Provider:	Client #:	Admission Date:	

Payor: ☐ Medicaid ☐ HMP ☐ Block/PA-2 **Discharge:** ☐ Completion ☐ ASA ☐ Admin. ☐ Other

	Standards	S	Comments
	Admission		
1	Appointment offered within the required time frames.		
2	Appointment Intake Form completed in full including date/time of contact, appt. offered and appt. taken		
3	Admitted within Federal Priority guidelines as applicable.		
4	Interim services provided, if required. (i.e. pregnant and/or IDU clients)		
5	FOCUS Admission Screen is completed correctly based on information in the record with verification of residency.		
6	FOCUS Demographic, Appt., Payors, Financial, Authorization and Level of Care Change Screens completed correctly and timely.		
7	Medicaid Help When You Need It, Privacy Notice, and Advanced Directives are provided to Medicaid & HMP consumers at admission.		
8	Recipient Rights/42 CFR/45 CFR statements provided.		
9	Initial Fee Agreement Form is completed in-full.		
10	Fee Agreement Form is reviewed every 90-days, or as needed.		
11	Verification of Income is documented in the chart.		
12	Dear Consumer Letter is completed in full and a copy is provided to the client. (Medicaid & HMP)		
13	Dear Consumer Letter is completed in full and a copy is provided to the client for all reauthorization of services, if indicated.		
14	Release(s) of Information are complete and valid.		
	Assessment		
15	Assessment & Re-assessments are completed within the appropriate time frames.		
16	Assessment addresses the ASAM placement dimensions, Stages of Change, and the DSM diagnostic impression, and medical necessity.		
17	Interpretive summary is clinically focused rather than a historical repetition of the biopsychosocial.		
	Health		
18	Primary Care Physician (or lack of one) is identified in the chart.		
19	Documentation is evident in the chart to verify Care Coordination efforts. (i.e. physical exams, lab results, TB tests, psych. eval., etc..)		
20	Evidence of the MAPS is in each chart for all Methadone funded clients.		

#	Standards	S	Comments
		Total	
Health - Cont.			
21	Evidence of a medication review is conducted every sixty (60) days for all Methadone funded clients.		
22	Prescribed medications are documented and updated, as necessary.		
23	Communicable Disease Risk Screen is completed in full.		
24	Communicable Disease Risk Screen indicates referrals & follow-up documentation for high-risk behaviors.		
Treatment Plan			
25	Treatment plan is timely and provides evidence of client participation.		
26	Treatment plan is individualized, identifies goals with specific objectives, services, activities, and timeframes for completion.		
27	If client has goal of abstinence or is in the action stage of change, the treatment plan contains objectives for measuring abstinence (drug screen, PBT, etc.)		
28	Treatment Plan for significant other includes objectives related to the impact of substance disorder.		
29	Treatment Plan review is conducted every ninety (90) days.		
30	Continued stay requests are submitted timely with a rationale based on the treatment plan goals, ASAM Dimensions and medical necessity.		
Service Delivery			
31	Progress and group notes contain the file number, date, time of session, and clinician's signature. Progress notes provide documentation of progress towards treatment plan goals and objectives.		
32	Aftercare plans are completed based on QA Guidelines with specific referrals and ancillary services, as needed.		
Additional Documentation			
33	FOCUS Discharge Screen is correct, based on the information in the record.		
34	Case is closed in FOCUS in a timely manner.		
	Total	0	
	Satisfactory = 1 Unsatisfactory = 0 N/A = Blank — **Total Compliance Points**		
	Compliance Percentage	####	

Consultation Comments: