Core Scoring Grid			
GENERAL	**Met (1)**	**Not Met (0)**	**N/A**
The record is accurate and clearly legible to someone other than the writer.	ENTIRE record is accurate and clearly legible.	ENTIRE record is NOT accurate or clearly legible.	No N/A
Each page of record identifies the member.	ALL pages within the record identifies the member.	Not all of the pages within the record identifies the member.	No N/A
All entries in the record include the name of the person making the entry.	All entries in the record include the name of the person making the entry.	Not All entries in the record include the name of the person making the entry.	No N/A
All entries in the record include the name of the person making the entry's professional degree and their relevant identification number, if applicable.	All entries in the record include the name of the person making the entry's professional degree and their relevant identification number, if applicable. *Professional degree can include graduate and undergraduate professional degrees such as B.A., B.S., M.S., M.A., Ph.D, AP RN, etc.	Not All entries in the record include the name of the person making the entry's professional degree and their relevant identification number, if applicable.	If the person making the entry has no professional degree or relevant id number.
All entries in the record include date where appropriate.	ALL record entries include date.	Not all record entries include date.	No N/A
All entries in the record include signature (including electronic signature for EMR systems) where appropriate.	ALL record entries include signature including electronic signatures.	Not all record entries include signature.	No N/A
Each record includes member's address.	Record contains member's FULL mailing address or documentation of why not Ex. Jane Doe 123 Alphabet St, Lafayette, LA 70508. Member Homeless.	Record does NOT contain member's FULL mailing address and NO documentation of why not. Ex. Jane Doe Lafayette, LA 70508	No N/A
Each record includes employer and/or school address, if applicable.	Record includes employer and/or school address OR there is documentation showing mbr not employed and/or not attending school. Ex. Jane Doe is disabled and unemployed. Johnnie Doe is not currently employed.	Record does NOT include employer and/or school address.	No N/A
Each record includes home, school, and/or work telephone numbers.	Record contains member's (or guardian) home, school, and/or work telephone numbers OR it is documentation showing why no telephone number is listed for mbr. Ex. Jane Doe is currently unemployed and reports having no access to a phone.	Record does NOT contain telephone numbers. No documentation why not.	No N/A
Each record includes emergency contact information.	Record includes emergency contact information OR documentation why not. Ex. Jane Doe reports having no living relatives and no support system. Jane Doe refuses to provide emergency contacts.	Record does NOT include emergency contact information. No documentation why not.	No N/A
Each record includes date of birth.	Record includes full date of birth of mbr.	Record does not include full date of birth.	No N/A
Each record includes gender.	Record includes either biological gender or self-identified gender. OR there is documentation as to why not. Ex. Member refused to identify as specific gender. Mbr refused to disclose identified gender.	Record does NOT include gender whether biological or self-identified without documentation.	No N/A
Each record includes relationship and/or legal status.	Record includes relationship and/or legal status of member OR there is documentation as to why not. Relationship status=married, single, divorce, etc. Legal status=minor, under custodial care of, emancipated, competent major, etc. Ex. Member refused to disclose.	Record does NOT include relationship and/or legal status. No documentation as to why not.	No N/A
For members 0 to 17, documentation of guardianship is included in the record, and proof of guardianship, if applicable.	Record includes documented proof of guardianship of member from someone other than biological parents OR documentation why guardianship proof could not be obtained. *Can include emancipation paperwork, state custody, shared custody, etc.	Record does NOT include documented proof of guardianship OR documentation why not.	If mbr is age 18 and older OR if no proof of guardianship required (biological parents). Remove: For Psychiatric Inpatient, NO proof of guardianship needed for those 18 years of age or older.
For members 0 to 17, there is evidence that services are in context of the family.	Record includes evidence that services are in context of the family OR documentation that mbr is emancipated and mbr does not want family involved. Family can include biological family, adopted family, state authorities servicing as custodial guardians, etc.	Record does not include evidence that services are in context of family. No documentation why not.	If mbr is age 18 and older
For members 0 to 17, there is evidence of ongoing communication with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.	Record includes evidence of ongoing communication with appropriate family mbrs and/or legal guardians OR documentation of why not such as that mbr is emancipated and mbr does not want family involved. Family can include biological family, adopted family, state authorities servicing as custodial guardians, etc.	Record does not include evidence of ongoing communication with appropriate family and/or legal guardians. No documentation why not.	If mbr is age 18 and older
For members 0 to 17, there is evidence of ongoing coordination with appropriate family members and/or legal guardians, including any agency legally responsible for the care or custody of the child.	Record includes evidence of ongoing coordination with appropriate family mbrs and/or legal guardians OR documentation why not such as that mbr is emancipated and mbr does not want family involved. Family can include biological family, adopted family, state authorities servicing as custodial guardians, etc.	Record does not include evidence of ongoing communication with appropriate family and/or legal guardians. No documentation why not.	If mbr is age 18 and older
Each member has a separate record.	Evidence of one member per record.	Evidence of multiples members' information being kept in one record.	No N/A
For telemedicine/telehealth services, there is evidence in the record of verification of recipient's identity.	Evidence in the record of verification of recipient's identity.	NO evidence in the record of verification of recipient identity.	No telemedicine/telehealth services provided
For telemedicine/telehealth services, when possible (i.e. at the next in person treatment planning meeting), providers must have the recipients sign all documents that had verbal agreements previously documented.	Evidence of all documents with verbal agreements previously documented are signed within record.	NO evidence of documents with verbal agreements previously documented signed in the record.	No telemedicine/telehealth services provided
MEMBER RIGHTS			
There is evidence of a Consent for Treatment or Informed Consent in the record that is signed by the member and/or legal guardian.	Evidence of a Consent for Treatment or Informed Consent that is signed by member and/or legal guardian in the record. An LPC Declaration is acceptable. If not signed, documentation indicating why not. *Examples: Member PEC'd to Inpatient Psychiatric Hospital and refuses voluntary consent; Member legal guardian incarcerated and unable to provide written consent; etc.	No signature found in record to consent for treatment or informed consent. No documentation why not.	No N/A
The Patient Bill of Rights is either signed or refusal is documented.	Patient bill of rights is signed by mbr and/or legal guardian OR documentation of refusal and/or rationale why not.	No signed patient bill of rights found in record. No documentation why bill of rights is not signed.	No N/A
For members 18 years of age and older, the member is given information to create psychiatric advance directives or refusal is documented.	Documentation that PAD information was given to mbr and/or refusal for information by mbr documented.	No documentation pertaining to PAD information being given to mbr or refusal by mbr within record.	If mbr is under the age of 18.
There is evidence of the member being given information regarding member's rights to confidentiality.	Evidence of member being given information regarding member rights to confidentiality found within the record.	NO evidence of member being given information regarding member's right to confidentiality found within the record.	No N/A
If utilizing telemedicine/telehealth services, the consent form includes the rationale for using telemedicine/telehealth in place of in-person services	Evidence of rationale for use of telemedicine/telehealth on the consent form in place of in-person.	NO evidence of rationale for use of telemedicine/telehealth on the consent form in place of in-person. **If no consent form found in the record for telemedicine/telehealth services, score this item as 0 and remaining consent form items referencing telemedicine/telehealth services as N/A.	No telemedicine/telehealth services provided.
If utilizing telemedicine/telehealth services, the consent form includes the risks of telemedicine/telehealth, including privacy related risks.	Evidence that consent form includes risks of telemedicine/telehealth including privacy related risks. *LPC statements would have this. Other LMHPs may not. Addendums or separate form from in-person consent to address this for other agencies.	NO evidence that consent form includes risks of telemedicine/telehealth including privacy related risks.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
If utilizing telemedicine/telehealth services, the consent form includes the benefits of telemedicine/telehealth, including privacy related risks.	Evidence that consent form includes benefits of telemedicine/telehealth including privacy related risks.	NO evidence that consent form includes benefits of telemedicine/telehealth including privacy related risks.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
If utilizing telemedicine/telehealth services, the consent form includes possible treatment alternatives.	Evidence that consent form includes possible treatment alternatives to telemedicine/telehealth services.	NO evidence that consent form includes possible treatment alternatives to telemedicine/telehealth services.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
If utilizing telemedicine/telehealth services, the consent form includes risks of possible treatment alternatives.	Evidence that consent form includes risks of possible treatment alternatives.	NO evidence that consent form includes risks of possible treatment alternatives.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
If utilizing telemedicine/telehealth services, the consent form includes benefits of possible treatment alternatives.	Evidence that consent form includes benefits of possible treatment atlernatives.	NO evidence that consent form includes benefits of possible treatment atlernatives.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
If utilizing telemedicine/telehealth services, the consent form includes the risks and benefits of no treatment	Evidence that consent form includes risks and benefits of no treatment.	NO evidence that consent form includes risks and benefits of no treatment.	No telemedicine/telehealth No telemedicine/telehealth services provided or no telemedicine/telehealth consent form
For telemedicine/telehealth services, there is consent signed by the recipient or authorized representative in the record authorizing recording of the session.	Evidence that consent is signed by recipient or authorized representative in the record to record session.	NO evidence that consent is signed by recipient or authorized representative in the record to record session.	No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
For telemedicine/telehealth services, providers need the consent of the recipient and/or the recipient's parent or legal guardian (and their contact information) prior to initiating a telemedicine/telehealth service with the recipient if the recipient is 17 years old or under.	Evidence that if member is 17 years of age or under consent is obtained from recipient and/or recipient's parents or legal guardian is in the record including contact information.	NO evidence that if member is 17 years of age or under consent is obtained from recipient and/or recipient's parents or legal guardian is in the record including contact information.	if member is 18 years of age or older. No telemedicine/telehealth services provided or no telemedicine/telehealth consent form found within record.
INITIAL EVALUATION			
An initial/Annual assessment is in the record.	An initial/annual assessment is found within the record. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	No initial/annual assessment found within record. No documentation of incomplete assessment. **If no initial/annual assessment found within the record, mark this item as 0. Remaining items referencing assessment can be N/A.	No N/A
An initial/Annual assessment is completed by a licensed mental health professional.	Evidence that assessment is completed by an LMHP. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session. *Must be performed by LMHP, not provisionally licensed individual such as PLPC or LMSW.	Evidence that assessment is NOT completed by an LMHP.	All ASAM Levels, specific element to be scored found under ASAM Level specific tab. No initial/annual assessment found within the record.
For members 0 to 17 years of age, there is evidence the legal guardian is involved in the assessment.	There is evidence the legal guardian is involved in assessment with mbr OR there is documented proof of mbr being emancipated and not wanting family involvement. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	There is NO evidence of legal guardian involvement.	If Member is 18 years of age or older. No initial/annual assessment found within the record.
Any standardized assessments are clearly documented, if applicable.	There is clear documentation of standardized assessments within record. Ex. CALOCUS and LOCUS. Based on diagnosis of mbr, evidence of PHQ-9, GAD-7, AUDIT C, Beck's Inventory, Vanderbilt ADHD, ETC.	it is indicated in the record that a standardized assessment was completed, but no assessment is present within the record.	No indication of need for standardized assessment to be completed.

