MH 709-MHLA Only

MHLA-Behavioral Health Expansion Prevention Services and/or Activities

I. Contact/Service Information

Date of Service: 7/30/21 Funding Plan: MHSA-PEI

Rendering Provider Name(s): Karen Karg

Time (Min): 0:50

Procedure Code: H2014 Service Modality: Individual or Group (*Circle one*) Face-to-Face or Telephonic: (*Circle one*)

Participant Name: Johnette Doe Participant ID (PID): 1234567

[If this is a Group: Name of the group (if applicable), for example, Stress Management Group]

SERVICE RECIPIENT Select the individual(s) receiving services. *(For this Project, the MHLA box should always be checked.)*	
x	MHLA

PREVENTION PRACTICE: General category staff is working under or to which client is served					
	Psychological First Aid/Skills for Psychological Recovery	**X**	Prevention - Prolonged Engagement*		Other_____

***Name of the curriculum, or course title provided under Prolonged Engagement:**
Grief and Loss

II. Notes/Future Plans & Recommendations

This staff met with client telephonically due to the Covid-19 pandemic to continue their work on the grief and loss curriculum. However, client indicated she experienced increased difficulties in daily functioning in addition to finding out her best friend, who had been extremely supportive, was now moving out of state. Due to this client's change in functioning, this staff believed a referral to a higher level of services would be most appropriate.

This staff reviewed the "My Needs to Reduce the Distress of Grief" worksheet as outlined in the curriculum and spoke to client about the benefits to receiving more targeted services to help her better cope with her distress, but that this therapist would continue to meet with client during her transition to this clinic's behavioral health unit. This staff will complete transfer paperwork for the referral and follow-up with client next week to continue the Grief and Loss curriculum with "Deep Abdominal (or belly) Breathing as a Way to Cope with Stress" until client is linked with mental health treatment services. Client agreed to this plan.

Staff Signature** **Date** **Co-Signature**** **Date**

****Must include Discipline/Title and License/Certification/Registration Number (if applicable)**

Agency Name:
Los Angeles County – Department of Mental Health