CONTRA COSTA
HEALTH SERVICES
Behavioral Health Division

Progress Note / Billing Form

NAME / MRN

Service Date: _____ **RU:** _____

Staff #:_____ **Hours*** _____ **Mins** _____ **# in Group:** _____

Co-Staff #: _____ **Hours*** _____ **Mins** _____ **Total Travel Time: Hours** ____ **Mins** _____

*** Service duration must include travel time, if applicable**

Services: (Check one)

☐ **300** No Show	☐ **313** Evaluation	☐ **351** Group Therapy	☐ **571** Case Mgmt - Plan Develpmt
☐ **400** Client Cancel	☐ **315** Plan Develpmt	☐ **355** Group Rehab	☐ **540** Non-Billable Services
☐ **700** Staff Cancel	☐ **317** Rehab	☐ **357** Group Collateral	☐ **580** Non-Billable - Lock-outs
☐ **371** Crisis Int.	☐ **331** Assessment	☐ **541** Case Mgmt - Placement	
☐ **311** Collateral	☐ **341** Indiv Therapy	☐ **561** Case Mgmt - Linkage	

Location of Services: (Check one)

☐ **1** Office	☐ **5** School	☐ **11** Faith-based	☐ **15** Licensed Care Fac. (Adult)	☐ **19** Residential Tx Center (Child)
☐ **2** Field	☐ **8** Correctional Facility	☐ **12** Healthcare	☐ **16** Mobile Service	
☐ **3** Phone	☐ **9** Inpatient	☐ **13** Age-Specific Center	☐ **17** Non-Traditional Location	☐ **20** Telehealth
☐ **4** Home	☐ **10** Homeless/Shelter	☐ **14** Client's Job-site	☐ **18** Other	☐ **21** Unknown

Service Strategies: (Check up to three, if applicable)

☐ **50** Peer/Family Services	☐ **53** Supportive Education	☐ **56** With Social Services	☐ **59** With Develpmt Disabled
☐ **51** Psycho-Education	☐ **54** With Law Enforcement	☐ **57** With Substance Abuse	☐ **60** Ethnic-specific Services
☐ **52** Family Support	☐ **55** With Health Care	☐ **58** With Aging Providers	☐ **61** Age-specific Services
			☐ **99** Unknown

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

☐ **Interpreter** **Name of Interpreter:** _____

Language service provided in other than English: ☐ **Spanish** ☐ **Other**_____

Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.

1a. Treatment goal(s) addressed, if appropriate.

1b. Description of Current Situation/Reason for Contact:
(Status update, needs, clinical impressions)

Current DSM Diagnosis __ __ __.__ __

Name:_____MRN: _____

2. Focus of Activity:

(Intervention and Response to Intervention, what did you do? What is the consumer's response?)

3. Plan (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the consumer/family/providers are to do.*

Signature / License / Job Title | **Printed Name** | **Date**

Co-Signature / License (if applicable) | **Date**

Data Entry Clerk Initials