

Progress Note Template

Mental Health Individual Provider (MHIP)

INSTRUCTIONS: This template should be used by providers offering services to Medi-Cal clients in an outpatient office or clinic setting (e.g. Organizational providers). It meets Medi-Cal requirements for documentation of Progress Notes. For additional details regarding Progress Note requirements, see Documentation Guide for Clinical staff on the CalMHSA website at: [Clinical Practice - California Mental Health Services Authority California Mental Health Services Authority](#)

Late Entries: Progress Notes must be completed within 3 business days of providing a service, with the exception of notes for crisis services, which must be completed within 24 hours.

Check here if this note is entered late: Late Entry

Service Date:		Medical Record #:		Provider #:	
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Client Information

Last Name:		First Name:	
Preferred Language:		Date of Birth:	
Service was provided in the client's preferred language?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, by: <input type="checkbox"/> Interpreter <input type="checkbox"/> Clinician	

Service Details

Instructions: Face-Face/Direct Service, Documentation and Travel time should add up to Total Service Time.							
Face-face/ Direct Service Time:		Documentation Time:		Travel Time:		Total Service Time:	
Service Type:	<input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Collateral <input type="checkbox"/> Family Therapy <input type="checkbox"/> Assessment <input type="checkbox"/> Case Management/Brokerage <input type="checkbox"/> Care plan/Treatment plan (Needed for Case Management/Brokerage only) <input type="checkbox"/> Crisis Intervention <input type="checkbox"/> No show						
CPT/HCPCS Code:							
Location:	<input type="checkbox"/> Office <input type="checkbox"/> Field <input type="checkbox"/> Telephone <input type="checkbox"/> Home <input type="checkbox"/> School Satellite <input type="checkbox"/> Satellite <input type="checkbox"/> Telehealth						

Clinical Details

Narrative: A narrative describing the service, including how the service addressed the person’s behavioral health needs.
Groups have special requirements¹

Next Steps: Including but not limited to planned action steps by the provider or by the beneficiary, collaboration with the beneficiary or other provider(s) and any update to the Problem List as appropriate.

Referrals Provided: Not needed Previously referred

NOTE: Linkage to medical, educational, social, pre-vocational, rehabilitative or other community services is considered Case Management (CM) and requires a Care Plan. See Care Plan template on page 3.

<input type="checkbox"/> Substance Use Disorder Services	<input type="checkbox"/> Primary Care Physician (Refer if last seen more than 1 year ago).	<input type="checkbox"/> Specialty Medical Services
<input type="checkbox"/> Dental	<input type="checkbox"/> TFC <input type="checkbox"/> ICC <input type="checkbox"/> IHBS	<input type="checkbox"/> Other

If other, describe here:

Case Management Care Plan: Not needed--- SKIP THIS SECTION AND MOVE TO SIGNATURE

Initial Care Plan Update to Care Plan

¹ Document a single progress note signed by one of the practitioners. Describe specific involvement and specific amount of time of involvement of each practitioner in the group activity, including time spent traveling to/from the service and documenting the service. The full list of group participants must be maintained outside of the beneficiary’s health record.

Include a narrative to address the following:

1. What is the agreed-upon need that is being addressed?
2. What Case Management services are being utilized to address the need?
3. What specific action steps will be taken by client and/or provider. Indicate timeframes.
5. What progress has been made towards completing the action steps?
6. New/revised action steps?
7. What is the Transition plan once goals are achieved?

Client actively participated in the development of these goals.

Signatures

Print Name of Service Provider		Title and Credentials	
Signature		Date	
Print Name of Supervisor (if needed)		Title and Credentials	
Signature		Date	