MEDICAID COMMUNITY MENTAL HEALTH SERVICES PROGRAM
GUIDELINES, INSTRUCTIONS AND CHECKLIST
Effective October 1, 2015 (rev. 11-10-15)

Provider: _____

Date of Review: _____ Type of Review (Check One): ☐ Full Review ☐ 90 Day Review ☐ 60 Day Review ☐ Focused Review*

Certifying Agency: ☐ DHS ☐ DCFS

Individual Clinical Records Reviewed (Initials & Provider record #):

1)_____	8)_____	15)_____
2)_____	9)_____	16)_____
3)_____	10)_____	17)_____
4)_____	11)_____	18)_____
5)_____	12)_____	19)_____
6)_____	13)_____	20)_____
7)_____	14)_____	

Reviewer(s): _____ _____

_____ _____

Legend:
F = Full Compliance
S = Substantial Compliance
M = Minimal Compliance
N = Non-Compliant
U = Standard or issue is not applicable
Pts = Points awarded for level of compliance
Tot = Total points possible for full compliance

*Focused Review - follow-up review to determine implementation of Plan of Correction.

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.27 Provider Qualifying Conditions									
	a) A Provider shall, at a minimum, directly provide Mental Health Assessment, ITP development, review, and modification (see Section 132.148(c)) and at least one additional Part 132 mental health service. Directly provided means that the QMHP and LPHA who signed the mental health assessment and ITP are employed by or contractual employees of the Provider. The Public Payer may waive the requirement of at least one additional Part 132 mental health service if it deems that such waiver increases the availability of mental health services to Medicaid-eligible Clients.	G: Someone employed by, or on contract with, the provider must provide at least one other service. I: If not, there must be a written waiver from the state agency. G: Being certified for a service does not indicate provision of the service.							1
	c) Billings for services rendered under this Part shall be submitted only by the Provider that directly provided the service and only to the Public Payer that is funding the service.	G: If a primary contractor is found to be submitting billings for services provided by another certified provider, that will be cited here and points will be lost. If provider does not subcontract, then these points are scored as U.							1
Section 132.30 Application, Certification and Recertification Processes									
	d)3) A Provider shall deliver only mental health services under this Part for which it is certified.	G: If provider was certified for all services provided, score this item as U. If one service was provided for which the provider was not certified, no points are awarded for this item. I: If no billing run is available for review, ask provider for a list of all services that they have provided during the time period of the review.							9
Section 132.65 Organizational Requirements									
Deemed	a) The provider shall operate in a manner consistent with all applicable State laws and federal regulations, and adopted procedures.	Instruction (I): This item is not scored. However, the state agency can note and take action based on evidence of non-compliance with applicable laws, regulations, and procedures.							
Deemed	b) A provider shall have written operating policies and procedures that detail and explain the operation of programs and the delivery of services, including a description of staff decision-making authority.	I: An organizational chart is an acceptable method for documenting decision-making authority. Guideline G: The operating policies and procedures must describe how the provider operates its programs and delivers services.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.65 Organizational Requirements									
Deemed	c) A provider shall have proof of insurance against professional and physical liabilities.	G: The provider must show a certificate or set of certificates demonstrating that the provider is insured for professional and physical liabilities.							1
Deemed	d) A provider shall ensure the availability of staff or consultants capable of using languages or methods of communication used by Medicaid-eligible clients served by the provider.	G: The provider must show a written plan for ensuring the availability of staff using languages or methods of communication used by the Medicaid-eligible clients served.							1
Deemed	e) The provider shall have an active system of program evaluation. 1) This system shall monitor quantitative characteristics such as caseload information and qualitative characteristics such as client satisfaction.	G: The provider must show a program evaluation plan and reports or other documents demonstrating that the program evaluation system is active.							1
Deemed	2) The evaluation system shall include mechanisms for producing evaluation reports that describe the outcome of monitoring activities and provide for the use of the results to improve the program.	G: The provider must show an annual program evaluation report or other documents demonstrating that the program evaluation was completed and included recommendations for program improvements.							1
	f) The provider shall have an active system for determining compliance with all client record requirements of this Part. 1) The provider shall maintain policies describing the methods for performing client record compliance audits. Audits shall be performed by persons not involved in providing services to the clients whose records are reviewed; 2) The provider shall maintain procedures describing the method for selecting cases for client record compliance audits. Procedures shall include methods for ensuring a review of 10 percent of the clients served under this Part annually; and	G: This point is for having compliant policies and procedures that include all information indicated in f)1)-3).							1
	3) Client record compliance audits shall verify each client record's compliance with requirements included in Sections 132.100, 132.142, 132.145(b), 132.148, 132.150 and 132.165.	G: These points are for having client record audits that cover all required items in f)3). Review up to five audits completed during the time period of the review for compliance using Client Record Audit Checklist.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.70 Personnel and Administrative Recordkeeping									
Deemed	a) The provider shall have a comprehensive set of personnel policies and procedures that include, but are not limited to: 1) Job descriptions and qualifications and documentation of current licensure and certification for all staff, including those on contract with the provider or with an entity subcontracting with the provider. The provider shall also maintain job descriptions for volunteers and unpaid personnel;	I: Select 10 staff names. These will be the same staff names sampled for other Personnel requirements. Verify that each staff person in the sample has a job description, current license if applicable and that provider has documented their qualifications. G: Staff includes employees, persons on contract with the provider, and persons who are associated with another entity that subcontracts with the provider. G: Volunteers and unpaid personnel must have job descriptions.							1
