**COMPLETED BY:**

1. Staff delivering services within scope of practice. Co-signature must be completed within reasonable time.

**COMPLIANCE REQUIREMENTS:**

1. A Daily Progress Note must be completed for each day of service during which the client participates in the treatment scheduled.
2. Weekly summaries are no longer required for Day Rehabilitation and Day Treatment Intensive, nor for residential levels of care or other bundled services. Weekly summaries have been replaced by this Daily Note requirement.
3. Providers shall complete at minimum a daily progress note for services that are billed on a daily basis (i.e., bundled services), such as Crisis Residential Treatment, Adult Residential Treatment, DMC/DMC-ODS Residential Treatment, and day treatment services (including Therapeutic Foster Care, Day Treatment Intensive, Day Rehabilitation, Intensive Outpatient and Partial Hospitalization Programs).
4. If a bundled service is delivered on the same day as a second service that is not included in the bundled rate, there must also be a progress note to support the second, unbundled service.
5. Content of each progress note must support the client participated in a minimum of 50% of the scheduled treatment hours.
6. The Daily Progress Note Template shall be used for all day treatment service activities. All prompts must be addressed, or reason why not documented. (Effective 01/01/2024 per [BHIN 23-068):](https://www.dhcs.ca.gov/Documents/BHIN-23-068-Documentation-Requirements-for-SMH-DMC-and-DMC-ODS-Services.pdf)
7. **Date of Service**
8. **Duration** of direct patient care for the service
9. **Location/Place** **of Service**
10. **Specific Service(s) Provided** - All groups, activities and meetings, provided to the client. Document client participation or failure/refusal to participate.
11. **Observations of Client’s Behavior-** Document staff observations including client behavior, participation, and response during the treatment and/or in the milieu or N/A if client was not present.
12. **Possible Side Effects of Medications** – Document any possible side effects of medications or medication changes observed, or N/A if none are observed.
13. **Contact with Client family, friends, natural supports, CFT, mental health team, authorized legal representatives and/or public entities involved with the client** – Document summary of any meetings(s), or interaction(s) with those listed, or N/A if none occurred.
14. **Name/ Signature**/ **Date of signature-** Must be legible.
15. Every progress note within the EHR must be completed and final approved within 3 business days with the exception of crisis services**,** which shall be completed within 1 calendar day. (Date of service is day 1).
	1. Progress notes signed by a provider needing co-signature are considered “on time” when the provider signs the note within 3 business days and the co-signer signs with a reasonable time.
	2. Notes will no longer be disallowed for being final approved late but may be marked out of compliance.

**DOCUMENTATION STANDARDS:**

1. Service entry shall be completed as a part of the progress noting process.
2. Completion and final approval of the progress note by the staff is a certification the documented service was provided personally, and the service was provided to a beneficiary meeting access criterion, or during assessment to determine if the beneficiary meets criteria.
3. Data must be entered into the Electronic Health Record (EHR). Paper forms are only to be completed when the EHR is not accessible and/or when staff have not yet been trained in the EHR.
4. Progress notes are not viewed as complete until they are final approved. When it is not completed and final approved, the note is at risk for deletion by another server.