Presenting problem(s) are identified.	Record indicates presenting problem(s). If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT indicate presenting problem(s)	No N/A
An initial primary treatment DSM diagnosis is present in the record.	Record includes initial primary tx DSM diagnosis. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include an initial primary tx DSM diagnosis.	No N/A
The reasons for admission or initiation of treatment are indicated.	Record includes reasons for admission or initiation of treatment. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include reasons for admission or initiation of treatment.	No N/A
The reasons for admission or initiation of treatment are appropriate to services being rendered.	Record includes that reasons for admission or initiation of treatment are appropriate to services being rendered. If not appropriate level of care, there is documentation why mbr is admitted. Ex. Mbr awaiting placement at higher level of care, will remain under our care until able to be placed successfully. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include reasons for admission or initiation of treatment that are appropriate to services being rendered.	No N/A
A complete mental status exam is in the record, documenting the member's affect.	Record includes member's affect on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's affect on MSE	No N/A
A complete mental status exam is in the record, documenting the member's speech.	Record includes member's speech on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's speech on MSE	No N/A
A complete mental status exam is in the record, documenting the member's mood.	Record includes member's mood on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's mood on MSE	No N/A
A complete mental status exam is in the record, documenting the member's thought content.	Record includes member's thought content on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's thought content on MSE	No N/A
A complete mental status exam is in the record, documenting the member's judgement.	Record includes member's judgment on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's judgment on MSE	No N/A
A complete mental status exam is in the record, documenting the member's insight.	Record includes member's insight on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's insight on MSE	No N/A
A complete mental status exam is in the record, documenting the member's attention or concentration.	Record includes member's attention or concentration on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's attention or concentration on MSE	No N/A
A complete mental status exam is in the record, documenting the member's memory.	Record includes member's memory on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's memory on MSE	No N/A
A complete mental status exam is in the record, documenting the member's impulse control.	Record includes member's impulse control on the MSE. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include member's impulse control on MSE	No N/A
The behavioral health treatment history includes family history information.	The behavioral health history includes family hx OR documentation why not. Ex. No family hx available. Member unwilling to share family hx. Member is poor historian.	There is evidence within the record of family involvement in tx, but no documentation of family hx.	No initial/annual assessment found within the record.
A behavioral health history is in the record, including any previous providers.	The behavioral health history includes previous providers OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian.	There is evidence within the record of previous providers, but no documentation within the BH HX.	No initial/annual assessment found within the record.
A behavioral health history is in the record, including treatment dates, if applicable.	The behavioral health history includes treatment dates OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why	There is evidence within the record of treatment dates, but no documentation within the behavioral health history.	If no previous providers. No initial/annual assessment found within the record.
A behavioral health history is in the record, including treatment modality, if applicable.	The behavioral health history includes treatment modality OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why	There is evidence within the record of prior treatment modalities, but no documentation within the behavioral health history.	If no previous providers. No initial/annual assessment found within the record.
A behavioral health history is in the record, including member response, if applicable.	The behavioral health history includes member response to treatment modality OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete.	There is evidence within the record of member response, but no documentation within the behavioral health history.	If no previous providers. No initial/annual assessment found within the record.
The medical treatment history includes known medical conditions.	The medical health history includes known medical conditions OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why	There is evidence within the record of medical conditions, but no documentation within the medical health history.	No initial/annual assessment found within the record.
The medical treatment history includes allergies and/or adverse reactions and dates.	The medical health history includes allergies and/or adverse reactions and dates OR documentation why not. Ex. Member reports no allergies or prior adverse reactions to medications. Member unwilling to share hx. Member is poor historian.	There is evidence within the record of allergies and/or adverse reactions, but no documentation within the medical health history.	No initial/annual assessment found within the record.
The medical treatment history includes providers of previous treatment, if applicable.	The medical health history includes providers of previous treatment OR documentation why not. Ex. No previous treating providers. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	There is evidence within the record of previous tx, but no documentation within the medical health history.	If no previous medical treatment providers. No initial/annual assessment found within the record.
The medical treatment history includes current treating clinicians.	The medical health history includes current treating clinicians OR documentation why not. Ex. Member unwilling to share current treating clinicians. Member unable to recall name of clinician. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	There is evidence within the record of current treating clinicians, but no documentation within the medical health history.	No initial/annual assessment found within the record.
The medical treatment history includes current therapeutic interventions and responses, if applicable.	The medical health history includes current therapeutic interventions and responses OR documentation why not. Ex. Member unable to recall current interventions. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not	There is evidence within the record of current therapeutic itnerventions and response, but no documentation within the medical health history.	If no current treating clinician and would not have current therapeutic interventions and/or responses. No initial/annual assessment found within the record.
The medical treatment history includes family history.	The medical health history includes family history OR documentation why not. Ex. No family involvement. Member unwilling to share hx. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	There is evidence within the record of family involvement in tx, but no documentation of family hx within the medical treatment hx.	If no family medical history is available. No initial/annual assessment found within the record.
Current medications are listed (PH & BH).	Record includes current medications (PH & BH) OR documentation why not. Ex. Member unable to recall specific meds prescribed to them. Member unwilling to share info. Member is poor historian. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record indicates member on medication, but no medications listed in record.	Member not on medication.
Prescriber of current medications are listed (PCP & BH).	Record includes list of the prescriber of current medications OR documentation why not. Ex. Member unable to recall prescriber. Member unwilling to share info. Member is poor historian.	Record indicates member on medications and/or current medications are listed, but no prescriber identified. No medications listed, but prescriber is identified.	Member not on medication. No initial/annual assessment found within the record.
Medication dosage is listed.	Record includes medication dosage OR documentation why not. Ex. Member unable to recall specific dosage prescribed to them. Member unwilling to share info. Member is poor historian.	Record indicates member on medication, but does not include medication dosage.	Member not on medication. No initial/annual assessment found within the record.
Medication frequency is listed.	Record includes medication frequency OR documentation why not. Ex. Member unable to recall specific frequency prescribed to them. Member unwilling to share info. Member is poor historian.	Record indicates member on medication, but does not include frequency of medication.	Member not on medication. No initial/annual assessment found within the record.
Medication start date is listed.	Record includes start dates of medications listed OR documentation why not. Ex. Member unable to recall specific start dates of meds prescribed to them. Member unwilling to share info. Member is poor historian.	Record indicates member on medication, but does not list start dates of medication. Medication area not addressed.	Member not on medication. Provider is not a prescriber. No initial/annual assessment found within the record.
Response to medication and other concurrent treatment (successful/unsuccessful) is documented.	Record includes documentation of response to medication and other concurrent treatment.	Record indicates member on medication or other concurrent treatment, but does not document response (successful/unsuccessful). Medication area not addressed.	Member not on medication. Provider is not a prescriber. No initial/annual assessment found within the record.
Problems/side effects are documented, if applicable.	Record includes documentation of problems/side effects to medications.	Record indicates member on medication, but no documentation of either "no problems/side effects" or that there are problems/side effects. Medication area is not completed.	Member not on medication. Provider is not a prescriber. No initial/annual assessment found within the record.

