to diagnosis, progress and/or barriers to recovery, and/or unplanned events.

1. **Problem/Behavioral Health Need Addressed:** (Describe problem/need, reason for contact, status update, clinical impression).

2. **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).

3. **Plan: (**Describe next steps – action steps by provider of client, collaboration with the client or other providers, updates to the problem list as appropriate).

CLINICIAN: _____ (Print) _____ (Signature, Registration/License #) _____ Date ☐ **Late Entry**

LICENSED SUPERVISOR: _____ (If organizational Intern above) (Print) _____ (Supervisor's signature, License #) _____ Date

NOTE: Beneficiary records are subject to CCMHP review. Treatment records must be maintained for the minimum period required by applicable state and federal law. For adults, records must be maintained for at least ten (10) years after the last date of service. For children, records must be maintained until the beneficiary's 25th birthday.