CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

Network Provider Progress Note

CONTRA COSTA MENTAL HEALTH PLAN
Care Management Unit
1330 Arnold Drive, Suite 143
Martinez, CA 94553
Ph (925) 372-4400 Fax (925) 372-4410

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

Date of Session: / / **Start Time:** **End Time:** **Total Minutes:**

Type of MH Service:
- ☐ Individual
- ☐ Group
- ☐ Family w/client
- ☐ Assessment
- ☐ Collateral
- ☐ Family w/o client
- ☐ Not Billable Service
- ☐ No Show
- ☐ Cancelled

Note: Assessment is the only code that is billable up to and including date of provider signature on the Intake. The exception is billing for unplanned crisis sessions.

Location of Service: _____
(Indicate: School, Office, Phone, Home, School, Other-State)

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

Individuals Present at Session:	Relationship to Beneficiary:

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

1. **Description of Current Situation: (**e.g. Reason for contact, Beneficiary's concern(s), status update since last contact, clinical/behavioral acuity, current stressors, and/or needs, etc.)

2. **Focus of Activity: (**Intervention, response to intervention, etc.)

3. **Plan: (**e.g. Coordination of care, referrals, and/or follow-up. Include person's planned action and staff's planned action, 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.