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| Beneficiary Name | Beneficiary ID |
| **Service Types:** INT=Intake/Assess GR=Group CR=Crises CO=Collateral CM=Case Mngt TP=Tx Planning TR=Transport MED=Medication D=Discharge IND=Crisis OR Counseling O=Other | |
| **Index of Challenges / Barriers:** 1) Substance Use Disorder 2) Mental Health 3) Physical Health 4) Employment/Education 5) Financial/Housing 6) Legal 7) Psycho-Social /Family 8) Spirituality | |

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| Service Date\*  \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_ | Start Time  \_\_\_\_\_ : \_\_\_\_\_ am / pm | | End Time  \_\_\_\_\_ : \_\_\_\_\_ am / pm | Service Type (see above) | | Tx Plan Index(s)  (see above) |
| Topic of the session |  | | | | | |
| Provider support & Interventions |  | | | | | |
| Description of client’s specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals |  | | | | | |
| Client’s plan (including new issues or problems that affect treatment plan) |  | | | | | |
| **Printed Name, Title** | | **Signature, Credentials** | | | **Date of Completion\*** | |

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| --- | --- | --- | --- | --- | --- | --- |
| Service Date\*  \_\_\_\_\_ /\_\_\_\_\_ /\_\_\_\_\_\_\_ | Start Time  \_\_\_\_\_ : \_\_\_\_\_ am / pm | | End Time  \_\_\_\_\_ : \_\_\_\_\_ am / pm | Service Type (see above) | | Tx Plan Index(s)  (see above) |
| Topic of the session |  | | | | | |
| Provider support & Interventions |  | | | | | |
| Description of client’s specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals |  | | | | | |
| Client’s plan (including new issues or problems that affect treatment plan) |  | | | | | |
| **Printed Name, Title** | | **Signature, Credentials** | | | **Date of Completion\*** | |

\*The date of service may be different than the date note is signed. Notes must be legibly printed, signed and dated by the counselor/therapist no later than seven (7) calendar days from the date of the counseling session.