|  |
| --- |
| Provider Contact (name & title):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tx Modality: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tx Level: \_\_\_\_\_\_\_\_\_ |
| Open File: □ Closed File: □Client ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Review Date: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Primary Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reviewed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SIGNATURE TIME LINES1. Admission Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Discharge Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_or N/A: \_\_\_2. Date Medical Necessity Established \_\_\_\_\_\_\_\_\_\_\_. The Physician shall review & sign each beneficiary’s chart within 30 days of admission to tx & establish med nec..3. Date of Initial tx plan: \_\_\_\_\_\_\_\_\_\_\_\_ within 30 calendar days of admission the beneficiary & counselor shall sign, indicating their participation, their plan.4. Date of MD signature on tx plan: \_\_\_\_\_\_\_\_\_ within 15 calendar days of counselor signature the MD shall sign the clt plan.5. Dates of updated Clt Plans: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_. Every 90 days from date of initial clt plan and 90 days thereafter or when a change in problem identification or focus of tx occurs the clt plan shall be updated and signed by the counselor & clt. If clt is not available to sign the plan, the note must reflect efforts to meet with clt to review plan and sign. 6. MD Signature/Review Updated Clt Plan: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ within 15 calendar days of counselor signature the MD shall sign the clt updated plan indicating medical necessity for continued treatment.7. Date of MD & Counselor Signature indicate Justification for Continuing Tx Services: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. No sooner than 5 months and no later than 6 months after the clt’s admission to tx date or date of most recent Justification for Cont Tx Services the Counselor & MD shall indicated medical necessity for continuing tx services. Additional Dates: \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_  | PHYSICIAN: REVIEW &/or SIGNATURE |
|  | Yes | No | N/A |
| 1. Med Nec-SUD Admit Justif
 |  |  |  |
| 1. DSM Code Diagnosis
 |  |  |  |
| 1. Initial Treatment Plan
 |  |  |  |
| 1. Physical Examination
 |  |  |  |
| 1. Updated Treatment Plan
 |  |  |  |
| 1. DOB or Term of Pregnancy
 |  |  |  |
| 1. Justification for Cont. Tx
 |  |  |  |
| 1. Medication Management
 |  |  |  |
|  |  |  |  |
| ADMISSIONS, NOTIFICATION & AGREEMENTS |
| 1. Consent for Treatment (current)
 |  |  |  |
| 1. Signed Admission Agreement
 |  |  |  |
| 1. Client Rights-signed w/ clt copy
 |  |  |  |
| 1. Statement of Non-Discrimin
 |  |  |  |
| 1. Grievance/Fair Hearing Info
 |  |  |  |
| 1. Program Rules
 |  |  |  |
| 1. Clt fees and Pymnt Agrmnt
 |  |  |  |
| 1. Access to treatment files
 |  |  |  |
| 1. Privacy & Confidentiality
 |  |  |  |
| 1. 42 CFR
 |  |  |  |
| 1. Release of Information
 |  |  |  |
| 1. Discharge Appeal Process
 |  |  |  |
| 1. Date of Admission
 |  |  |  |
| 1. Type of Admission
 |  |  |  |
| 1. Referrals Provided
 |  |  |  |
| 1. Health Questionnaire completed
 |  |  |  |
| 1. Race/Ethnic Background
 |  |  |  |
| 1. Address/Tele #
 |  |  |  |
| 1. DOB/Gender/Client ID
 |  |  |  |
| 1. Emergency Contact
 |  |  |  |
| 1. Schedule and Attendance
 |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Comments:  |
| ASSESSMENT | GROUP SESSIONS  |
|  | Yes | No | N/A |  | Yes | No | N/A |
| 1. Comprehensive SUD Assmnt
 |  |  |  | 1. Session Date & Time Note
 |  |  |  |
| 1. Housing/Ed & Emplymnt/Family
 |  |  |  | 1. Client’s Printed Name & Sig
 |  |  |  |
| 1. Previous Treatment History
 |  |  |  | 1. Start and End Time
 |  |  |  |
| 1. Special Issues e.g. CJ, Custdy, MH
 |  |  |  | 1. Group Topic
 |  |  |  |
| 1. ASAM placement
 |  |  |  | 1. Topic Relates to Clt Tx Plan
 |  |  |  |
