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

Provider Name: _____ Review Period: _____ to _____

Case Name: _____ Case Number: _____

Required Documentation

A. Documents for Review Period

1. *Network Provider Service Authorization* in file..... ☐ Y ☐ N
2. *Progress Report/Request for Reauthorization* (CARE—009) in file …… ☐ Y ☐ N ☐ N/A

Network Provider—Please identify corrections made: _____

Signature: _____

B. Assessment [*Biopsychosocial Assessment* (CARE-015), Psychological Evaluation]

1. Is assessment dated within last three years?…….. ☐ Y ☐ N
2. Are the following required elements documented:
   a. Presenting problem.…….…….. ☐ Y ☐ N ☐ Incomplete
   b. Developmental history, including pre-natal and perinatal events.…….….... ☐ Y ☐ N ☐ Incomplete
   c. Relevant family history.…….….... ☐ Y ☐ N ☐ Incomplete
   d. Social supports.…….…… ☐ Y ☐ N ☐ Incomplete
   e. Substance abuse history.…….….... ☐ Y ☐ N ☐ Incomplete
   f. Mental health services history.…….…. ☐ Y ☐ N ☐ Incomplete
   g. Medical history, including allergies.…….… ☐ Y ☐ N ☐ Incomplete
   h. Medication history, including medication allergies, adverse reactions to …... medications, or lack of known allergies/sensitivities ☐ Y ☐ N ☐ Incomplete
   i. Mental status.…….…….. ☐ Y ☐ N ☐ Incomplete
   j. Assessment of risk.…….….….. ☐ Y ☐ N ☐ Incomplete
   k. Client strengths.…….…… ☐ Y ☐ N ☐ Incomplete
   l. Signature ☐ Licensure ☐.…….…….. ☐ Y ☐ N
   m. DSM IV-TR 5 axis diagnosis.……..…. ☐ Y ☐ N
   n. If the assessment was completed by a registered intern is there a licensed supervisor co-signature?..... ☐ Y ☐ N ☐ N/A
   o. Changes/corrections have been initialed by worker…….. (no sticky notes or white-out used) ☐ Y ☐ N ☐ Incomplete

Network Provider—Please identify corrections made: _____

Signature: _____

C. Treatment 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 ☐ Incomplete
   b. Proposed type(s) of intervention(s).…….…….…… ☐ Y ☐ N ☐ Incomplete

c. Proposed duration of intervention(s)…….……... ☐ Y ☐ N ☐ Incomplete

d. Focus of intervention consistent with client plan goals..……..…… ☐ Y ☐ N ☐ Incomplete

e. Plan consistent with diagnosis(es)……...…….…… ☐ Y ☐ N ☐ Incomplete

f. Signed by appropriate provider……...…….. ☐ Y ☐ N ☐ Incomplete

g. Signed by client or parent/guardian……... ☐ Y ☐ N ☐ Incomplete

Network Provider—Please identify corrections made: _____

Signature _____

D. Other required documents

1. Consent for treatment of minor…… ☐ Y ☐ N ☐ N/A

A. Progress Notes:

1. Are the following required elements documented in all notes:

a. Actual date service was provided……. ……..... ☐ Y ☐ N

b. Location of service ……...……... ☐ Y ☐ N

c. Time units (in minutes) recorded in progress notes as reflected in billing statements..... ☐ Y ☐ N

d. Type of service....……. ☐ Y ☐ N

e. Name of client……...…….……... ☐ Y ☐ N

f. A clear but brief synopsis of services and specific intervention (i.e. problem solving) ☐ Y ☐ N

g. Signature of service provider and their degree, license, or job title..…… ☐ Y ☐ N

h.. Changes/corrections have been initialed by worker…….. (no sticky notes or white-out used) ☐ Y ☐ N

Network Provider—Please identify corrections made: _____

Signature: _____

A.	Posted Materials: English and Spanish					B.	Appropriateness of Space		
	1.	Guide to Medi-Cal MH Poster…..	☐ Y	☐ N		1.	Confidentiality……..	☐ Y	☐ N
	2.	Grievance Appeal Forms & Envelopes on display…….	☐ Y	☐ N		2.	Cleanliness……	☐ Y	☐ N
	3.	Grievance/Appeal Poster……...	☐ Y	☐ N		3.	Safety……	☐ Y	☐ N
	4.	Patients' Rights Poster……..	☐ Y	☐ N		4.	Handicapped Access…….	☐ Y	☐ N

Network Provider—Please identify corrections made: _____

Signature: _____

Reviewed by: _____ *Review Date:* _____

☐ Michelle Johnson (530) 886-5463 ☐ Tom Lind (530) 889-6752 ☐ Linda Helling (530) 886-5419

Comments/Suggestions: _____

_____

Network Provider Acknowledgement: _____ *Date:* _____

Network Provider acknowledges receipt of copy of audit tool(s) and need for correction(s). Network Provider will return signed audit tools confirming corrections have been completed within 30 days of date of audit.

☐ Network Provider unavailable to sign on day of audit. Audit tools mailed for review, confirmation of corrections and signature.