Deemed	2) Documentation that staff providing or supervising services pursuant to this Part meet the staff qualifications defined in this Part, and that their individual performance is evaluated no less frequently than once every 12 months; and	I: Staff qualifications for delivering services are evaluated under the requirements for each service. Staff qualifications for providing clinical direction for services are evaluated in Section 132.145(e). Staff qualifications for reviewing and approving the Mental Health Assessment and Individual Treatment Plan are evaluated in Section 132.148. I: Select 10 staff names. These will be the same staff names sampled for other Personnel requirements. Review their personnel file for documents showing performance evaluations were completed at least once every 12 months.							3
Deemed	3) Documentation that the provider has written personnel policies concerning hiring, evaluating, disciplining and terminating staff.	G: The provider must show a document or set of documents covering all of the elements.							1
Deemed	b) The provider must show documentation indicating that staff have engaged in professional development and continuing education activities. Acceptable documentation may include, but is not limited to, training approval forms, reimbursement/payments for training, training calendars, outlines of training activities, or a list of notifications or training events.	I: Review 10 staff records previously selected.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.70 Personnel and Administrative Recordkeeping									
	c) Providers shall not allow any person to work or volunteer in any capacity until the provider has inquired of the Department of Public Health as to information in the Health Care Worker Registry concerning the person. If the Registry has information substantiating a finding of abuse or neglect against the person, the provider shall not employ him or her in any capacity.	I: Verify compliance with this standard for all providers. Select 10 staff names. Review each of their personnel files for evidence of having checked with the Healthcare Worker Registry and not found any substantiated charge of abuse or neglect. G: For DCFS providers, all employees hired BEFORE 2/1/13 will need to be screened through the Registry by 4/1/13.							3
	d) Providers shall perform background checks in compliance with requirements set forth in the Healthcare Worker Background Check Act as implemented by the Illinois Department of Public Health in rule [77 Ill. Adm. Code 955].	I: If any of the staff reviewed for 132.70c) were NOT active in the Registry, there must be evidence in the personnel record that the provider initiated a Background Check for the staff member and that the Background Check cleared before the staff member was hired or allowed to work alone with clients. G: Providers who are licensed as child care facilities as defined in Title 89, Chapter III, Sub-chapter d, Part 385, Section 385.20 are not required to comply with this item. This item should be scored U for those providers.							3
Deemed	e) Each provider shall develop, implement and maintain a plan for clinical supervision of QMHPs, MHPs and RSAs who perform Part 132 services. Supervision must be documented in a written record. Supervision of staff as noted in this subsection must be for a minimum of one hour per month through face-to-face, teleconference or videoconference. 1. QMHPs must be supervised by an LPHA. 2. MHPs and RSAs must be supervised by, at a minimum, a QMHP. 3. LPHAs are not required to have clinical supervision under this Section.	G: This point is for having a compliant clinical supervision plan. I: Ask to see the written plan.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.70 Personnel and Administrative Recordkeeping									
Deemed		G: These points are for having documentation that clinical supervision was provided as required. The content of the supervision must be documented and must indicate that the supervision covered material other than administrative issues (e.g., paperwork, attendance, etc.) and/or client-focused treatment reviews. G: Group supervision is permitted. I: Review 10 staff records previously selected and verify that the QMHP, MHP and RSA level staff have received 1 hour documented clinical supervision per month for the previous 12 months.							3
Section 132.80 Fiscal Requirements									
	b) The Provider shall determine if there are any third party payers liable for treatment costs incurred by a Client and shall follow procedures for seeking payment from these parties and for calculating subsequent Medicaid charges as outlined in 89 Ill. Adm. Code 140. A third party payer is any entity, other than the Client or Public Payer, with an obligation to the client to pay for Part 132 services.	G: Provider must have procedure for checking on Third Party Liability for each client for whom Part 132 services are billed.							1
Section 132.85 Recordkeeping									
Deemed	a) The provider shall maintain records, including but not limited to the following: 1) Documents required for cost reporting and audit purposes as per the executed contract between the provider and the public payer; 2) Service billing files; 3) Clinical records as defined in Section 132.100; and 4) Individual client information, including: guardianship, representative payee, trust beneficiary and resource availability, and all other documents as required in this Part.	G: Do not score this item here, as these items are scored in other areas.							
Deemed	b) Required records shall be retained for a period of not less than 6 calendar years from the date of service, except that if an audit is initiated within the required retention period the records shall be retained until the audit is completed and every exception resolved. This provision is not to be construed as a statute of limitations.	G: The provider must show its policies, procedures, or practices indicating compliance with this requirement.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.85 Recordkeeping									
Deemed	d) The compilation and storage of and accessibility to client information and clinical records shall be governed by written policies and procedures, in accordance with The Confidentiality Act, HIPAA and HITECH.	G: The policies and procedures must reference the Confidentiality Act, HIPAA and HITECH.							1
Deemed	e) Clinical records and other client information shall be secured from theft, loss, or fire.	I: During the site walk-through, observe the provider's methods for securing clinical records and other client information. If the provider stores these materials at an uncertified site, ask the provider for its policies, procedures, or a description of practices indicating how security is maintained for those materials.							1
Section 132.85 Recordkeeping									
	f) Electronic signature or computer-generated signature codes are acceptable as authentication of record content when compliant with the following requirements: 1) In order for a provider to employ electronic signatures or computer-generated signature codes for authentication purposes, the provider shall adopt a policy that permits authentication by electronic or computer-generated signature. 2) At a minimum, the policy shall include adequate safeguards to ensure confidentiality of the codes, including, but not limited to, the following: A) Each user shall be assigned a unique identifier that is generated through a confidential access code. B) The provider shall certify in writing that each identifier is kept strictly confidential. This certification shall include a commitment to terminate a user's use of a particular identifier if it is found that the identifier has been misused. "Misused" shall mean that the user has allowed another person or persons to use his or her personally assigned identifier or that the identifier has otherwise been inappropriately used. C) The user shall certify in writing that he or she is the only person with user access to the identifier and the only person authorized to use the signature code.	G: If the provider uses electronic signature or computer-generated signature codes, the provider shall have a written policy to ensure confidentiality of the codes. G: Each user of an electronic signature shall certify in writing that he or she is the only person having access to his or her assigned code. If no statement exists for a staff, then that staff's electronic signature and credentials on any Medicaid document are <u>not original</u> and citations will be made for each of the applicable items. If such a statement does exist, the electronic signature will be considered original for purposes of this Part. I: Compliance will be determined through review of originally selected 10 staff records. (See 132.70)							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.85 Recordkeeping									