The initial history for members under the age of 21 includes prenatal and perinatal events, if information is available.	The initial history includes prenatal and perinatal events for members under age of 21 OR there is documentation why it is not included. Ex. Information is unavailable. Member or member guardian does not have access to this information. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Initial history does not include prenatal and perinatal events AND there is no documentation why not.	member is 21 years old or older.
The initial history for members under the age of 21 includes a complete developmental history (physical, psychological, social, intellectual and academic).	The initial history includes complete developmental history for members under age of 21 OR there is documentation why it is not included. Ex. Information is unavailable. Member or member guardian does not have access to this information.	Initial history does not include complete developmental history AND there is no documentation why not.	member is 21 years old or older.
Assessment of risk includes the presence or absence of current and past suicidal or homicidal risk, danger toward self or others.	Assessment of risk includes the presence or absence of current and past suicidal or homicidal risk, danger toward self or other. OR there is documentation why not. Ex. Member denies current and past suicidal or homicidal behaviors. Member refuses to share information about past suicidal/homicidal behaviors. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Assessment of risk does NOT include the presence or absence of current and past suicidal or homicidal risk, danger towards self or others AND there is no documentation why not. **No Assessment of risks found, mark item as 0 then remaining risk assessment items as N/A.	No N/A
The record includes documentation of previous suicidal or homicidal behaviors.	The record includes documentation of previous suicidal or homicidal behaviors OR there is documentation why not. Ex. Member denies past suicidal or homicidal behaviors. Member refuses to share information about past suicidal/homicidal behaviors. No previous suicidal or homicidal behaviors noted. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	Record does NOT include documentation of previous suicidal or homicidal behaviors AND there is no documentation why not.	No risk assessment found within the record.
The record includes documentation of dates of previous suicidal or homicidal behaviors.	The record includes documentation of dates of previous suicidal or homicidal behaviors OR there is documentation why not. Ex. Member denies current and past suicidal or homicidal behaviors. Member refuses to share information about past suicidal/homicidal behaviors. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The record includes documentation of dates of previous suicidal or homicidal behaviors AND there is no documentation why not.	No previous suicidal or homicidal behaviors noted. No risk assessment found within the record.
The record includes documentation of methods of previous suicidal or homicidal behaviors.	The record includes documentation of methods of previous suicidal or homicidal behaviors OR there is documentation why not. Ex. Member denies current and past suicidal or homicidal behaviors. Member refuses to share information about past suicidal/homicidal behaviors. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The record includes documentation of methods of previous suicidal or homicidal behaviors AND there is no documentation why not.	No previous suicidal or homicidal behaviors noted. No risk assessment found within the record.
The record includes documentation of lethality of previous suicidal or homicidal behaviors.	The record includes documentation of lethality of previous suicidal or homicidal behaviors OR there is documentation why not. Ex. Member denies current and past suicidal or homicidal behaviors. Member refuses to share information about past suicidal/homicidal behaviors.	The record includes documentation of lethality of previous suicidal or homicidal behaviors AND there is no documentation why not.	No previous suicidal or homicidal behaviors noted. No risk assessment found within the record.
Documentation of any abuse the member has experienced or if the member has been the perpetrator of abuse.	Record includes documentation of any abuse member has experienced or if member has been the perpetrator of abuse OR	Record does NOT include documentation of any abuse member has experienced or if member has been the	No assessment found within the record.
Substance use assessment was conducted.	Evidence of substance use assessment being conducted including documentation that pt denies use. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	No evidence of substance use assessment being conducted. **If no substance use assessment conducted, mark item as 0 and remaining items referencing substance use as N/A.	No N/A
Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use.	If there is evidence of substance, documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use OR documentation why not. Ex. Member denies use. Member poor historian. Member unable to recall all prior substances. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	If there is evidence of substance use, but NO documentation of past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications and nicotine use AND NO documentation why not.	No substance use assessment found within record.
The record documents the presence or absence of relevant legal issues of the member and/or family.	The record documents the presence or absence of relevant legal issues of the member and/or family. Ex. Member denies legal issues. Member poor historian. Member unable to provide information on family. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The record does NOT document the presence or absence of relevant legal issues of the member and/or family.	No initial/annual assessment found within record.
There is documentation that the member was asked about community resources (family, support groups, social services, school based services, other social supports) that they are currently utilizing.	There is documentation that the member was asked about community resources. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	There is NOT documentation that the member was asked about community resources.	No initial/annual assessment found within record.
The record documents the assessment of the member's strengths.	The record documents the assessment of the member's strengths. If incomplete assessment is found, there is documentation as to why it	The record does NOT document the assessment of the member's strengths.	No initial/annual assessment found within record.
The record documents the assessment of the member's needs.	The record documents the assessment of the member's needs. If incomplete assessment is found, there is documentation as to why it is incomplete.	The record does NOT document the assessment of the member's needs.	No initial/annual assessment found within record.
The assessment documents the spiritual variables that may impact treatment.	The assessment documents the spiritual variables that may impact treatment OR documentation why not. Ex. Member unwilling to share spiritual variables that may impact tx. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The assessment does NOT document the spiritual variables that may impact treatment AND is NOT documented why not.	No initial/annual assessment found within record.
The assessment documents any financial concerns.	The assessment documents any financial concerns OR documentation why not. *IF underage member, guardian/caretaker should be asked. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The assessment does NOT document any financial concerns AND documetnation why NOT.	No initial/annual assessment found within record.
The assessment documents any challenges related to transportation.	The assessment documents any challenges related to transportation. *IF underage member, guardian/caretaker should be asked. If incomplete assessment is found, there is documentation as to why it is incomplete. *This item pertains to accessing services and any related transportation issue. For ex., if someone was IP, do they have transportation for follow-up appts, etc. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The assessment does NOT document any challenges related to transportation.	No initial/annual assessment found within record.
Telemedicine use documented, if applicable.	Telemedicine use documented within the record.	Telemedicine use NOT documented within the record.	Telemedicine was not used with member.
The member's desired outcomes of treatment are clearly documented in the record.	The member's desired outcomes of treatment are clearly documented in the record. *Should be member if they are able to identify desired outcomes for themselves (in the instance of children). If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session.	The member's desired outcomes of treatment are NOT clearly documented in the record.	No N/A
There is evidence of preliminary discharge planning.	There is evidence of preliminary discharge planning or documentation why not. If incomplete assessment is found, there is documentation as to why it is incomplete. Ex. Met with mbr to complete initial assessment; however, did not complete and mbr failed to return for second session. *More than just a re-evaluate in a few months. Does not need to be specific dates for preliminary. Providing the member with resources to utilize in the event member does not return.	There is NO evidence of preliminary discharge planning.	No N/A
Indication and identification of any standardized assessment tool or comprehensive screening completed (i.e. a PHQ-9, GAD-7) as dictated by diagnosis.	There is indication for and identification of any standardardized assessment tool or comprehensive screening completed as dictated by diagnosis.	There is NO indication for and identification of any standardized assessment tool or comprehensive screening completed as dictated by diagnosis.	Not dictated by diagnosis.
Documentation of referrals, if applicable.	There is Documentation of referrals in the record, if applicable.	There is NO Documentation of referrals in the record, WHEN applicable.	There is no evidence of documentation for referrals needed.
An initial health screening, such as the Healthy Living Questionnaire or the PBHCI, is included in the record. (Unless directed by the plan, this is for informational purposes and not counted against a provider in the compliance rating.)	An initial health screening, such as the Healthy Living Questionnaire or the PBHCI, is included in the record.	No 0.	If an initial health screening, such as the Healthy Living Questionaire is not in the record.
TREATMENT PLAN	***Based on Most recent tx plan; can review prior tx plan to see progression and updates.**		
The treatment plan is in the record.	The treatment plan is in the record or there is documentation why not. Ex. Member did not return to complete tx plan. Member not admitted following assessment, referred elsewhere.	The treatment plan is not in the record. **If No treatment plan,mark item as 0 and remainder of items referencing the tx plan as N/A.	Member left tx before tx plan could be developed.
Treatment plan is signed by the member.	Treatment plan is signed by the member OR documentation why not. Ex. Member unable to sign at time of completion and did not return. Member sedated and unable to sign. Member too young to sign, but guardian signed. Member gave verbal consent and agreement to tx plan (witnessed by 2 staff).	Treatment plan is not signed by the member and no documentation why not.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan is signed by member's guardian, if applicable.	Treatment plan is signed by member's guardian, if applicable.	Treatment plan is not signed by member's guardian, if applicable.	Mbr is 18 years of age or older OR Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan signed by treating LMHP including credentials in signature.	Treatment plan signed by treating licensed clinician including credentials in signature.	Treatment plan was not signed by treating licensed clinician including credentials in signature.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan signed by caregiver or other treating professionals or paraprofessionals involved in tx team.	Treatment plan signed by caregiver or other treating professionals or paraprofessionals involved in tx team OR documentation why not.	Treatment plan not signed by caregiver or other treating professionals or paraprofessionals involved in tx team AND no documentation why not.	Member left tx before tx plan could be developed. No treatment plan found within record.
Date of treatment plan.	The treatment plan is dated.	The treatment plan is not dated.	Member left tx before tx plan could be developed. No treatment plan found within record.
Indication if it is an “initial” or an “updated” treatment plan.	Indication if it is an “initial” or an “updated” treatment plan. *Inpatient world, rather than "update", you may see "revised".	No Indication if it is an “initial” or an “updated” treatment plan.	Member left tx before tx plan could be developed. No treatment plan found within record.

