## Placer/Sierra County Systems of Care Network Provider Behavioral Health Audit Tool

Provide	r Name:	R	eview Period: _	to		
Case Name:				DOB:	DOB:	
		Required Documentation	<u>n</u>			
A. Doc	cuments	for Review Period				
1.	Network	Provider Initial Authorization in file?	П Ү	Пи		
2.	Request	for Reauthorization/Treatment Plan Report (CARE—009) in fi		□N	□ N/A	
s. Asse	essment	[Biopsychosocial Assessment (CARE-015), Psycho	logical Evaluatio	nl		
1.		ment dated within last three years?		_		
2.		ollowing required elements documented:				
a.		senting problem		Y □N	☐ Incomplete	
b.		velopmental history, including pre-natal and perinatal events			Incomplete	
c.		levant family history	<u>—</u>	_	Incomplete	
d.		cial supports	_	_	Incomplete	
e.		ostance abuse history.	_	=	Incomplete	
f.		ental health services history.		=	Incomplete	
		dical history, including allergies.		=	☐ Incomplete	
g. h.		dication history, including medication allergies, adverse reaction			Incomplete	
11.		dications, or lack of known allergies/sensitivities	JIIS 10		пеотресс	
;		ental status		Y □N	☐ Incomplete	
1.		sessment of risk	_		Incomplete	
J. k.	_	ent strengths.		_	Incomplete	
k. 1.		nature Licensure			meompiete	
1.	SIE	mature Licensure		I 🔲 IN		
m.		M IV-TR 5 axis diagnosis		Y N		
n.		he assessment was completed by a registered intern is there a li			_	
		pervisor co-signature?			∐ N/A	
0.		anges/corrections have been initialed by worker	<u> </u>	Y N	☐ Incomplete	
	(no	sticky notes or white-out used)				
Audito	r Feedback					
ruuno	T CCGOGC					
-						
Netwoi	rk Provide	—Please identify corrections made:				
	opies of t	he completed corrections have been attached for	review (REQUIR	EED)		
	a:					
	Signature	::				

Revised 1-31-2013

	atment Plan [Unified Service Plan (CARE-008) or other format]								
1.	Is there a Treatment Plan for this entire review period?	☐ Y	□N						
2.	Are the following required elements documented:								
	a. Specific, observable, and/or quantifiable goals	☐ Y	∐N	Incom					
	b. Proposed type(s) of intervention(s)	☐ Y	□N	Incom					
	c. Proposed duration of intervention(s)	☐ Y	□N	Incom					
	d. Focus of intervention consistent with client plan goals	$\square$ Y	$\square$ N	Incom					
	e. Plan consistent with diagnosis(es)	$\square$ Y	$\square$ N	Incom					
	f. Signed by appropriate provider	$\square$ Y	$\square$ N	Incom					
	g. Signed by client or parent/guardian	☐ Y	$\square$ N	Incom					
	Auditor Feedback:								
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	Network Provider—Please identify corrections made:								
	Network Provider—Please identify corrections made:								
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-	☐ Copies of the completed corrections have been attached for revie								

D.	Oth		equired documents sent for treatment of minor			П ү	Пи	□ N/A					
A.	Pro		s Notes:	•••••	• • • • • • • • • • • • • • • • • • • •		1\						
	1.		the following required elements of Are the CARE041 and CARE04 Actual date service was provide Location of service	11g Progress Notes bein d d in progress notes as re	g used	Y Y ng Y	□ N □ N □ N □ N						
		e. f.	Type of service  Name of client  A clear but brief synopsis of ser			Y	□ N □ N □ N						
		g. h. i.	solving) Signature of service provider an Changes/corrections have been (no sticky notes or white-out use	initialed by worker			□ N □ N						
		j.	•	,	completed corr	rectly Y	□N						
		rida	uditor Feedback:										
	•												
	•												
	•	Netv	vork Provider—Please identify con	rrections made:									
		1400	voik i to vider — i lease identity con										
	•		Copies of the completed corrections or missing notes have been attached for review (REQUIRED)										
			-	<u> </u>			ow (IEE Q	, IIII )					
		Sig	nature:										
A.	Pos	ted N	Aaterials: English & Spani	sh	В. <b>Арр</b> і	ropriateness of S	pace						
			<u> </u>										
	1. 2.	Grie Env	de to Medi-Cal MH Poster evance Appeal Forms & elopes on display	☐ Y ☐ N ☐ N ☐ N		Confidentiality			□ N □ N				
	3. 4.	Pati	-	$\begin{array}{ccc} \square \ Y & \square \ N \\ \square \ Y & \square \ N \end{array}$		Safety Handicapped Access			□ N □ N				
		Audi	tor Feedback:										
	Natural Provider Diago identify corrections made:												
		Network Provider—Please identify corrections made:											
		Sig	nature:										
Revi	ewed	by:			Revie	ew Date:							
	☐ Michelle Johnson (530) 886-5463 ☐			Marie Osborne (530) 886-2937 Rich Hill (530) 889-7272									
	Wal	ly Kel	ler (530) 886-5410	Derek Holley (530) 88	36-5407	☐ Janet Muehe-I	Hayward (53	80) 886-54	435				
	Jeff	Steer	(530) 886-6716										
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