| 1. Oriented within 72 hrs. of admit
 |  |  |  | 6. |  |  |  |
| 1. Counselor Signature(s) and Date
 |  |  |  | 7. |  |  |  |
| 1. Diagnosis
 |  |  |  | DISCHARGE PLANNING |
| 1. Risk assmnt e.g. suicide, homicide
 |  |  |  | 1. Plan links back to tx plan goals
 |  |  |  |
| 1. Strengths/Risks/Goals/Objectives
 |  |  |  | 1. Plan Identifies Achievements
 |  |  |  |
|  |  |  |  | 1. Plan Identifies Relapse Triggers
 |
|  |  |  |  | 1. Plan Describes Suport Network
 |  |  |  |
| CLIENT TREATMENT RECOVERY PLAN | 1. Plan States Length of Tx
 |  |  |  |
| 1. |  |  |  | 1. Plan Provides Referrals
 |  |  |  |
| 1. Plan is individualized
 |  |  |  | 1. Plan States Prognosis
 |  |  |  |
| 1. Plan states Clients Goal(s)
 |  |  |  | 1. Prep w/i 30 Days Prior Dischge
 |  |  |  |
| 1. Plan states Client Strengths
 |  |  |  |  |  |  |  |
| 1. Plan states Objectives and Goals
 |  |  |  |  |  |  |  |
| 1. Plan states Barriers to goals
 |  |  |  | PROGRESS NOTES |
| 1. Plan Identifies Resources
 |  |  |  | 1. Notes Reflect Relevant Care
 |  |  |  |
| 1. Target Dates are Stated
 |  |  |  | 1. Notes Reflect Tx Plan Goals
 |  |  |  |
| 1. Descrip & Freq of Counseling
 |  |  |  | 1. Notes written w/i 7 Days of Ser
 |  |  |  |
| 1. Primary Counselor Identified
 |  |  |  | 1. B.I.R.P. or Other Note Format
 |  |  |  |
| 1. Client Participation Noted
 |  |  |  | 1. Referrals Reflect Clt Tx Needs
 |  |  |  |
| 1. Signatures and Dates as Required
 |  |  |  | 6. |  |  |  |
| 1. Plan Updated When Appropriate
 |  |  |  | MEDICATION ASSISTED TREATMENT |
| 1. Clt Sig or Effort to Obtain Clt Sig
 |  |  |  | 1. Physician Notes
 |  |  |  |
| 1. Stage of Change
 |  |  |  | 1. Clt Med Management
 |  |  |  |
| 1. Total # of tx plans w/clt signature
 |  |  |  | 1. Medical Release(s)
 |  |  |  |
| 1. Total # of tx plans
 |  |  |  | 1. Clt Med History
 |  |  |  |
| OTHER TREATMENT DOCUMENTS | 5. |  |  |  |
| 1. Drug Screen/UA Results
 |  |  |  | Comments: |
| 1. Coordination of Care Indicated
 |  |  |  |
| 1. Attendance &Type of Serv Noted
 |  |  |  |
| 1. Exceptions to Tx Freq Noted
 |  |  |  |
| 1. Progress Report(s)
 |  |  |  |
| 1. Counselor legibly Print/Sign/Date
 |  |  |  |
| 1. Other Services e.g. tranport
 |  |  |  |
| 1. Child Care Provided
 |  |  |  |
| 1. Indiv sched in chart & appt book
 |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| PERINATAL TREATMENT  |  |
|  | Yes | No | N/A | Comments: |
| 1. Case Management Notes-Wkly
 |  |  |  |
| 1. Physician Appt Regular √ Up(s)
 |  |  |  |
| 1. Previous Treatment History
 |  |  |  |
| 1. Special Issues Case Managed
 |  |  |  |
| 1. Weekly Tx Schedule Provided
 |  |  |  |
| 1. Admission Priority Noted
 |  |  |  |
| 1. Admit Within 14 Days of Request
 |  |  |  |
| 1. Interim Services Provided
 |  |  |  |
| 1. Gender Specific Environment
 |  |  |  |
| 1. 10.Child Custody Involvement
 |  |  |  |
| 1. Wkly Prog Reflects Tx Plan Goals
 |  |  |  |
|  |  |  |  |
| TREATMENT AND EDUCATION |
| 1. HIV/AIDS/Hep C/ TB
 |  |  |  |
| 1. Effects of ETOH & Drugs on Fetus
 |  |  |  |
| 1. Referrals for Prenatal Care
 |  |  |  |
| 1. Referrals for Mental Health Service
 |  |  |  |
| 1. Intimate Partner Violence
 |  |  |  |
| 1. Safe Housing
 |  |  |  |
| 1. Child Care
 |  |  |  |
| 1. Employment Support
 |  |  |  |
| 1. Vocational Training
 |  |  |  |
| 1. Education ( GED, Other)
 |  |  |  |
| 1. Financial Services
 |  |  |  |
| 1. Health and Wellness
 |  |  |  |
| 1. Parenting Skills
 |  |  |  |
| 1. Trauma Informed Treatment
 |  |  |  |
| 1. Reproductive Health
 |  |  |  |
|  |  |  |  |
|  |  |  |  |
| OTHER PERINATALTREATMENT SERVICES |
| 1. Transportation Assistance
 |  |  |  |
| 1. Primary Pediatric Care Appts
 |  |  |  |
| 1. Primary Care Appts
 |  |  |  |
| 1. Health and Safety Info
 |  |  |  |
| 1. Child Development
 |  |  |  |
| 1. Life Skills
 |  |  |  |
| 1. Effects of Breast Feeding & SUD
 |  |  |  |
| 1. Family Services & Interventions
 |  |  |  |
| 1. Dental Care Appts
 |  |  |  |
|  |  |  |  |
|  |  |  |  |