Treatment plan signed by Member and/or Member's guardian as documented proof of agreement with treatment plan.	Treatment plan is signed by Member and/or Member's guardian.	Treatment plan is NOT signed by Member and/or Member's guardian.	Member left tx before tx plan could be developed. No treatment plan found within record.
The treatment plan is updated whenever goals are achieved or new problems are identified.	The treatment plan is updated whenever goals are achieved or new problems are identified OR documentation why not such as no new problems identified, current goals still in progress, no new goals developed, current goals not achieved, etc.	The treatment plan is not updated whenever goals are achieved or new problems are identified.	Member left tx before tx plan could be developed. No treatment plan found within record.
Progress on all goals are included in the update.	Progress on all goals are included in the update OR documentation why not.	Progress on all goals are not included in the update.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan is based on the assessment (initial or updated).	Treatment plan is based on the assessment (initial or updated).	Treatment plan is not based on the assessment (initial or updated).	Member left tx before tx plan could be developed. No treatment plan found within record.
Member's strengths are included in the treatment plan.	Member's strengths are included within the treatment plan.	Member's strengths are NOT included within the treatment plan.	Member left tx before tx plan could be developed. No treatment plan found within record.
Member's needs are included in the treatment plan.	Member's needs are included within the treatment plan.	Member's needs are NOT included within the treatment plan.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan utilizes input from the member, family, natural supports, and/or treatment team.	Treatment plan utilizes input from the member, family, natural supports, and/or treatment team OR documentation why not.	Treatment plan does not utilizes input from the member, family, natural supports, and/or treatment team AND NO documentation why not.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan is developed by an LMHP.	Treatment plan is developed by an LMHP.	Treatment plan is not developed by an LMHP.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan is consistent with diagnosis.	Treatment plan is consistent with diagnosis.	Treatment plan is not consistent with diagnosis.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan has long term goals.	Treatment plan has long term goals. **Add for reviewers: long term goals are the broad goals.	Treatment plan does not have long term goals.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan has short term goals/objectives/interventions.	Treatment plan has short term goals/objectives/interventions. **Add for reviewers: short term goals may be used interchageably with objectives/interventions within treatment plan.	Treatment plan has no short term goals/objectives/interventions.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan goals/objectives/interventions are specific.	Treatment plan goals/objectives/interventions are specific.	Treatment plan goals/objectives/interventions are not specific.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan goals/objectives/interventions are measurable.	Treatment plan goals/objectives/interventions are measurable.	Treatment plan goals/objectives/interventions are not measurable.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan goals/objectives/interventions are action-oriented.	Treatment plan goals/objectives/interventions are action-oriented.	Treatment plan goals/objectives/interventions are not action-oriented.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan goals/objectives/interventions are realistic.	Treatment plan goals/objectives/interventions are realistic.	Treatment plan goals/objectives/interventions are not realistic.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan goals/objectives/interventions are time-limited.	Treatment plan goals/objectives/interventions are time-limited.	Treatment plan goals/objectives/interventions are not time-limited.	Member left tx before tx plan could be developed. No treatment plan found within record.
There is evidence the treatment has been revised/updated to meet the changing needs of the member, if applicable.	There is evidence the treatment has been revised/updated to meet the changing needs of the member, if applicable.	There is evidence the treatment has not been revised/updated to meet the changing needs of the member, if applicable.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan reflects services to be provided in the amount.	Treatment plan reflects services to be provided in the amount.	Treatment plan does not reflects services to be provided in the amount.	Member left tx before tx plan could be developed. No treatment plan found within record. N/A: Inpatient
Treatment plan reflects services to be provided in the type.	Treatment plan reflects services to be provided in the type.	Treatment plan does not reflects services to be provided in the type.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan reflects services to be provided in the duration.	Treatment plan reflects services to be provided in the duration.	Treatment plan does not reflects services to be provided in the duration.	Member left tx before tx plan could be developed. No treatment plan found within record.
Treatment plan reflects services to be provided in the frequency.	Treatment plan reflects services to be provided in the frequency.	Treatment plan does not reflects services to be provided in the frequency.	Member left tx before tx plan could be developed. No treatment plan found within record.
Individualized Crisis Plan is in the record, including any changes related to COVID-19 risks.	Individualized Crisis Plan is in the record. *Specific to member such as supports. Add for reviewer: documentation why plan is not in the record such as member declines crisis plan.	Individualized Crisis Plan is not in the record. **If no crisis plan found within record, 0 for this item and N/A for remainder of crisis plan items.	Member left tx before crisis plan could be developed.
For telemedicine/telehealth services, there is evidence in the record of a back-up plan (e.g., phone number where recipient can be reached) to restart the session or to reschedule it, in the event of technical problems.	Evidence found in record of back-up plan to restart session and/or reschedule it in event of technical problems.	NO evidence of back-up plan to restart or reschedule session in the event of technical problems found in record.	if no telemedicine/telehealth services documented within the record.
For telemedicine/telehealth services, there is evidence in the record of a a safety plan that includes at least one emergency contact and the closest ER location, in the event of a crisis.	Evidence found in the record of safety plan that includes at least one emergency contact and closest ER location in event of crisis.	NO evidence of safety plan that includes at least one emergency contact and closest ER location in event of crisis found within record.	if no telemedicine/telehealth services documented within the record.
Crisis plan signed by Member and/or member's guardian as proof of participation in the development of crisis plan.	Crisis plan signed by Member and/or Member's guardian. Add for reviewer: documentation why plan is not in the record such as member declines crisis plan.	Crisis plan NOT signed by Member and/or Member's guardian.	Member left tx before crisis plan could be developed. No crisis plan found within record.
Crisis plan is updated as needed to meet participant's needs.	Crisis plan is updated as needed to meet participant's needs OR documentation of why no updates needed. Add for reviewer: documentation why plan is not in the record such as member declines crisis plan and/or to update plan.	Crisis plan is not updated as needed to meet participant's needs.	Member left tx before crisis plan could be developed. No crisis plan found within record.
Peer Support Services (PSS): Peer support services are person-centered.	Evidence found that PSS are person-centered.	NO evidence found that PSS are person-centered.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer support services are recovery focused.	Evidence found that PSS are recovery-focused.	NO evidence found that PSS are recovery-focused.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to set goals related to home.	Documentation found that recovery planning is assisting member to set goals related to home OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to set goals related to home AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to set goals related to work.	Documentation found that recovery planning is assisting member to set goals related to work OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to set goals related to work AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to set goals related to community.	Documentation found that recovery planning is assisting member to set goals related to community OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to set goals related to community AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to set goals related to health.	Documentation found that recovery planning is assisting member to set goals related to health OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to set goals related to health AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to home.	Documentation found that recovery planning is assisting member to accomplish goals related to home OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to accomplish goals related to home AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to work.	Documentation found that recovery planning is assisting member to accomplish goals related to work OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to accomplish goals related to work AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to community.	Documentation found that recovery planning is assisting member to accomplish goals related to community OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to accomplish goals related to community AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Recovery planning assists members to accomplish goals related to health.	Documentation found that recovery planning is assisting member to accomplish goals related to health OR documentation why not being targeted at this time.	NO documentation found that recovery planning is assisting member to accomplish goals related to health AND no documentation why not.	If Member is not receiving PSS.
PROGRESS NOTES			
Progress notes reference treatment goals.	All progress notes reference treatment goals. *Add for Reviewers: IPP, group and/or individual progress notes to be monitored.	All progress notes do not reference treatment goals.	Member attended only one session then did not return. Member referred out after assessment.
All progress notes document clearly who is in attendance during each session (outpatient services).	All progress notes document clearly who is in attendance during each session (outpatient services).	All progress notes do not document clearly who is in attendance during each session (outpatient services).	If provider isn't delivering outpatient services.
The progress notes describe progress or lack of progress towards treatment plan goals.	The progress notes describe progress or lack of progress towards treatment plan goals.	The progress notes does not describe progress or lack of progress towards treatment plan goals.	Member attended only one session then did not return. Member referred out after assessment.
The progress notes describe/list member strengths.	The progress notes describe/list member strengths OR documentation of why not.	The progress notes does not describe/list member strengths and no documentation why not.	Member attended only one session then did not return. Member referred out after assessment.
The progress notes describe/list how strenghts impact treatment.	The progress notes describe/list how strenghts impact treatment OR documentation of why not.	The progress notes does not describe/list how strenghts impact treatment and no documentaion why not.	Member attended only one session then did not return. Member referred out after assessment.
The progress notes describe/list limitations.	The progress notes describe/list limitations OR documentation of why not.	The progress notes does not describe/list limitations and no documentaion why not.	Member attended only one session then did not return. Member referred out after assessment.
The progress notes describe/list how limitations impact treatment.	The progress notes describe/list how limitations impact treatment OR documentation of why not.	The progress notes does not describe/list how limitations impact treatment and no documentaion why not.	Member attended only one session then did not return. Member referred out after assessment.
The progress notes document continuous substance use assessment (if applicable).	The progress notes document continuous substance use assessment (if applicable).	The progress notes does not document continuous substance use assessment (if applicable).	No evidence found within record indicating continuous substance use assessment needed.
The progress notes document on-going risk assessments (including but not limited to suicide and homicide).	The progress notes document on-going risk assessments (including but not limited to suicide and homicide). on-going=every session For Reviewers add: risk assessment=informal risk assessments and/or formal risk assessments.	The progress notes does not document on-going risk assessments (including but not limited to suicide and homicide).	Member attended only one session then did not return. Member referred out after assessment.
The progress notes document (including but not limited to suicide and homicide) monitoring of any at risk situations.	The progress notes document (including but not limited to suicide and homicide) monitoring of any at risk situations.	The progress notes does not document (including but not limited to suicide and homicide) monitoring of any at risk situations.	Member attended only one session then did not return. Member referred out after assessment. No indication of Member requiring monitoring of at risk situations.
Compliance or non-compliance with medications is documented (if applicable).	Compliance or non-compliance with medications is documented (if applicable).	Compliance or non-compliance with medications is not documented (if applicable).	Member is not on medications.

