MH 225DO
Revised 11-17-09

DAILY SERVICE LOG

DMH Directly-Operated

Activity Date: ______________

☐ **Day Treatment** ☐ **Outpatient**

Client ID#	Client Last Name & First Initial	*1. Place of ServiceCode	Telephone	Procedure Code	*EBP/SS	Face to Face Hr	Face to Face Min	Other Time Hr	Other Time Min	# of Collateral	Employee Last Name, First Initial	Total Time Hr	Total Time Min	Claim Medi-Cal	Plan	2. Screening Referral	3. Pregnancy	4. Emergent	5 SED	6. SOC
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		
			☐											☐		☐	☐	☐	☐	☐
		Address:																		

(Columns "Client ID#" through "# of Collateral": **Rendering Provider**; columns "Employee Last Name, First Initial" and "Total Time": **Other Participating Staff**)

By signing below, I attest that I have provided the mental health services on this Service log and that all information is accurate, complete and truthful to the best of my knowledge and belief. I further attest that the services provided by me, as reflected on this Service log form were consistent with the client's treatment plan and, if services are to be claimed to Medicare and/or Medi-Cal, were reasonable and medically necessary. Claims for services submitted as a result of this Service log are supported by documentation.

Rendering Provider:________________________________ **Date Received:**_______/_______/_______ **Entered By:**________________________________
Signature

☐ **Share of Cost information was completed by designated staff other than Rendering Provider** ______________________________ ______________________________
Name **Signature**

1. Place of Service Code: For Medicare or Medi/Medi clients, for codes other than 11 and 12 record the address where the service was provided.
2. Screening Referral: For EPSDT clients, check this box if the Agency of Primary Responsibility is other than code 7 (None).
3. Pregnancy: For clients with Pregnancy or Pregnancy/Emergency Aid Code, check this box if the client is pregnant.
4. Emergency: For clients with Emergency or Pregnancy/Emergency Aid Code, check this box if the service is a crisis intervention, crisis stabilization, or emergency medication support.
5. SED-Serious Emotional Disturbance: For clients with Healthy Families, check this box if the child meets the definition of (SED).
6. SOC-Share of Cost: For clients with a Share of Cost, check this box. If checked, an eligibility check must be run.

* A list of codes can be found in the IS Codes Manual located at: http://dmh.lacounty.gov/hipaa/index.html

Provider #: Rendering Provider: Staff Code:

Los Angeles County – Department of Mental Health