COMMUNITY SERVICE AGENCY
DAILY CLINICAL RECORD DOCUMENTATION FORM - DATE: _____ 200_

CSA Name: _____ Provider ID #: _____Site Location: _____

Client Name: _____ AHCCCS ID#: _____ CIS ID#: _____ Diagnosis Code: _____

Case Manager (or other Clinical Team representative): _____

Check only one box (one sheet used for each service):

☐ H2014 Skills Training and Development (Individual)	☐ H0038 HQ Self Help/Peer Services (Group)
☐ H2014 HQ Skills Training and Development (Group)	☐ H2016 Comprehensive Community Support Services (Peer Support)
☐ H2017 Psychosocial Rehabilitation Living Skills Training	☐ H2027 Psychoeducational Services (Pre-Job Training and Development)
☐ H0025 Behavioral Health Prevention/Promotion Education	☐ H2012 Supervised Behavioral Health Day Treatment
☐ H2025 Ongoing Support to Maintain Employment	☐ H2015 Comprehensive Community Support Services (Supervised Day Program)
☐ T1019 Personal Care Services (up to 11 ¾ hours)	☐ H2026 Ongoing Support to Maintain Employment (Per diem)
☐ T1020 Personal Care Services (12 or more hours)	
☐ S5110 Home Care Training Family (Family Support)	
☐ H0038 Self Help/Peer Services	
OTHER (Non-Title XIX/XXI reimbursable services)	
☐ H0046 Mental Health Services (NOS)	☐ H0043 Supported Housing
☐ T1013 Sign Language or Oral Interpretive Services	☐ S9986 Non-Medically Necessary Services (Flex Fund Services)
☐ S9986 HW Medicare Part D Premium	☐ H0046 SE Mental Health Services (NOS)

NON-EMERGENCY TRANSPORTATION SERVICES							
☐ A0090	☐ S0215	☐ A0999	☐ A0130 TN	☐ A0210	☐ A0170	☐ T2005 TN	☐ T2007
☐ A0190	☐ S0209	☐ A0100	☐ S0215 TN	☐ A0140	☐ A0120	☐ A0180	
☐ A0130	☐ S0209 TN	☐ A0200	☐ A0110	☐ T2005	☐ A0160	☐ A0120 TN	

Duration of service(s) provided to client: Time In _____ Time Out_____

Summary of service(s) provided to client:

_____ _____ _____
PRINTED Name and Title/Credentials of CSA provider **SIGNATURE** of CSA service provider Date

COMMUNITY SERVICE AGENCY
MONTHLY SUMMARY

DATE: _____ 200_

Instructions: This form must be submitted to the client's case manager every thirty (30) days. If the client does not have an assigned case manager, submit the monthly summary to the behavioral health provider who has signed the client's service plan.

Case Manager (or other Clinical Team representative); _____ Phone #: _____

Client Name: _____

Service Code	Time In	Time Out	Total Time

Monthly Summary (including progress and/or regression) in the goals/objectives listed in the service plan:

_____
_____
_____
_____
_____
_____

Client feedback on reaching goals/objectives listed in the service plan (i.e., client does or does not continue to be in agreement with goals/objectives identified in service plan):

_____
_____
_____
_____
_____
_____

_____ _____

PRINTED Name and Title/Credentials of CSA provider Date

_____

SIGNATURE of CSA service provider