Indication of ongoing discussion of discharge planning to alternative or appropriate level of care.	Indication of ongoing discussion of discharge planning to alternative or appropriate level of care. (Must occur a minimum of 1 time a month, can be referenced when reviewing the treatment plans but must specifically referrence discharge)	No indication of ongoing discussion of discharge planning to alternative or appropriate level of care.	Member attended only one session then did not return. Member referred out after assessment.
Progress notes include date of service noted.	Progress notes include date of service noted.	Progress notes do not include date of service noted.	No N/A
Progress notes include begin times of service noted.	Progress notes include begin times of service noted.	Progress notes do not include begin times of service noted.	No N/a
Progress notes include end times of service noted.	Progress notes include end times of service noted.	Progress notes do not include end times of service noted.	No N/A
Progress notes include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.	Progress notes include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.	Progress notes do not include signature of the person making the entry. If initials are utilized, initials of providers must be identified with correlating signatures.	No N/a
Progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.	Progress notes include the functional title, applicable educational degree and/or professional license of the person making the entry.	Progress notes do not include the functional title, applicable educational degree and/or professional license of the person making the entry.	No N/A
The progress notes document the dates or time periods of follow up appointments with outpatient providers.	The progress notes document the dates or time periods of follow up appointments.	The progress notes do not document the dates or time periods of follow up appointments.	N/A: Inpatient psychiatric hospitalization (If provider is not OP provider)
Provider documents when the member misses appointments, if applicable.	Provider documents when the member misses appointments, if applicable. Add for reviewers: either missed appt is documented OR no appts were missed per documentation.	Provider does not document when the member misses appointments, if applicable.	No N/A
When appropriate there is evidence of supervisory oversight of the treatment record (Records are reviewed on a regular basis with appropriate actions taken.)	When appropriate there is evidence of supervisory oversight of the treatment record (refer to manual for specifics re: supervisory oversight). *Examples of supervisory oversight could include, but not limited to: case staffing form; progress note update with supervisor signature; supervision log note; Treatment plan and updates with involved persons signatures; progress notes supervisor signature following staff signature; etc.	When appropriate there is no evidence of supervisory oversight of the treatment record.	If supervisory oversight not required such as an LMHP and/or MD.
Progress notes document specifically if service was provided through Telemedicine/Telehealth. (outpatient services)	Progress notes document specifically if service was provided through Telemedicine/Telehealth.	Progress notes do not document specifically if service was provided through Telemedicine/Telehealth.	No telemedicine/telehealth services provided. If provider is not providing outpatient services.
Services documented in the progress note reflect services billed.	Services documented in the progress note reflect services billed.	Services documented in the progress note do not reflect services billed.	Member attended only one session then did not return. Member referred out after assessment, no progress notes.
The progress notes reflect reassessments, if applicable.	The progress notes reflect reassessments and reassessment present, if applicable.	The progress notes reflects need for reassessment, but reassessment did not occur, if applicable.	Member left treatment before reassessment was due. Add for reviewer: Documentation does not support need for reassessment.
There is evidence of progress summaries in the record.	There is evidence of progress summaries in the record.	There is no evidence of progress summaries in the record. **No progress summaries found within record, mark this item 0 and remaining progress summary items as N/A.	There is no progress summary in the record due to the member's length of time in treatment. N/A: Inpatient Psych Hospitalization
There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.	There is evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.	There is no evidence of progress summaries completed at least every 90 days, or more frequently as needed, if applicable.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries document the start and end date for the time period summarized.	Progress summaries document the start and end date for the time period summarized.	Progress summaries do not document the start and end date for the time period summarized.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries indicate who participated.	Progress summaries indicate who participated.	Progress summaries do not indicate who participated.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries indicate where contact occurred.	Progress summaries indicate where contact occurred.	Progress summaries do not indicate where contact occurred.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries indicate what activities occurred.	Progress summaries indicate what activities occurred.	Progress summaries do not indicate what activities occurred.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.	Progress summaries indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.	Progress summaries do not indicate how the recipient is progressing or lack of progression toward the personal outcomes in the treatment plan.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries document any deviation from the treatment plan, if applicable.	Progress summaries document any deviation from the treatment plan, if applicable.	Progress summaries do not document any deviation from the treatment plan, if applicable.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.	Progress summaries document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.	Progress summaries do not document any changes in the recipient's medical condition, behavior or home situation that may indicate a need for a reassessment and/or treatment plan change, as applicable.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.	Progress summaries include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.	Progress summaries do not include signature of the person completing the summary. If initials are utilized, initials of providers must be identified with correlating signatures.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.	Progress summaries include the functional title, applicable educational degree and/or professional license of the person completing the summary.	Progress summaries do not include the functional title, applicable educational degree and/or professional license of the person completing the summary.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries are dated.	Progress summaries are dated.	Progress summaries are not dated.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
Progress summaries shall be signed by the person providing the services.	Progress summaries shall be signed by the person providing the services.	Progress summaries are not signed by the person providing the services.	There is no progress summary in the record. N/A: Inpatient Psych Hospitalization
For telemedicine/telehealth services,There is evidence in the record the member was informed of all persons who are present.	Evidence in the record member is informed of all persons present.	NO evidence in the record of member being informed of all persons present.	if no telemedicine/telehealth services documented within the record.
For telemedicine/telehealth services,There is evidence in the record the member was informed of the role of each person.	Evidence in the record member informed of role of each person present.	NO evidence in the record of member being informed of role of each person present.	if no telemedicine/telehealth services documented within the record.
For telemedicine/telehealth services, evidence in the record that, regardless of the originating site, providers must maintain adequate	Evidence of medical documentation within record to support reimbursement of telemedicine/telehealth service visit.	NO evidence of adequate medical documentation to support reimbursement of visit.	if no telemedicine/telehealth services documented within the record.
For telemedicine/telehealth services, documentation if recipient refused services delivered through telehealth.	Evidence of documentation of member refusing services delivered via telehealth.	NO evidence of documentation of member refusing services delivered via telehealth.	if no telemedicine/telehealth services documented within the record.
Peer Support Services (PSS): Peer support services are face-to-face interventions with the member present.	Evidence found that PSS are face-to-face interventions with the member present.*face to face can include telehealth video.	NO Evidence found that PSS are face-to-face interventions with the member present.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer support services may include, but are not limited to utilizing 'lived experience' to translate and explain the recovery process step by step.	Evidence of PSS utilizing "lived experience" to translate and explain the recovery process step by step OR documentation as to why not.	NO Evidence of PSS utilizing "lived experience" to translate and explain the recovery process step by step AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer support services may include, but are not limited to utilizing 'lived experience' to translate and explain the expectations of services.	Evidence of PSS utilizing 'lived experience' to translate and explain the expectations of services OR documentation as to why not.	NO Evidence of PSS utilizing 'lived experience' to translate and explain the expectations of services AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer Support Services are therapeutic or have programmatic content.	Evidence that PSS are therapeutic and/or have programmatic content OR documentation as to why not.	NO Evidence that PSS are therapeutic and/or have programmatic content AND no documentation why not.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer Support Services do not contain recreational, social, or leisure (activities) in nature services.	Evidence that PSS does NOT contain recreational, social, or leisure in nature services.	There IS evidence that PSS contains recreational, social, or leisure in nature services.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer Support Services documented do not provide transportation.	Evidence that PSS does NOT provide transportation.	There IS evidence that PSS IS providing transportation.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer Support Services do not document general office/clerical tasks as part of rendered services.	Evidence that PSS does NOT document general office/clerical tasks as part of rendered services.	There IS evidence that PSS IS documentating general office/clerical tasks as part of rendered services.	If Member is not receiving PSS.
Peer Support Services (PSS): Peer Support Services do not document attendance in meetings or sessions without a documented purpose/benefit from the peer's presence in that meeting or session.	Evidence that PSS does NOT document attendance in meetings or sessions without a documented purpose/benefit from the peer's presence in that meeting or session.	There IS evidence that PSS documents attendance in meetings or sessions WITH a documented purpose/benefit from the peer's presence in that meeting or session.	If Member is not receiving PSS.
CONTINUITY AND COORDINATION OF CARE			
The record documents that the member was asked whether they have a PCP.	The record documents that the member was asked whether they have a PCP. *regardless of response, looking for documentation proving this was asked.	The record does not documents that the member was asked whether they have a PCP.	No N/A; either member was asked or not.
PCP's name is documented in the record, if applicable.	PCP's name is documented in the record, if applicable.	PCP's name is not documented in the record, if applicable.	Member does not have a PCP. If the member was not asked, this will be marked as N/A.
PCP's address is documented in the record, if applicable.	PCP's address is documented in the record, if applicable.	PCP's address is not documented in the record, if applicable.	Member does not have a PCP. If the member was not asked, this will be marked as N/A.
PCP's phone number is documented in the record, if applicable.	PCP's phone number is documented in the record, if applicable.	PCP's phone number is not documented in the record, if applicable.	Member does not have a PCP. If the member was not asked, this will be marked as N/A.
If the member has a PCP, there is evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.	If the member has a PCP, there is evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.	If the member has a PCP, there is no evidence of provider attempting or successfully communicating with PCP or there is documentation that the member/guardian refused consent for the release of information to the PCP.	Member does not have a PCP. If the member was not asked, this will be marked as N/A.
The record documents that the member was asked whether they are being seen by another behavioral health clinician.	The record documents that the member was asked whether they are being seen by another behavioral health clinician. *regardless of response, looking for documentation proving this was asked.	The record does not documents that the member was asked whether they are being seen by another behavioral health clinician.	No N/A; either member was asked or not.
Other behavioral health clinician's name is documented in the record, if applicable.	Other behavioral health clinician's name is documented in the record, if applicable.	Other behavioral health clinician's name is not documented in the record, if applicable.	Member not being seen by other behavioral health clinician. If the member was not asked, this will be marked as N/A.
Other behavioral health clinician's address is documented in the record, if applicable.	Other behavioral health clinician's address is documented in the record, if applicable.	Other behavioral health clinician's address is not documented in the record, if applicable.	Member not being seen by other behavioral health clinician. If the member was not asked, this will be marked as N/A.
Other behavioral health clinician's phone number is documented in the record, if applicable.	Other behavioral health clinician's phone number is documented in the record, if applicable.	Other behavioral health clinician's phone number is not documented in the record, if applicable.	Member not being seen by other behavioral health clinician. If the member was not asked, this will be marked as N/A.
If the member is being seen by another behavioral health clinician, there is evidence of provider attempting or successfully communicating with primary behavioral health clinician or there is documentation that the member/guardian refused consent for the release of information to the PCP.	If the member is being seen by another behavioral health clinician, there is evidence of provider attempting or successfully communicating with primary behavioral health clinician or there is documentation that the member/guardian refused consent for the release of information to the PCP.	If the member is being seen by another behavioral health clinician, there is no evidence of provider attempting or successfully communicating with primary behavioral health clinician or there is documentation that the member/guardian refused consent for the release of information to the PCP.	Member not being seen by other behavioral health clinician. If the member was not asked, this will be marked as N/A.
Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.	Provider documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable. Ex. Physical therapy, substance use, PCP, etc.	Provider does not documents any referrals made to other clinicians, agencies, and/or therapeutic services, if applicable.	Member does not need any additional referrals.
Release of Information signed or refusal noted for communications with other treating providers, if applicable.	Release of Information signed or refusal noted for communications with other treating providers, if applicable.	No release of Information signed or refusal noted for communications with other treating providers, when	Member has no other treating providers.
MEDICATION MANAGEMENT (IF APPLICABLE)			
Each record indicates what medications have been prescribed.	Each record indicates what medications have been prescribed OR documentation why not.	Each record does not indicate what medications have been prescribed AND does not have documentation why	Member does not receive medication management from this provider.
Each record indicates the dosages of each medication.	Each record indicates the dosages of each medication OR documentation why not.	Each record does not indicate the dosages of each medication.	Member does not receive medication management from this provider.
Each record indicates the dates of initial prescription or refills.	Each record indicates the dates of initial prescription or refills OR documentation why not.	Each record does not indicate the dates of initial prescription or refills.	Member does not receive medication management from this provider.
Documentation of member education of prescribed medication including benefits.	Documentation of member education of prescribed medication including benefits OR documentation why not.	NO documentation of member education of prescribed medication including benefits.	Member does not receive medication management from this provider.
Documentation of member education of prescribed medication including risks.	Documentation of member education of prescribed medication including risks OR documentation why not.	No documentation of member education of prescribed medication including risks.	Member does not receive medication management from this provider.
Documentation of member education of prescribed medication including side effects.	Documentation of member education of prescribed medication including side effects OR documentation why not.	No documentation of member education of prescribed medication including side effects.	Member does not receive medication management from this provider.
Documentation of member education of prescribed medication including alternatives of each medication.	Documentation of member education of prescribed medication including alternatives of each medication OR documentation why not.	No documentation of member education of prescribed medication including alternatives of each medication.	Member does not receive medication management from this provider.
For members 18 and over, documentation of the member understanding and consenting to the medication used in treatment.	For members 18 and over, documentation of the member understanding and consenting to the medication used in treatment.	For members 18 and over, no documentation of the member understanding and consenting to the medication used in treatment.	Member does not receive medication management from this provider. Member under the age of 18.
For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	For children and adolescents no documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.	Member does not receive medication management from this provider. Member is 18 years or older.
Documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients for controlled substances or otherwise applicable. (*Reference list labeled "common controlled substances" on later tab)	Documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients for controlled substances or otherwise applicable.	No documentation that a query was done through the Prescription Monitoring Program (PMP) for behavioral health patients for controlled substances or otherwise applicable.	Member does not receive medication management from this provider. Member is not receiving controlled substances.
AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).	AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).	No AIMS (Abnormal Involuntary Movement Scale) performed when appropriate (e.g., member is being treated with antipsychotic medication).	Member does not receive medication management from this provider. Member not on any antipsychotic medication.
Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring. (*Reference list labeled "common Anitpsychotics" on later tab)	Initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring.	No initial and ongoing medical screenings are completed for members prescribed antipsychotic medication including but not limited to weight, BMI, labs and chronic conditions to document ongoing monitoring.	Member does not receive medication management from this provider. Member not on any antipsychotic medication.
There is evidence that lab work is ordered, if applicable.	There is evidence that lab work is ordered, if applicable.	There is no evidence that lab work is ordered by prescribing provider, when applicable.	Member does not receive medication management from this provider. Lab work wasn't required on member.

