|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Client: | Client #: | | | Program: | |
| Date of Service: | Unit: | | Subunit: | | # of Clients: |
| Server ID: | Service Time  : | | Travel Time: | | Documentation Time: |
| Person Contacted: | Place: | | Outside Facility: | | Appointment Type: |
| Billing Type (Language Services Provided in: | | Intensity Type (Interpreter Utilized): | | | |
| Diagnosis At Service (This Client) ICD-10 Code(s): | | Service: | | | |
| **OVERVIEW OF GROUP**  **Document the global focus and intended outcome of the group intervention:** | | | | | |
| **INDIVIDUAL GROUP SPECIFICS** | | | | | |
| **COLLATERAL SERVER (Document the clinically compelling reason for a collateral server):** | | | | | |
| **TRAVEL TO / FROM:** | | | | | |
| **INTERVENTION (How does the service address the beneficiary’s behavioral health need(s) – symptoms, condition, diagnosis, and/or risk):** | | | | | |
| **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 providers(s), and/or update to 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#**