CONTRA COSTA
BEHAVIORAL HEALTH
A Division of Contra Costa Health Services

# WRAP Progress Note/ Billing Form

NAME / MRN _____

Facility Name: _____ ID: _____ Program Name: _____ ID: _____

Provider: _____ ID: _____ Number in Group: _____ Group ID: _____

Elapsed Time (Total Minutes): _____ Travel Time (Total Minutes): _____

Service (Begin) Date: _____ Begin Time: 12:00 am

**Services:** (Check one)

| | | | |
|---|---|---|---|
| ☐ **300** No Show | ☐ **313** Evaluation | ☐ **351** Group Therapy | ☐ **561** Case Mgmt – Linkage |
| ☐ **400** Client Cancel | ☐ **315** Plan Develpmt | ☐ **355** Group Rehab | ☐ **564** ICC |
| ☐ **700** Staff Cancel | ☐ **317** Rehab | ☐ **357** Group Collateral | ☐ **571** Case Mgmt - Plan Develpmt |
| ☐ **371** Crisis Int. | ☐ **331** Assessment | ☐ **358** IHBS | ☐ **540** Non-Billable Services |
| ☐ **311** Collateral | ☐ **341** Indiv Therapy | ☐ **541** Case Mgmt - Placement | ☐ **580** Non-Billable - Lock-outs |

**Place of Service** (check one)

| | | | |
|---|---|---|---|
| ☐ Office | ☐ Inpatient Psychiatric | ☐ Residential Txt Center (Child) | ☐ Telehealth – Pt Home |
| ☐ Field | ☐ Inpatient Health | ☐ Residential Txt Center (Adult) | ☐ Telehealth – Other than Pt Home |
| ☐ Phone | ☐ Emergency Room | ☐ Hospice | ☐ Age Specialty Center |
| ☐ Home | ☐ Jail | ☐ Skilled Nursing Facility | ☐ Faith Based Location |
| ☐ School | ☐ Emergency Shelter | ☐ Mobile Service | ☐ Nontraditional Location |
| ☐ Satellite | ☐ Primary Care Health Clinic | ☐ Job Site | ☐ Other Location |

**Service Strategies:** (Check up to three, if applicable)

| | | | |
|---|---|---|---|
| ☐ **50** Peer/Family Services | ☐ **53** Supportive Education | ☐ **56** With Social Services | ☐ **59** With Develpmt Disabled |
| ☐ **51** Psycho-Education | ☐ **54** With Law Enforcement | ☐ **57** With Substance Abuse | ☐ **60** Ethnic-specific Services |
| ☐ **52** Family Support | ☐ **55** With Health Care | ☐ **58** With Aging Providers | ☐ **61** Age-specific Services |
| | | | ☐ **99** Unknown |

**Is the client pregnant?** ☐ **Yes** ☐ **No** **(If yes, please document how service was pregnancy-related)**

☐ **Interpreter** **Name of Interpreter:** _____

**Language service provided in other than English:** ☐ **Spanish** ☐ **Other**_____

**CURRENT DIAGNOSIS**: ICD-10 Code, DSM-5 Diagnosis and Narrative

ICD-10 Code: _____ DSM-5 Diagnosis: _____ (Primary)

DSM-5 Narrative Diagnosis: _____

ICD-10 Code: _____ DSM-5 Diagnosis: _____ (Secondary)

DSM-5 Narrative Diagnosis: _____

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**Chart to: Goals/Strategies on plan; impairment related to diagnosis; progress and/or barriers to recovery; or unplanned events.**

**1a. Treatment goal(s) addressed, if appropriate.**

**1b. Description of Current Situation/Reason for Contact:** (Status update, needs, clinical impressions)

**2. Focus of Activity:** (Intervention and Response to Intervention, what did you do? What is the client's response?)

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**2. Plan** (e.g. Coordination of Care, Referrals, Follow-up) *Specify what the client/family/providers are to do.*

| Signature/License/Job Title | Printed Name | Date |
|---|---|---|
| Co-Signature/License (if applicable) | Printed Name | Date |

Data Entry Clerk Initials