There is evidence the ordered lab work is received by the clinician ordering the lab work, if applicable.	There is evidence the ordered lab work is received by the clinician ordering the lab work, if applicable.	There is no evidence the ordered lab work is received by the clinician ordering the lab work, if applicable.	Member does not receive medication management from this provider. Lab work wasn't required on member.
There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.	There is evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician. *Add for reviewer: Can include statement within progress note stating labs were reviewed and/or signature and date on the actual labs as being reviewed.	There is no evidence ordered lab work has been reviewed by the clinician ordering the lab work, if applicable as evidenced by date and signature of clinician.	Member does not receive medication management from this provider. No lab work was required on member.
When a primary care physician is identified, there is evidence the prescriber attempted coordination of care within 14 calendar days after initiation of a new medication.	When a primary care physician is identified, there is evidence the prescriber attempted coordination of care within 14 calendar days after initiation of a new medication.	When a primary care physician is identified, there is no evidence the prescriber attempted coordination of care within 14 calendar days after initiation of a new medication.	Member does not receive medication management from this provider. Member has no PCP OR member refuses consent to coordinate with PCP.
There is evidence of medication monitoring in the treatment record, documenting adherence.	There is evidence of medication monitoring in the treatment record, documenting adherence.	There is no evidence of medication monitoring in the treatment record, documenting adherence.	Member does not receive medication management from this provider.
There is evidence of medication monitoring in the treatment record, documenting efficacy.	There is evidence of medication monitoring in the treatment record, documenting efficacy.	There is no evidence of medication monitoring in the treatment record, documenting efficacy.	Member does not receive medication management from this provider.
There is evidence of medication monitoring in the treatment record, documenting adverse effects.	There is evidence of medication monitoring in the treatment record, documenting adverse effects.	There is no evidence of medication monitoring in the treatment record, documenting adverse effects.	Member does not receive medication management from this provider.
RESTRAINTS AND SECLUSION			
Documentation of alternatives/other less restrictive interventions were attempted.	Documentation of alternatives/other less restrictive interventions were attempted.	No documentation of alternatives/other less restrictive interventions were attempted.	Member not placed in restraints/seclusion.
Documentation of restraint/seclusion order.	Documentation of restraint/seclusion order.	No documentation of restraint/seclusion order.	Member not placed in restraints/seclusion.
Documentation of physician notification of restraint.	Documentation of physician notification of restraint.	No documentation of physician notification of restraint.	Member not placed in restraints/seclusion.
Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application.	Documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application.	No documentation of member face to face assessment by a physician or physician extender (e.g., PA, NP, APRN) within one hour of restraint initiation/application.	Member not placed in restraints/seclusion.
Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application.	Documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application.	No documentation must show evidence of consultation with the physician or physician extender (e.g., PA, NP, APRN) within 24 hours of restraint initiation/application.	Member not placed in restraints/seclusion.
Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).	Documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).	No documentation of members' parent/guardian notification of restraint/seclusion as soon as possible of restraint occurring (children only).	Member is under the age of 18 and not placed in restraints/seclusion. Member is 18 years or older.
PATIENT SAFETY			
If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken and monitoring occurred.	If the member was placed on a special watch for harmful behavior, documentation of the appropriate precautions taken and monitoring occurred.	If the member was placed on a special watch for harmful behavior, there was no documentation of the appropriate precautions taken and monitoring occurred.	Member not placed on special watch.
If the member was placed in restraints/seclusion, documentation of required monitoring. (A patient in seclusion or restraints shall be evaluated every 15 minutes and documentation of these evaluations shall be entered into the patient's record.)	If the member was placed in restraints/seclusion, documentation of required monitoring.	If the member was placed in restraints/seclusion, documentation of required monitoring.	Member not placed in restraints/seclusion.
If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable.	If the member was a victim of abuse or neglect, documentation of report to the appropriate protective agency and Health Standards, as applicable.	If the member was a victim of abuse or neglect, there was no documentation of report to the appropriate protective agency and Health Standards, as applicable.	Member did not report being a victim of abuse or neglect.
CULTURAL COMPETENCY			
Primary language spoken by the member is documented.	Primary language spoken by the member is documented.	Primary language spoken by the member is not documented.	No N/A
Any translation needs of the member are documented, if applicable.	Any translation needs of the member are documented, if applicable.	Any translation needs of the member are not documented,when applicable.	If no translation needs were identified.
Language needs of the member were assessed (i.e. preferred method of communication), if applicable.	Language needs of the member were assessed OR documentation that member declined to identify.	Language needs of the member were not assessed (i.e. preferred method of communication), if applicable.	No N/A
Identified language needs of the member were incorporated into treatment, if applicable.	Identified language needs of the member were incorporated into treatment, if applicable.	Identified language needs of the member were not incorporated into treatment, if applicable.	if no language needs were identified.
Religious/Spiritual needs of the member were assessed.	Religious/Spiritual needs of the member were assessed OR documentation that member declined to identify.	Religious/Spiritual needs of the member were not assessed.	No N/A
Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.	Identified religious/spiritual needs of the member were incorporated into treatment, if applicable.	Identified religious/spiritual needs of the member were not incorporated into treatment, if applicable.	if no religious/spiritual needs were identified.
Racial needs of the member were assessed.(i.e. oppression, privledge, prejudice…etc.), if applicable.	Racial needs of the member were assessed OR documentation that member declined to identify. Add for reviewers additional examples: member identifies working more successfully with particular race of therapist. Cultural-racial aspects, socio-economic aspects.	Racial needs of the member were not assessed.(i.e. oppression, privledge, prejudice…etc.), if applicable.	No N/A
Identified racial needs of the member were incorporated into treatment, if applicable.	Identified racial needs of the member were incorporated into treatment OR documentation that member declined.	Identified racial needs of the member were not incorporated into treatment, if applicable.	if no racial needs were identified.
Ethnic needs of the member were assessed.	Ethnic needs of the member were assesse OR documentation that member declined to identify.	Ethnic needs of the member were not assessed.	No N/A
Identified ethnic needs of the member were incorporated into treatment, if applicable.	Identified ethnic needs of the member were incorporated into treatment OR documentation that member declined to identify.	Identified ethnic needs of the member were not incorporated into treatment, if applicable.	if no ethnic needs were identified.
Sexual health related needs were assessed.	Sexual health related needs were assesse OR documentation that member declined to identify.	Sexual health related needs were not assessed.	No N/A
Identified sexual health related needs of the member were incorporated into treatment, if applicable.	Identified sexual health related needs of the member were incorporated into treatment OR documentation that member declined to identify.	Identified sexual health related needs of the member were not incorporated into treatment, if applicable.	if no sexual health related needs were identified.
ADVERSE INCIDENTS	***Current AI reporting form includes ANEE: Abuse, Neglect, Extortion, Exploitation, and Death**		
For members 0 to 17, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.	For members 0 to 17, documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.	For members 0 to 17, no documentation that any adverse incident was reported to the guardian, if the incident did not involve the guardian, within 1 business day of discovery.	Member had no adverse incidents. Member is over the age of 18. Incident involved the guardian.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.	Documentation within the record that adverse incidents listed on the **adverse incident reporting form** were reported to the appropriate protective agency within 1 business day of discovery. (*Current AI reporting form includes ANEE: Abuse, Neglect, Extortion, Exploitation, and Death).	No documentation that adverse incidents listed on the adverse incident reporting form were reported to the appropriate protective agency within 1 business day of discovery.	Member had no adverse incidents.
Documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.	Documentation within the record that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.	No documentation that adverse incidents involving direct care staff were reported to the licensing agency, as appropriate.	Member had no adverse incidents.
Documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.	Documentation within the record that adverse incidents listed on the **adverse incident reporting form** were reported to the health plan within 1 business day of discovery. (*Current AI reporting form includes ANEE: Abuse, Neglect, Extortion, Exploitation, and Death).	No documentation that adverse incidents listed on the adverse incident reporting form were reported to the health plan within 1 business day of discovery.	Member had no adverse incidents.
DISCHARGE PLANNING			
Documentation of discussion of discharge planning/linkage to next level of care.	Documentation of discussion of discharge planning/linkage to next level of care OR documentation of member leaving AMA.	No documentation of discussion of discharge planning/linkage to next level of care.	Member has not been discharged.
Appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan. If not, barriers noted, when member is discharged or transitioned to a different level of care.	Appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan OR documentation of barriers. Ex. Member refused follow-up appointments. Follow-up Clinic does not give appointments, only walk-ins. Add: Member leaving AMA.	No appointment date and/or time period of follow up with transitioning behavioral health provider documented on the discharge plan AND NO documentation of barriers.	Member has not been discharged.
There is documentation that communication/collaboration occurred with the receiving clinician/program. If not, barriers noted, when member is discharged or transitioned to a different level of care.	There is documentation that communication/collaboration occurred with the receiving clinician/program OR documentation of barriers. Ex. Member refused follow-up. Add: Member leaving AMA.	There is no documentation that communication /collaboration occurred with the receiving clinician/program AND NO documentation of barriers.	Member has not been discharged.
PCP appointment date and/or time period of follow up documented if medical co morbidity present. If not, barriers noted, when member is discharged or transitioned to a different level of care.	PCP appointment date and/or time period of follow up documented if medical co morbidity present OR documentation of barriers. Ex. Member refused follow-up appointments. Follow-up Clinic does not give appointments, only walk-ins. Add: Member leaving AMA.	No PCP appointment date and/or time period of follow up documented if medical co morbidity present and NO documentation of barriers.	Member has not been discharged. If medical co-morbidity is not present.
Medication profile provided to outpatient provider during transition of care. If not, barriers noted, when member is discharged or transitioned to a different level of care.	Medication profile provided to outpatient provider during transition of care OR documentation of barriers. Ex. Member refused. Add: Member leaving AMA.	No Medication profile provided to outpatient provider during transition of care and NO barriers documented.	Member has not been discharged.
Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.	Medication profile reviewed with member during transition of care, when member is discharged or transitioned to a different level of care. Add: Member refuses to review or leaves AMA.	Medication profile not reviewed with member during transition of care, when member is discharged or transitioned to a different level of care.	Member has not been discharged.
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	Course of treatment reflected in the discharge summary, when member is discharged or transitioned to a different level of care. Add: Member refuses to review or leaves AMA.	Course of treatment not reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	Member has not been discharged.
Course of treatment (the reason(s) for treatment and the extent to which treatment goals were met) reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	Course of treatment reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	Course of treatment not reflected in the discharge summary, when member is discharged or transitioned to a different level of care.	Member has not been discharged.
A discharge summary details the recipient's progress prior to a transfer or closure, when member is discharged or transitioned to a different level of care.	The discharge summary details the recipient's progress prior to a transfer or closure.	There is no discharge summary that details the recipient's progress prior to a transfer or closure.	Member has not been discharged.
A discharge summary must be completed within 14 calendar days following a recipient's discharge or transition to a different level of care.	The discharge summary is completed within 14 calendar days following a recipient's discharge or transition to a different level of care.	The discharge summary was not completed within 14 calendar days following a recipient's discharge or transition to a different level of care.	Member has not been discharged.

