|  |  |
| --- | --- |
| Person Served Name:        | Avatar ID Number:       |
| **Service Date:** Enter Service Date | **Documentation Time:** Total Minutes for Documentation |
| **Preferred Language:** Enter Preferred Language | **Interpreter Utilized:** Choose answer |

|  |
| --- |
| **Residential Treatment Sessions:** Please list all sessions the person-served attended during the date of service. |
|

|  |  |  |  |
| --- | --- | --- | --- |
| **Start & End Times** | **Type of Contact** | **Type of Session/Service** | **Topic of Session or Purpose of Service** |
| Enter Start & End Time of Session | Choose Type of Contact | Choose Type of Session/Service | Enter Topic of Session or Purpose of Service |

 |

|  |
| --- |
| **Residential Treatment Travel Times:** Please list all sessions that required travel time during the date of service. |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Travel to:** **Start Time** | **Travel to:** **End Time** | **Travel from:** **Start Time** | **Travel from:** **End Time** | **Total Travel Time** |
| Start Time | End Time | Start Time | End Time | Total Minutes for Travel Time |

 |

|  |
| --- |
| **Must include an accurate picture of the person’s condition, treatment/intervention provided, response to care at the time the service was provided, and next steps including planned action steps by the provider/person served.** |
| Enter Text |
| **If services were provided in the community, identify the location and how you ensured confidentiality.**Enter Location & How Confidentiality Was Maintained |

|  |  |  |
| --- | --- | --- |
| **Counselor/LPHA Printed Name, Title**Enter Staff Who Provided Clinical Service | **Counselor/LPHA Signature** | **Date of Completion** |