

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):

<input type="checkbox"/> H2014 Skills Training and Development (Individual)	<input type="checkbox"/> H0038 HQ Self Help/Peer Services (Group)						
<input type="checkbox"/> H2014 HQ Skills Training and Development (Group)	<input type="checkbox"/> H2016 Comprehensive Community Support Services (Peer Support)						
<input type="checkbox"/> H2017 Psychosocial Rehabilitation Living Skills Training	<input type="checkbox"/> S5150 Unskilled Respite (up to 12 hours)						
<input type="checkbox"/> H0025 Behavioral Health Prevention/Promotion Education	<input type="checkbox"/> S5151 Unskilled Respite (more than 12 hours)						
<input type="checkbox"/> H2025 Ongoing Support to Maintain Employment	<input type="checkbox"/> H2027 Psychoeducational Services (Pre-Job Training and Development)						
<input type="checkbox"/> T1019 Personal Care Services (up to 11 ¾ hours)	<input type="checkbox"/> H2012 Supervised Behavioral Health Day Treatment						
<input type="checkbox"/> T1020 Personal Care Services (12 or more hours)	<input type="checkbox"/> H2015 Comprehensive Community Support Services (Supervised Day Program)						
<input type="checkbox"/> S5110 Home Care Training Family (Family Support)	<input type="checkbox"/> H2026 Ongoing Support to Maintain Employment (Per diem)						
<input type="checkbox"/> H0038 Self Help/Peer Services							
OTHER (Non-Title XIX/XXI reimbursable services)							
<input type="checkbox"/> H0046 Mental Health Services (NOS)	<input type="checkbox"/> H0043 Supported Housing						
<input type="checkbox"/> T1013 Sign Language or Oral Interpretive Services	<input type="checkbox"/> S9986 Non-Medically Necessary Services (Flex Fund Services)						
<input type="checkbox"/> S9986 HW Medicare Part D Premium	<input type="checkbox"/> H0046 SE Mental Health Services (NOS)						
NON-EMERGENCY TRANSPORTATION SERVICES							
<input type="checkbox"/> A0090	<input type="checkbox"/> S0215	<input type="checkbox"/> A0999	<input type="checkbox"/> A0130 TN	<input type="checkbox"/> A0210	<input type="checkbox"/> A0170	<input type="checkbox"/> T2005 TN	<input type="checkbox"/> T2007
<input type="checkbox"/> A0190	<input type="checkbox"/> S0209	<input type="checkbox"/> A0100	<input type="checkbox"/> S0215 TN	<input type="checkbox"/> A0140	<input type="checkbox"/> A0120	<input type="checkbox"/> A0180	
<input type="checkbox"/> A0130	<input type="checkbox"/> S0209 TN	<input type="checkbox"/> A0200	<input type="checkbox"/> A0110	<input type="checkbox"/> T2005	<input type="checkbox"/> A0160	<input type="checkbox"/> 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