CPST/PSR Scoring Grid			
CPST/PSR: INITIAL EVALUATION	**Met (1)**	**Not Met (0)**	**N/A**
Medical necessity is documented by a LMHP or physician, for adults, as evidenced by individuals exhibiting impaired emotional, cognitive or behavioral functioning that is the result of mental illness in order to meet the criteria for disability.	Medical necessity is documented by a LMHP or physician, for adults.	Medical necessity is NOT documented by a LMHP or physician for adults.	No N/A
Evidence the individual's impairment substantially interferes with role functioning.	The record has evidence of substantial impairment interfering with role functioning.	The record does NOT have evidence of substance impairment interfering with role	No N/A
Evidence the individual's impairment substantially interferes with occupational functioning.	The record has evidence of substantial impairment interfering with occupational functioning.	The record does NOT have evidence of substance impairment interfering with	No N/A
Evidence the individual's impairment substantially interferes with social functioning.	The record has evidence of substantial impairment interfering with social functioning.	The record does NOT have evidence of substance impairment interfering with	No N/A
Services are recommended by an LMHP or physician.	Services are recommended by an LMHP or physician.	Services are NOT recommended by an LMHP or physician.	No N/A
Assessments must be performed at least every 365 days or as needed anytime there is significant change to the member's	Evidence of assessments must be performed at least every 365 days or as needed anytime there is	No assessment was performed every 365 or when evidence of change in member	Member left prior to 365 days and no reassessment was able to be completed.
For members 6 - 17 years of age, there is evidence of the CALOCUS being utilized as part of the assessment.	Evidence of CALOCUS used for members 6-17 years of age.	NO evidence of CALOCUS used for members 6-17 years of age.	Member not 6-18 years of age.
For members 18 years of age and over, has at least a score of three on the level of care utilization system (LOCUS).	*At least score of 3 on the level of care OR composite score of 17-19 on LOCUS Or documented why NOT.	Does NOT have at least a score of 3 on LOC OR composite score of 17-19.	Member under age of 19.
For members 18 years of age and over, member must meet the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of, serious mental illness (SMI) as evidenced by a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. *Dimension 2	Evidence of meeting SAMHSA definition of SMI aeb a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. *Dimension 2	NO evidence of meeting SAMHSA definition of SMI aeb a rating of three or greater on the functional status domain on the Level of Care Utilization System (LOCUS) rating. *Dimension 2	Member under age of 19.
The assessment documents that in addition to having a diagnosable mental disorder, the condition must substantially interfere with, or limit, one or more major life activities, such as: • Basic daily living (for example, eating or dressing); • Instrumental living (for example, taking prescribed medications or getting around the community); and • Participating in a family, school, or workplace.	The assessment documents a diagnosable mental disorder and that the condition substantially interferes with, or limits, individual in one or more major life activities (see item for examples).	The assessment does NOT document a diagnosable mental disorder and that the condition substantially interferes with, or limits, individual in one or more major life activities (see item for examples).	No N/A
There is evidence of medical necessity, If applicable, for members 18 years of age and over, with longstanding deficits who do not experience any acute changes in their status and has previously met the criteria stated above regarding LOCUS scores, but who now meets a level of care of two or lower on the LOCUS, and needs subsequent medically necessary services for stabilization and maintenance at a lower intensity, may continue to receive CPST services and/or PSR.	Medically necessary reason for continued admission at this level of care is documented for members 19 years of age and over.	NO medically necessary reason documented for continued admission at this level of care for members 19 years of age and over.	Member under age of 19.

CPST/PSR: TREATMENT PLAN			
Treatment plan has recovery focused goals targeting areas of risk identified in the assessment.	Treatment plan has recovery focused goals targeting areas of risk identified in the assessment.	Treatment plan does NOT have recovery focused goals targeting areas of risk identified in the	No N/A
Treatment plan has recovery focused objectives/interventions targeting areas of risk identified in the assessment.	Treatment plan has recovery focused objectives/interventions targeting areas of risk identified in	Treatment plan does NOT have recovery focused objectives/interventions	No N/A
Treatment plan has recovery focused goals targeting areas of need identified in the assessment.	Treatment plan has recovery focused goals targeting areas of need identified in the assessment.	Treatment plan does NOT have recovery focused goals targeting areas of need identified in the	No N/A
Treatment plan has recovery focused objectives/interventions targeting areas of need identified in the assessment.	Treatment plan has recovery focused objectives/interventions targeting areas of need identified in	Treatment plan does NOT have recovery focused objectives/interventions	No N/A
Treatment plan clearly identifies actions to be taken by provider.	Treatment plan clearly identifies actions to be taken by provider.	Treatment plan does NOT clearly identify actions to be taken by provider.	No N/A
Treatment plan clearly identifies actions to be taken by member/guardians.	Treatment plan clearly identifies actions to be taken by member/guardians.	Treatment plan does NOT clearly identify actions to be taken by member/guardians.	No N/A
Treatment plan clearly identifies specific interventions that will address specific problems/needs identified in the assessment.	Treatment plan clearly identifies specific interventions that will address specific problems/needs	Treatment plan does NOT clearly identify specific interventions that will address	No N/A
Transition plan describes how member will transition from adolescence to adulthood in the record for members ages 15 to 21.	Transition plan describes how member will transition from adolescence to adulthood in the	Transition plan does NOT describe how member will transition from adolescence to	Member is not between the ages of 15 and 21.
The treatment plan review is conducted at least once every 180 days or more often as indicated.	The treatment plan review is conducted at least once every 180 days or more often if indicated.	The treatment plan review is NOT conducted at least once every 180 days or more often if indicated.	No N/A
The treatment plan review is in consultation with provider staff.	The treatment plan review is in consultation with provider staff.	The treatment plan review is NOT in consultation with provider staff.	No N/A
The treatment plan review is in consultation with the member/caregiver.	The treatment plan review is in consultation with the member/caregiver.	The treatment plan review is NOT in consultation with the member/caregiver.	No N/A
The treatment plan review is in consultation with other stakeholders.	The treatment plan review is in consultation with other stakeholders.	The treatment plan review is NOT in consultation with other stakeholders.	No N/A
Documentation of the treatment plan review.	Documentation of the treatment plan review.	NO documentation of the treatment plan review.	No N/A
Evidence the member received a copy of the plan upon completion.	Evidence the member received a copy of the plan upon completion.	NO evidence the member received a copy of the plan upon completion.	No N/A
CPST/PSR: PROGRESS NOTES			
Services are provided at the provider agency, in the community, in the member's place of residence, and/or via telehealth/telemedicine	Services are provided at the provider agency, in the community, in the member's place of residence,	Services are NOT provided at the provider agency, in the community, in the member's	No N/A
Services may be furnished in a nursing facility only in accordance with policies and procedures issued by the Department.	Services furnished in a nursing facility are in accordance with policies and procedures issued by	Services furnished in a nursing facility are NOT in accordance with policies and procedures	Services not furnished in a nursing facility.
Services are documented as being provided individually or in a group setting.	Services are documented as being provided individually or in a group setting.	Services are NOT documented as being provided individually or in a group setting.	No N/A

Services are documented as being provided face-to-face and/or via telehealth as per LDH guidelines.	Services are documented as being provided face-to-face and/or via telehealth as per LDH guidelines.	Services are NOT documented as being provided face-to-face and/or via telehealth as per LDH guidelines.	No N/A
Services are appropriate for age.	Services are appropriate for age.	Services are NOT appropriate for age.	No N/A
Services are appropriate for development level.	Services are appropriate for development level.	Services are NOT appropriate for development level.	No N/A
Services are appropriate for education level.	Services are appropriate for education level.	Services are NOT appropriate for education level.	No N/A
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and not be provided at a work site which is job tasks-oriented and not directly related to the treatment of the member's needs.	Services are directed exclusively toward the treatment of the Medicaid-eligible individual and not be provided at a work site which is job tasks-oriented and not directly related to the treatment of the	Services are NOT directed exclusively toward the treatment of the Medicaid-eligible individual and not be provided at a work site which is job tasks-oriented and not	No N/A
Services must be directed exclusively toward the treatment of the Medicaid-eligible individual and must not contain Service or service components in which the basic nature is to supplant housekeeping, homemaking or other basic services for the convenience of the individual receiving services.	Services are directed exclusively toward the treatment of the Medicaid-eligible individual and must not contain Service or service components in which the basic nature is to supplant housekeeping, homemaking or other basic services for the convenience of the individual	Services are NOT directed exclusively toward the treatment of the Medicaid-eligible individual and must not contain Service or service components in which the basic nature is to supplant housekeeping, homemaking or	No N/A
Progress notes for PSR services document restoration, rehabilitation and/or support to develop social and interpersonal skills to increase community tenure in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to develop social and interpersonal skills to increase community tenure in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to develop social and interpersonal skills to increase community tenure in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	No N/A

Progress notes for PSR services document restoration, rehabilitation and/or support to enhance personal relationships in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to enhance personal relationships in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to enhance personal relationships in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	No N/A
Progress notes for PSR services document restoration, rehabilitation and/or support to establish support networks in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to establish support networks in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to establish support networks in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	No N/A
Progress notes for PSR services document restoration, rehabilitation and/or support to increase community awareness in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to increase community awareness in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to increase community awareness in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	No N/A
Progress notes for PSR services document restoration, rehabilitation and/or support to develop coping strategies and/or effective functioning in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to develop coping strategies and/or effective functioning in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to develop coping strategies and/or effective functioning in the individual's social environment, including home, work and/or school in accordance with the treatment plan.	No N/A
Progress notes for PSR services document restoration, rehabilitation and/or support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living in accordance with the treatment plan.	Progress notes for PSR services document restoration, rehabilitation and/or support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living in accordance with the treatment plan.	Progress notes for PSR services do NOT document restoration, rehabilitation and/or support to develop daily living skills to improve self-management of the negative effects of psychiatric or emotional symptoms that interfere with a person's daily living in accordance with the treatment plan.	No N/A
Progress notes for PSR services document implementing learned skills to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment in accordance with the treatment plan.	PSR progress notes for PSR services document implementing learned skills to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment in accordance with the treatment plan.	PSR progress notes for PSR services do NOT document implementing learned skills to assist the individual with effectively responding to or avoiding identified precursors or triggers that result in functional impairment in accordance with the treatment plan.	No N/A

