Provider Name :		**Site ID:**	
Visit Type:		**Facility Address:**	
Visit Date:		**Last Visit Date:**	
Score:	#DIV/0!	**How Conducted:**	
Follow-Up Needed:		**Visit Conducted by:**	
Claims Recoupment:		**Exit Interview With:**	

Subtotals	Totals Score	Possible
Releases	0	0
Treatment & CM	0	0
Overall Scores:	0%	0%

Comments:

Fill out below for file review.

FILE REVIEW		CLT 1	CLT 2	CLT 3	CLT 4	CLT 5	Score	Possible
1	**DHW General Release of Information form** filled out completely. [Scoring: 1 pt if filled out completely and 0 if missing or incomplete.]						0	
2	**All necessary ROIs** in place, completed with appropriate 42 CFR Part 2 and HIPAA language. [Scoring: 1 pt if all filled out correctly and 0 if any are incorrect]						0	
3	**TX Encounter Notes.** Notes for each treatment session charting the client's progress must include personalized description of the session. Group notes must reference EBP. If an ISAS or trainee, note must be co-signed by QP. [Scoring: 1 pt per note if all of above elements are included, if missing any of the elements 0 pt for that note]						0	
4	**Case Management Encounter Notes**. Notes for each Case Management session charting the client's progress must include personalized description of the session. If an ISAS or trainee, note must be co-signed by QP. [Scoring: 1 pt per note if all of above elements are included, 0 pt if NA or missing any of the elements for that note]						0	
5	**Treatment Plan** is developed within thirty (30) days of start of treatment in outpatient setting. [Scoring: yes=1, no or NA=0]						0	

6	**CM Plan** is completed within 30 days of first CM appointment and includes linkages to community resources as needed [Scoring: yes = 1, no or NA=0]						0	
7	**Plan Updates:** as required, at least every ninety (90) days in an outpatient setting. [Scoring: 1 pt for every treatment and case management plan update completed in timeframe]						0	
8	**Client Involved** in Tx and Case Management Plans. Was the development of plans (treatment and discharge criteria) a collaborative process involving the client? [Scoring: 1 pt per plan and plan update that is signed by client. If plan done in WITS will accept if client involvement box is checked]						0	
9	**Tx Plan Addresses Needs:** Does the plan address, refer, or defer all of the needs identified on SUD assessment (e.g. co-occurring disorders, safety, linguistic, trauma, cultural, etc.) [Scoring: yes =1, no or NA=0] 42 USC 300x-66.						0	
10	**CM Plan Addresses Needs**: Does the plan address, refer, or defer all of the needs identified on case management assessment (e.g. homeless, unemployed, medical, etc.) [Scoring: yes =1, no or NA=0]						0	
11	**Treatment Goals and Objectives:** Are the goals and objectives written in simple, measurable, attainable, realistic terms, with expected target dates (S.M.A.R.T.)? [Scoring: yes if all=1 pt, no or NA=0]						0	
12	**Treatment Interventions:** Are the interventions related to the goals, S.M.A.R.T., and do they include identified EBPs and frequency of services/interventions? [Scoring: yes if all=1 pt, no or NA=0]						0	
13	**Case Management Interventions:** Are the interventions S.M.A.R.T., and do they include linkages to needed services, frequency of services/interventions, and care coordination? [Scoring: Look at CM plan and evidence of care coordination (i.e. ROIs, encounter notes). No partial credit will be given if care coordination is only documented for some of the appropriate service providers. [yes= 1 pt if all elements documentedt, no or NA = 0 pts if NA or missing some elements]. SAPTBG -42 USC 300x-1(b)(1) (A)(iii) and 42 USC 300x-28(c) and §96.132(c)						0	

14	**Discharge Summary.** A completed discharge summary must be entered in the client record within fifteen (15) days following formal discharge or 30 days of inactivity. Summary must include status at intake and discharge including progress and/or lack of progress made in treatment and recommendations of referrals or services to be provided after discharge. [Scoring: yes =1, no or NA=0]						0	