PM Form 4.2.1, COMMUNITY SERVICE AGENCY/HCTC PROVIDER/HABILITATION PROVIDER DAILY CLINICAL RECORD DOCUMENTION FORM

CSA Name: | Provider ID #/NPI:

Site Location: | Client Name:

Client AHCCCS ID #: | CIS ID #:

Diagnostic Codes: | Case Manager (or other Clinical Team representative):

Title XIX/XXI Reimbursable Services

Select One Service:

Duration of services: hour(s) minute(s) Per Diem ☐

Non-Title XIX/XXI Reimbursable Services

☐ H0046 Mental Health Services (NOS) ☐ T1013 Sign Language or Oral Interpretive Services

☐ S9986 HW Medicare Part D Premium ☐ H0046 SE Mental Health Services (NOS)

☐ H0043 Supported Housing ☐ S9986 Non-Medically Necessary Services (Flex Fund Services)

Duration of services, if applicable: hour(s) minute(s) Per Diem ☐

Non-Emergency Transportation Services

Mileage Code: Base/Other:

Total Miles (miles must exceed 25 miles when using transportation code A0160)

Summary of Services Provided:

Printed Name and Title/Credentials of CSA Provider | Signature of CSA Service Provider | Today's Date

PM Form 4.2.1, COMMUNITY SERVICE AGENCY/HCTC PROVIDER/HABILITATION PROVIDER MONTHLY SUMMARY TO CASE MANAGER/CLINICAL TEAM

Instructions: This form must be submitted to the client's case manager every thirty (30) days to ensure coordination of care. 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.

CSA/HCTC/Habilitation Provider Name: Contact #:

Case Manager (or other Clinical Team representative):

Case Manager/Clinical Team contact phone #: Fax #:

Client Name: Client AHCCCS ID #:

Summary for: to:

Service Code/Description: # of times service provided:

Service Code/Description: # of times service provided:

Service Code/Description: # of times service provided:

Service Code/Description: # of times service provided:

Service Code/Description: # of times service provided:

Monthly Summary (including progress and/or lack of progress) in meeting the goals/objectives listed in the service plan ***specifically for this agency***:

Client feedback on reaching goals/objectives listed in the service plan ***specifically for this agency*** (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 | Signature of CSA Service Provider | Today's Date