|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 LINES  1. 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 |  |  |  |
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| 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 |  |  |  |
|  |  |  |  |
|  |  |  |  |