	D) The provider shall monitor the use of identifiers periodically and take corrective action as needed. The process by which the provider will conduct monitoring shall be described in the policy.								Scored Above
	3) A system employing the use of electronic signatures or computer-generated signature codes for authentication shall include a verification process to ensure that the content of authenticated entries is accurate. The verification process shall include, at a minimum, the following provisions: A) The system shall require completion of certain designated fields for each type of document before the document may be authenticated, with no blanks, gaps or obvious contradictory statements appearing within those designated fields. The system shall also require that correction or supplementation of previously authenticated entries shall be made by additional entries, separately authenticated and made subsequent in time to the original entry. B) The system shall make an opportunity available to the user to verify that the document is accurate and the signature has been properly recorded. C) The provider shall periodically sample records generated by the system to verify the accuracy and integrity of the system.	G: The provider shall review the use of codes periodically as defined by their policy to assure proper use. G: The system shall have a process that allows the user to verify the content of the entry is accurate.							1
	4) Each report generated by a user shall be separately authenticated.	G: Citation for violation of this standard will be made under each service when it is determined that notes, mental health assessment report or treatment plan are not properly signed.							
Section 132.90 Provider Sites									
Deemed	a) The Provider shall use sites deemed accessible in accordance with the Americans With Disabilities Act of 1990, as amended, and the Illinois Accessibility Code and the ADA Accessibility Guidelines, whichever is more stringent. Providers must maintain a written policy for reasonable modifications for the provision of services to Clients unable to access the Provider's sites due to physical inaccessibility.	I: If the sites have been adapted so that their parking lots, entrances, hallways and physical facilities such as lavatories, drinking fountains and ramps are available to persons with disabilities, the site(s) will be considered accessible. I: If any of the provider's sites are not accessible, the provider must produce a written policy that indicates the reasonable accommodations that will be made to allow all clients to access services.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.90 Provider Sites									
(2) Deemed	b) Provider sites shall be in compliance with approved State and local ordinances and codes relating to fire, building and sanitation, and health and safety requirements as follows: 1) Fire safety in accordance with the rules of the Office of the State Fire Marshal at 41 Ill. Adm. Code 100. 2) Building requirements shall be in compliance with the uniform or national building code adopted by the local or county ordinance.	G: For all sites, the provider must have a copy of a clearance letter, less than 12 months old, from the OSFM or from local fire authority noting compliance with NFPA 101, Life Safety Code. If the provider is certified by DHS, the clearance must come from the OSFM. I: Fire clearance letters are reviewed every 3 years during the full certification review. G: Building requirements are the responsibility of county and/or local authorities and will not be reviewed here.							1
Deemed	c)1) Develop and maintain a written external and internal emergency disaster plan, including a fire evacuation plan. External disasters include such occurrences as tornados, earthquakes and floods. Internal disasters include such occurrences as fire and heating and cooling systems failures.	I: Each site must have a plan to obtain point. G: Emergency disaster plans must indicate staff safety plans and continued operations should a disaster happen. Listed disasters are only examples.							1
Deemed	c)2) Designate space, equipment, and furnishings for the provision of services which shall be conducive to privacy, comfort and safety. This includes such aspects as child size furniture in children's programs, rooms sufficiently large to accommodate groups or families, and doors that close to afford privacy.	I: Review may include walk through of sites. I: All sites must have policies and procedures to obtain point.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.95 Utilization Review									
	The provider shall have a written utilization review (UR) plan and ongoing assessment of the medical necessity of Medicaid community mental health services, including the intensity/level of services and continued need for each service for the client. The written UR plan shall address: a) A review of medical necessity or that services are medically necessary, as determined by: 1) The definition of medical necessity in this Part; 2) The type, severity and chronicity of the client's symptoms; 3) The severity of impairment in the client's role functioning; 4) The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts; 5) The expected short-term and long-term outcome of each service needed by the client; and 6) Progress made in response to treatment, if the client is currently receiving treatment;	G: This point is for having a fully compliant UR plan that addresses items a) through j)							
(b) Deemed	b) The methods and procedures for performing and recording individual case reviews by persons not involved in providing services to the clients whose records are reviewed;								
	c) The authority and functions of the individual case review designated unit, which may be: 1) A representative committee, chaired by a QMHP, and including QMHPs, MHPs, and RSAs; or 2) A QMHP;								1
(d) Deemed	d) Procedures describing the method for selecting cases for quarterly case review and the procedures for reviewing 10 percent of the clients served under this Part annually;								
(e) Deemed	e) Procedures to ensure that the review includes and summarizes the client's progress over the previous 90 days;								
(f) Deemed	f) Procedures to ensure that the review includes and summarizes the client's involvement in service planning and provision over the previous 90 days;								
(g) Deemed	g) Policies and procedures for documenting and reporting individual case reviews findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department;								

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.95 Utilization Review									
(h) Deemed (i) Deemed (j) Deemed	h) Procedures for appeal by clients and staff affected by the UR decisions with which they disagree; i) Provisions for ensuring confidentiality of individual case reviews, determinations, results and/or recommendations in accordance with the Confidentiality Act and HIPAA; and j) Procedures for following up on case review recommendations.								Scored Above
	Individual Case reviews shall include an assessment of the intensity/level of services and continued need for each service for the client:	I: Review UR reports for 10 clients to verify implementation of the UR plan. G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3
	a) A review of medical necessity or that services are medically necessary, as determined by: 1) The definition of medical necessity in this Part; 2) The type, severity and chronicity of the client's symptoms; 3) The severity of impairment in the client's role functioning; 4) The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts; 5) The expected short-term and long-term outcome of each service needed by the client; and 6) Progress made in response to treatment, if the client is currently receiving treatment;	G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3
Deemed	e) … the review includes and summarizes the client's progress over the previous 90 days;	G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3
Deemed	f) …the review includes and summarizes the client's involvement in service planning and provision over the previous 90 days	G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3
Deemed	g) …documenting and reporting individual case reviews findings, determinations and recommendations to the supervising QMHP and, if applicable, the billing department;	G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3
Deemed	j) …following up on case review recommendations.	G: Points here are for having this item addressed in each of the Individual Case Reviews that are reviewed.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.100 Clinical Records									
	The Client's clinical record shall contain, but is not limited to the following: a) Identifying information, including Client's name, Medicaid recipient identification number, address and telephone number, gender, date of birth, primary language, method of communication and documentation of how anything other than verbal English communication needs were accommodated, name and phone number of emergency contact, date of initial contact and initiation of mental health services, third party insurance coverage, marital status, and source of referral;	I: Name, gender, date of birth, and primary method of communication are evaluated in Section 132.148(a)(2). Do not evaluate these four elements here. G: Identifying information may be documented in any part of the client's clinical record.							3
Deemed	b) Documentation of consent for or refusal of mental health services;	I: The requirements for consent are evaluated in Section 132.145(d)							
Deemed	c) Assessment and reassessment reports;	I: The requirements for assessment and reassessment reports are evaluated in Section 132.148(a).							
Deemed	d) A single consolidated ITP within a Provider organization. The ITP must be current;	G: All services provided must be included on a single plan.							3
	e) Admission Note or Healthy Kids Screen, if applicable;	I: The requirements for Admission Note are evaluated in Section 132.148(a)(3).							
Deemed	f) Documentation concerning the prescription and administration of psychotropic medication as specified in Section 132.150(c)(1);	I: The requirements for documenting the prescription and administration of psychotropic medications are evaluated in Section 132.150(c).							
Deemed	g) Documentation of missed appointments;	G: The provider must show that missed appointments are documented.							1
Deemed	h) Documentation of Client referral or transfer during any active service period to or from the Provider's programs or to or from other providers;	G: The provider must show documentation of referrals or transfers.							1
	i) Documentation to support services provided for which reimbursement is claimed shall be in the format specified by the Public Payer, shall be legible, shall support the amount of time claimed, and shall include, but not be limited to, the following	G: Documentation must be legible. I: Handwriting must be able to be read by someone other than the author. G: The note must include a narrative that shows that the indicated Part 132 service was provided for the entire duration of time indicated on the note.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.100 Clinical Records									
	1) The specific service, including whether the service was rendered in a group, individual or family setting and a note in the periodic report indicating the specific Part 132 mental health services billed by name or code;	G: Specific service means detail including group, individual and family. G: The record must include a note in the required format that includes the specific Part 132 mental health service(s) billed by name or code. G: If no note is found in the record to support the billed service, cite that here.							3
	2) The date the service was provided;	G: The clinical record must contain a note in the required format that indicates the date the service was provided.							3
	3) The start time and duration for each service.	G: Each service must be documented with a separate start time and duration.							3
	4) The original signature, name and credential of the staff providing the service	G: Original signature and credential(s) of staff providing service must be on note. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act.							3
	5) The site or, if off-site, the specific off-site location where services were rendered;	G: The record must reflect on-site vs off-site service. G: The record must include the specific location in which service was provided, both off-site and on-site.							3
	6) Written documentation of each service provided as described in Section 132.148, 132.150 or 132.165;	G: This requirement is not scored here. The requirement is to be scored under each applicable section of 132.148, 132.150, and 132.165.							

