



IS Group Service Log

DMH Directly-Operated

CONFIDENTIAL CLIENT INFORMATION SEE CALIFORNIA WELFARE AND INSTITUTION CODE 5328

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

Date Submitted: _____

Reporting Unit Name: _____

Group Information	
Group ID: _____	Activity Date: _____
Group Name: _____	
Service Loc. Code: _____	Procedure Code: _____

By signing below, I attest that I have provided the mental health services recorded on this Group 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 provide by me, as reflected on this Group 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 Group Service log are supported by documentation.

	Participating Staff			Total Time		Signature
	Last Name	First Name	Staff Code	Hrs	Mins	
1						
2						
3						
4						

Check if Client Present	Client ID		Client First Name		Client Last Name		Rendering Provider/Responsible Lead		Collateral	
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Number of Non-DMH Clients present: _____

Date Received: _____ Entered By: _____