Progress notes for CPST services document problem behavior analysis in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document problem behavior analysis in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document problem behavior analysis in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document emotional and behavioral management in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document emotional and behavioral management in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document emotional and behavioral management in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document developing and improving daily functional living skills in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document developing and improving daily functional living skills in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document developing and improving daily functional living skills in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document implementing social, interpersonal, self-care, and independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document implementing interpersonal goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document implementing interpersonal goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document implementing interpersonal goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document implementing self-care goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document implementing self-care goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOTdocument implementing self-care goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A
Progress notes for CPST services document implementing independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services document implementing independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	Progress notes for CPST services do NOT document implementing independent living skill goals in order to restore stability, support functional gains, and adapt to community living in accordance with the treatment plan.	No N/A

TGH Scoring Grid **If SUD, complete additional items on 3.2-WM			
TGH: INITIAL EVALUATION	**Met (1)**	**Not Met (0)**	**N/A**
The assessment protocol must differentiate across life domains.	The assessment protocol differentiates across life domains.	The assessment protocol does NOT differentiate across life domains.	No N/A
The assessment protocol must differentiate between risk factors.	The assessment protocol differentiates between risk factors.	The assessment protocol does NOT differentiate between risk factors.	No N/A
The assessment protocol must differentiate between protective factors.	The assessment protocol differentiates between protective factors.	The assessment protocol does NOT differentiate between protective factors.	No N/A
The assessment protocol must track progress over time.	The assessment protocol tracks progress over time.	The assessment protocol does NOT track progress over time.	No N/A
Requirements for pretreatment assessment are met prior to treatment commencing.	Requirements for pretreatment assessment are met prior to treatment commencing.	Requirements for pretreatment assessment are NOT met prior to treatment commencing.	No N/A
Screening is required upon admission.	Screening is completed upon admission.	Screening is NOT completed upon admission.	No N/A
Assessment is required upon admission.	Assessment is completed upon admission.	Assessment is NOT completed upon admission.	No N/A
The assessment protocol documents less intensive levels of treatment have been determined to be unsafe, unsuccessful or unavailable.	Evidence of documetnation that less intensive levels of tx have been determined to be unsafe, unsuccessful, or unavailable	NO evidence of documentation that less intensive levels of tx have been determined to be unsafe, unsuccessful, or unavailable within	No N/A
TGH: TREATMENT PLAN			
There is evidence of a standardized assessment and treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.	There is evidence of a standardized assessment and treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.	There is NO evidence of a standardized assessment and treatment planning tool such as the CALOCUS/CANS being utilized for treatment planning.	No N/A
Member’s plan of care was developed no later than 72 hours after admission unless clinical documentation notes member's refusal or unavailability.	Member’s plan of care was developed no later than 72 hours after admission unless clinical documentation notes member's	Member’s plan of care was developed MORE than 72 hours after admission unless clinical documentation notes member's refusal or unavailability.	Member discharged 71 hours or less after admission such as
The treatment plan must include behaviorally measurable discharge goals.	The treatment plan includes behaviorally measurable discharge goals.	The treatment plan does NOT include behaviorally measurable discharge goals.	No N/A
TGH: MEDICATION MANAGEMENT			

Psychotropic medications should be used with specific target symptoms identification.	Psychotropic medications are used with specific target symptoms identification.	Psychotropic medications are NOT used with specific target symptoms identification.	No N/A
Psychotropic medications should be used with medical monitoring.	Psychotropic medications are used with medical monitoring.	Psychotropic medications are NOT be used with medical monitoring.	No N/A
Psychotropic medications should be used with 24-hour medical availability when appropriate and relevant.	Psychotropic medications are used with 24-hour medical availability when appropriate and relevant.	Psychotropic medications are NOT be used with 24-hour medical availability when appropriate and relevant.	No N/A
TGH: DISCHARGE PLANNING			
Discharge planning within the first week of admission with clear action steps.	Discharge planning completed within the first week of admission with clear action steps.	Discharge planning is NOT completed the first week of admission with clear action steps.	Member discharged AMA within the first week of admission.
Discharge planning with target dates outlined in the treatment plan.	Discharge planning has target dates outlined in the treatment plan.	Discharge planning does NOT have target dates outlined in the treatment plan.	Member discharged AMA within the first week of admission.
ADDITIONAL TGH			
Recreational activities are provided for all enrolled members.	Recreational activities are provided for all enrolled members.	Recreational activities are NOT provided for all enrolled members.	No N/A
Members attend school, work and/or training.	Members attend school, work and/or training.	Members do NOT attend school, work and/or training.	No N/A
To enhance community integration, resident youth must attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution).	To enhance community integration, resident youth attends community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution).	To enhance community integration, resident youth does NOT attend community schools integrated in the community (as opposed to being educated at a school located on the campus of an institution).	No N/A
The psychologist or psychiatrist must see the member at least once.	The psychologist or psychiatrist sees the member at least once.	The psychologist or psychiatrist does NOT see the member at least once.	No N/A
The psychologist or psychiatrist must prescribe the type of care provided.	The psychologist or psychiatrist did prescribe the type of care provided.	The psychologist or psychiatrist did NOT prescribe the type of care provided.	No N/A
If the services are not time-limited by the prescription, review the need for continued care every 28 days.	If the services are not time-limited by the prescription, evidence of review of the need for continued care every 28 days.	If the services are not time-limited by the prescription, NO evidence of review of the need for continued care every 28 days.	Services are time limited by the prescription.
The individualized, strengths-based services and supports are identified in partnership with the child or adolescent and/or the family and support system, to the extent possible, and if developmentally appropriate.	The individualized, strengths-based services and supports are identified in partnership with the child or adolescent and/or the family and support system, to the extent possible, and if developmentally appropriate.	The individualized, strengths-based services and supports are NOT identified in partnership with the child or adolescent and/or the family and support system, to the extent possible, and if developmentally appropriate.	No N/A

The individualized, strengths-based services and supports are based on clinical assessments.	The individualized, strengths-based services and supports are based on clinical assessments.	The individualized, strengths-based services and supports are NOT based on clinical assessments.	No N/A
The individualized, strengths-based services and supports are based on functional assessments.	The individualized, strengths-based services and supports are based on functional assessments.	The individualized, strengths-based services and supports are NOT based on functional assessments.	No N/A
The individualized, strengths-based services and supports support success in community settings, including home and school.	The individualized, strengths-based services and supports support success in community settings, including home and school.	The individualized, strengths-based services and supports do NOT support success in community settings, including home and school.	No N/A
The TGH is required to coordinate with the child's or adolescent's community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.	The TGH coordinates with the child's or adolescent's community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.	The TGH does NOT coordinate with the child's or adolescent's community resources, including schools with the goal of transitioning the youth out of the program to a less restrictive care setting for continued, sometimes intensive, services as soon as possible and appropriate.	No N/A

PRTF Scoring Grid (*if mbr with co-occurring disorders refer to Level 3.7 Adolescent tab for scoring)

PRTF: INITIAL EVALUATION	Met (1)	Not Met (0)	N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the youth.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission in consultation with the youth OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission in consultation with the youth OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission in consultation with the parents/legal guardian.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission in consultation with the parents/legal guardian OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission in consultation with the youth OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the medical aspects of the recipient's situation.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of medical aspects of member's situation OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of medical aspects of member's situation OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the psychological aspects of the recipient's situation.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the psychological aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the psychological aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the social aspects of the recipient's situation.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the social aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the social aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the behavioral aspects of the recipient's situation.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the behavioral aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the behavioral aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that includes examination of the developmental aspects of the recipient's situation.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the developmental aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care. (*more towards IQ, age-appropriate development for tx.)	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission includes examination of the developmental aspects of the recipient's situation OR documentation why not OR evaluation for higher level of care.	No N/A
A diagnostic evaluation must be conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care.	Evidence of diagnostic evaluation being conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care OR documentation why not OR evaluation for higher level of care.	NO evidence of diagnostic evaluation being conducted within the first 24 hours of admission that reflects the need for inpatient psychiatric care OR documentation why not OR evaluation for higher level of care.	No N/A
PRTF: TREATMENT PLAN			

The plan must be developed no later than 72 hours after admission	Evidence that plan was developed no later than 72 hours after admission OR documentation why not.	NO evidence that plan was developed no later than 72 hours after admission OR documentation why not.	DC'd prior to 72 hours after admission.
The plan must be implemented no later than 72 hours after admission	Evidence that plan was implemented no later than 72 hours after admission OR documentation why not.	NO evidence that plan was implemented no later than 72 hours after admission OR documentation why not.	DC'd prior to 72 hours after admission.
The plan must be designed to achieve the recipient's discharge from inpatient status at the earliest possible time.	Evidence that plan was designed to achieve the recipient's discharge from inpatient status at the earliest possible time OR documentation why not. (*not uncommon to see up to 2 to 3 months in goals time range; expectation is acute, short stays.)	NO evidence that plan was designed to achieve the recipient's discharge from inpatient status at the earliest possible time OR documentation why not.	No N/A
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis	Evidence the plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis.	NO evidence the plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to determine that services being provided are or were required on an inpatient basis.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.	Evidence that plan is reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to recommend changes in the plan, as indicated by the member's overall adjustment as an inpatient.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of therapies designed to meet the objectives.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of activities designed to meet the objectives.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives. (ex. horse-back riding, fishing, off-site activities for "experiences" and field trip into communities)	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to prescribe an integrated program of experiences designed to meet the objectives.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, post-discharge plans.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans. (ex. re-integration with family for instance, x number of days to go home trial run).	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, coordination of inpatient services, with partial discharge plans.	DC'd prior to 30 days.

The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's family upon discharge.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's school upon discharge.	DC'd prior to 30 days.
The plan must be reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.	Evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.	NO evidence that plan was reviewed as needed or at a minimum of every 30 days by the facility treatment team to Include, at an appropriate time, related community services to ensure continuity of care with the member's community upon discharge.	DC'd prior to 30 days.
ADDITIONAL PRTF			
Members have access to education services.	Members have access to education services.	Members have NO access to education services.	No N/A
Member’s health is maintained (e.g. dental hygiene for a child expected to reside in the facility for 12 months).	Member’s health is maintained (e.g. dental hygiene for a child expected to reside in the facility for 12 months).	Member’s health is NOT maintained (e.g. dental hygiene for a child expected to reside in the facility for 12 months).	No N/A