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.100 Clinical Records									
Deemed	j) ITP reviews describing the Client's overall progress;	I: The requirements for reviewing the client's ITP are evaluated in Section 132.148(c)(5).							
Deemed	k) A written record of the Client's major accidents or incidents that occurred at the site, whether self-reported or observed, and resulting in an adverse change in the Client's physical or mental functioning; and	G: The provider must show documentation of reports of major accidents or incidents that occur at the site and involve a specific Medicaid client.							1
Deemed	l) Discharge summary documenting the outcome of treatment and, as necessary, the linkages for continued services.	I: The requirements for documentation of linkages are evaluated in Section 132.145(c). G: If the client has been discharged, the client record must contain documentation of the outcomes.							3
Section 132.142 Clients' Rights									
	To assure that a client's rights are protected and that all services provided to clients comply with the law, providers shall ensure that:								
	a) A client's rights shall be protected in accordance with Chapter 2 of the Mental Health and Developmental Disabilities Code [405 ILCS 5]. b) The right of a client to confidentiality shall be governed by the Confidentiality Act and the Health Insurance Portability and Accountability Act of 1996. c) Justification for restriction of a client's rights under the statutes cited in subsections (a) and (b) shall be documented in the client's record. Documentation shall include a plan with measurable objectives for restoring the client's rights that is signed by the client or the client's parent or guardian, the QMHP and the LPHA. In addition, the client affected by such restrictions, his or her parent or guardian, as appropriate, and any agency designated by the client pursuant to subsection (d)(2) of this section shall be notified of the restriction and given a copy of the plan to remove the restriction of rights.	G: If the written document(s) does not specifically reference Chapter 2, all the rights enumerated in Chapter 2 must be included in the document(s). G: The written document(s) must specifically reference the Confidentiality Act [740 ILCS 110] and HIPAA (45 CFR 160 and 164). G: The written document(s) must specifically reference components of Section 132.142(d). G: The Clients' Rights document must include the address and phone number of Equip for Equality and the Guardianship and Advocacy Commission. G: This point is for having a compliant document(s).							Scored Below

