Appendix C – Service Note Examples

Assessment Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer reviewed consents and informing materials with client/client's parent or guardian to ensure their understanding. Prior to the face-to-face assessment, this writer reviewed client's medical record to identify historical clinical information, safety concerns, and treatment history. This writer completed the intake assessment - see CalAIM assessment dated 7/3/23. This writer scheduled a follow up appointment with client/family on 7/11/23 to discuss treatment recommendations and next steps.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include the outcome of the assessment and next plans here.

TCM Progress Note Example

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Staff completed the referral process by summarizing client's anxiety symptoms and highlighting strengths, including supportive family members. Program ABC indicated client seemed appropriate for their program and provided staff with information on next steps. This staff will contact client to discuss eligibility for program and assist client in preparing to attend Program ABC.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

Care Plan is required for all TCM services

This writer provided TCM services to assist the client in accessing these needed services: LIST
The services activities included: LIST (Communication, Coordination, Referral, Monitoring service delivery, Monitoring individual progress)
This writer collaborated with the following person(s) to develop the goals of TCM services: LIST (Client, family, SW, PO, teacher, etc.)

This will pull from previously completed progress notes in SmartCare

Crisis Intervention Service Note Example

Staff can document the Crisis Intervention service in a service note, or document the Crisis Intervention service using the Crisis Assessment document in SmartCare and document the completion of the Crisis Assessment and direct the reader to the Crisis Assessment document dated __/__/__ on the Crisis Intervention service note. A service note is required for the service to be claimed.

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

Client presented at SLO Outpatient clinic stating he was feeling suicidal. "I just want to go to be with my wife." Client reported feeling depressed and hopeless over the recent loss of his wife.
Describe any SI/HI/SIB or signs of GD.
Describe any risk factors (presence of MI, SUD use/abuse, Hx of violence/self-injury/trauma), recent stressors, past attempts, hopelessness/lack of future orientation, lack of support.
Describe behavioral observations (Client was disheveled in appearance and wearing dirty clothing, which is a significant change from client's usual presentation. Client denied a current plan or intention to harm or kill himself and was receptive to services, as evidenced by his proactively coming to the clinic for help).
Describe protective factors (Client lives with his adult daughter and her partner; client reports his daughter has connected him with a widower support group at Hospice).
Safety Planning (Client was able to identify several coping strategies he can utilize to change is focus and thought patterns, including gardening, watching a sports game, and going for a walk. Client confirmed he has the Central Coast Hotline number saved in his phone and will utilize this resource as needed. Client has not thought of a specific plan or means that he would use to commit suicide and confirmed he does not have guns in his home and agreed to ensure his phone is charged and accessible so he can reach out for support as needed. Client identified his family as his main motivator to remain safe).
Disposition and Next steps:
Steps taken if client is a danger to others (Tarasoff): Phone call to intended victim/send Tarasoff notification letter/phone call to LE/sent Tarasoff worksheet to LE

Care Plan

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This will pull from previously completed progress notes in SmartCare - if this is blank include the outcome of the crisis assessment and next plans here.

Plan Development Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer explored with client the areas of functioning they would like to improve. This writer assisted client in identifying their strengths and social supports. Client shared a desire to increase their social interactions and connections. This writer will meet client at Hope House on 7/11/23 to tour the Wellness Center, look at the calendar of activities, and begin to work on building connections.

Care Plan

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This will pull from previously completed progress notes in SmartCare - if this is blank include next steps here.

Individual Therapy Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer processed client's feeling regarding family conflict. This writer and client rehearsed "I statements" to assist client in expressing their needs and feelings without others interpreting them as blaming or accusing. This writer assessed for risk factors and ruled out mandatory reporting obligations at this time. This writer scheduled a Family Therapy session for next week with client and their family. This writer will continue to assess for risk factors.

Care Plan

Indicate the goals, treatment, service activities, and assistance to address the objectives of the plan and the medical, social, educational, and other services needed by the beneficiary. Include how the beneficiary or their representative helped to develop the goals, and the progress toward meeting the established goals. Indicate transition plan if the individual has achieved the goals of the care plan.

This will pull from previously completed progress notes in SmartCare - if this is blank include next steps here.

Psychosocial Rebab Service Note Example:

Information

Describe current service(s), how the service addressed the beneficiary's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors).

This writer helped develop a list of expenses and income to assist client with creating a monthly budget to ensure they do not run out of money before the end of the month. This writer helped identify necessary vs. discretionary purchases and discussed choices in light of their overall goal. This writer will meet with client next week at the grocery store to support the client in maximizing food purchases.

Care Plan

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This will pull from previously completed progress notes in SmartCare - if this is blank include next steps here.