



# 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	Rendering Provider/Responsible Lead			Col	Collateral Type	* EBP/Srv Strategies Enter Code(s)	**Plan/Funding Source
	Client ID	Client Last Name & First Initial					
<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"/>							

Number of Non-DMH Clients present: \_\_\_\_\_

Date Received: \_\_\_\_\_ Entered By: \_\_\_\_\_

\* For each client's group service, you are required to go to the **SERVICE** screen to enter applicable Evidence-Based Practice (EBP) or Service Strategy code(s) BEFORE submitting the claim. The EBP/Service Strategy descriptions and codes can be found in the Codes Manual or you may download them at:

[http://dmh.lacounty.gov/hipaa/cp\\_ISForms\\_Clinical.htm](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, WC/FF (Wellness Center/Family Focused), FCCS**