

Class Member Treatment Planning Review

Review Date: _____ **Region:** 1 2 3 **CSN:** 1 2 3 4 5
 6 7

Time Spent: _____

Reviewer: Last Name: _____ First Name: _____

Client: Last Name: _____ First Name: _____ MI: _____

DOB: _____ **SS#** _____ **AMHI Class?** Yes ___ No ___

Case Manager: Last Name: _____ First Name: _____

Agency: _____ **Site:** _____

Program Type: CI ICM ICI ACT

Date(s) of Treatment Planning Review: From _____ To _____

I. Releases:

- a. Does the record document that the agency has planned with and educated the consumer regarding releases of information at Intake/Initial treatment planning process?
Yes No Evidence Found N/A, intake/initial treatment plan more than 1 year old

EVIDENCE: _____

Notes: _____

- b. Does the record document that the agency has planned with and educated the consumer regarding releases of information during each Treatment Plan review?
Yes No Evidence Found Initial Plan/90 day review not yet due

EVIDENCE: _____

Notes: _____

- c. Does the record document that the consumer has a Primary Care Physician (PCP)?
Yes No Evidence Found

EVIDENCE _____

Notes: _____

d. If **'c' is Yes**, has there been an attempt to obtain a release signed by the consumer for the sharing of information with the PCP?

Yes

No Evidence Found

N/A ('c' is no)

EVIDENCE: _____

Other (specify) _____

Notes: _____

II. Treatment Plan:

a. Does the record document that the domains of housing, financial, social, recreational, transportation, vocational, educational, general health, dental, emotional/psychological and psychiatric were assessed with the consumer in treatment planning?

Yes

No Evidence Found

Note: If 'no evidence found', plan of correction is required - complete Section VI a.1.

EVIDENCE: _____

Notes: _____

b. Does the record document that the treatment plan goals reflect the strengths of the consumer receiving services?

Yes

No Evidence Found

EVIDENCE: _____

Notes: _____

c. Does the record document that the treatment plan goals reflect the barriers of the consumer receiving services?

Yes

No Evidence Found

EVIDENCE: _____

Notes: _____

d. Does the record document that the individual's potential need for crisis intervention and resolution services was considered with the consumer during treatment planning?

Yes

No Evidence Found

EVIDENCE: _____

Notes: _____

e. Does the record document that the consumer has a crisis plan?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

f. If **'e' is No**, is the reason why documented?

Yes No Evidence Found N/A ('e' is yes)

EVIDENCE: _____

Other (specify) _____

Notes: _____

g. If **'e' is Yes**, has the crisis plan been reviewed as required every 3 months?

Yes No Evidence Found Initial Plan/90 day review not yet due N/A ('e' is no)

EVIDENCE: _____

Notes: _____

h. If **'e' is Yes**, has the crisis plan been reviewed as required subsequent to a psychiatric crisis?

Yes No Evidence Found No psychiatric crisis during review period N/A ('e' is no)

EVIDENCE: _____

Notes: _____

i. Does the record document that the consumer has a mental health Advance Directive?

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

j. If **'i' is Yes**, has the advance directive been reviewed at least annually by the CSW and consumer?

Yes No Evidence Found A year has not passed since initiation N/A ('i' is no)

EVIDENCE: _____

Other specify) _____

Notes: _____

k. If **'i' is No**, is the reason why documented?

Yes

No Evidence Found

N/A ('i' is yes)

Other (specify) _____

EVIDENCE: _____

Notes: _____

III. Needed Resources:

a. Does the record document that natural supports (family/friends) are being accessed as a resource?

Yes

No Evidence Found

EVIDENCE: _____

Other (specify) _____

Notes: _____

b. If **'a' is No**, has the worker discussed with the consumer the consideration of natural supports as a resource?

Yes

No Evidence Found

N/A ('a' is yes)

EVIDENCE: _____

Other (specify) _____

Notes: _____

c. Does the record document that generic resources (those resources that anyone can access) are being accessed?

Yes

No Evidence Found

EVIDENCE: _____

Other (specify) _____

Notes: _____

d. If **'c' is No**, has the worker discussed with the consumer the consideration of generic resources as a resource?

Yes No Evidence Found N/A ('c' is yes)

EVIDENCE: _____

Other (specify) _____

Notes: _____

e. Does the record document a resource need that has not been provided according to/within the expected response time? (Expected response times are defined in column 2 of the attached Unmet Need Standards)

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

f. If **'e' is Yes**, does the treatment plan reflect interim planning?

Yes No Evidence Found N/A ('e' is no)

EVIDENCE: _____

Notes: _____

g. If **'e' is Yes**, does the record document that the treatment team reconvened after the unmet need was identified?

Yes No Evidence Found N/A ('e' is no)

EVIDENCE: _____

Other (specify) _____

Notes: _____

IV. Service Agreements:

a. Does the record document that Service Agreements are required for this plan? (See Paragraph 69 Protocol for Definitions)

Yes No Evidence Found

EVIDENCE: _____

Notes: _____

b. If **'a' is Yes**, have the service agreements been acquired?

Yes ☐ No Evidence Found ☐ N/A ('a' is no) ☐

EVIDENCE: _____

Notes: _____

c. If **'a' is Yes**, are the service agreements current?

Yes ☐ No Evidence Found ☐ N/A ('a' is no) ☐

EVIDENCE: _____

Notes: _____

V. Vocational Services:

a. Does the record document that the vocational domain is addressed with the consumer on their initial/annual assessments?

Yes ☐ No Evidence Found ☐

EVIDENCE _____

Notes: _____

b. Does the record document that the vocational domain is being addressed with the consumer at each 90-day treatment plan review?

Yes ☐ No Evidence Found ☐

EVIDENCE: _____

Notes: _____

VI. Comments:

Overall Treatment Plan Review Comments:

- a. Plan of Correction requested? Yes No
- a.1. Plan of correction for Section II a. (required when not all domains are assessed)
 included? Yes No

If yes, complete the following:

- b. Date Plan of Correction due: _____
- c. Plan of Correction received? Yes No Date _____
- d. Were corrections made to the satisfaction of the CDC? Yes No

Plan of Correction Comments:
