Therapeutic Behavioral Service

Contractor Name: ____

Contractor Provider #: __________________

Therapist Name / Number: _________________________________

Sevice Code: 58

Cnts (Contacts):	Time:
# of contacts in which there is a face-to-face or telephone contact with the client or support person	code in minutes

Location Code: *Identifies the location where the service was rendered:*

A = Office

B = Field (when the locatior is away from the clinician's usual place of business, except for Correctional Fac & IP)

C = Correctional Facility (e.g., jail, prison, camp/ranch, etc.)

D = Inpatient (e.g., Hosp, PHF, SNF, IMD, MHRC)

E = Homeless/Emergency Shelter

F = Faith-based (e.g., church, temple, etc)

G = Health/Primary Care

H = Home

I = Age-Specific Community Center

J = Client's Job Site

L = Licensed Community Care Facility (e.g., Group Home)

M = Mobile Service

N = Non-Traditional service location (e.g., park bench, on street, under bridge, abandoned building)

O = Other Community location

P = Phone

R = Residential Care Facility/ Community Treatment Facility (CTF)

S = School

T = Telehealth

U = Unknown/Not Reported

Month: _______________ **Year:** __________

Client Name (last, first name) / MH #		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
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I hereby certify that the above claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Total Service Duration: ____

Signed ____ **Date** ______________________________________