



COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

DAILY SERVICE LOG v.3

DMH-Directly Operated

CONFIDENTIAL CLIENT INFORMATION | CALIFORNIA WELFARE & INSTITUTIONS CODE SEC. 5238

Provider #: _____

Activity Date: _____

Rendering Provider: _____

Staff Code: _____

<input type="checkbox"/> Day Treatment				<input type="checkbox"/> Outpatient													
RENDERING PROVIDER										OTHER PARTICIPATING STAFF							
Client ID #	Client Last Name & First Initial	Service Location Code	Telephone	Procedure Code	* EBP/Srv Strategies Enter Code(s)	Face to Face		Other Time		Col	Employee Name Last Name, First Initial	Total Time		Bill Medi-Cal	Bill Medi-care	**Plan/Funding Source	
						Hr	Min	Hr	Min			Hr	Min				
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		
			<input type="checkbox"/>											<input type="checkbox"/>	<input type="checkbox"/>		

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: _____
Signature

Date Received: ____ / ____ / ____

Entered By: _____

Daily Srv Log-DO v.3.3
Rev. 7/15/2008 -et

* For a list of Evidence-Based Practices (EBP)/Service Strategies, please see the Codes Manual or download EBP/Service Strategy Codes at:

http://dmh.lacounty.gov/hipaa/cp_ISForms_Clinical.htm

**For MHSA providers, please indicate the full name of the Plan/Funding Source, i.e.,

FSP, Non FSP, Family Support, Wellness Center/Family Focused (WC/FF), FCCS