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.142 Clients' Rights									
	d) Staff shall inform the client <u>prior to evaluation</u> services of the following: 1) The rights in accordance with subsections (a), (b) and (c); 2) The right to contact the Guardianship and Advocacy Commission and Equip for Equality, Inc. Staff shall offer assistance to a client in contacting these groups, giving each client the address and telephone number of the Guardianship and Advocacy Commission and Equip for Equality, Inc.; 3) The right to be free from abuse, neglect and exploitation; 4) The right to be provided mental health services in the least restrictive setting; 5) The right or the guardian's right to present grievances up to and including the provider's executive director or comparable position. The client or guardian will be informed on how his or her grievances will be handled at the provider level. A record of such grievances and the response to those grievances shall be maintained by the provider. The executive director's decision on the grievance shall constitute a final administrative decision (except when such decisions are reviewable by the provider's governing board, in which case the governing board's decision is the final authority at the provider level); 6) The right not to be denied, suspended or terminated from services or have services reduced for exercising any rights; and 7) The right to contact the public payer or its designee and to be informed of the public payer's process for reviewing grievances. 8) The right to have disabilities accommodated as required by the American With Disabilities Act, section 504 of the Rehabilitation Act and the Human Rights Act [775 ILCS 5]. e) The information in subsection (d) shall be explained using language or a method of communication that the client understands and documentation of such explanation shall be placed in the clinical record.	G: If the client record only contains a signature page for the staff who explained the rights, the signature page must reference the clients' rights version that was explained. If the version that was explained was not fully compliant, cite that here.							1

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.142 Clients' Rights									
		G: There must be a signed and dated statement by the staff person who explained the rights in (d) to the client attesting to having explained them and to his or her belief that they were understood. There must be written evidence that these rights were explained prior to evaluation services and annually thereafter. G: Scoring here is for having the signed staff statement in the client record dated within the required timeline. I: For initial Clients' Rights, compare date of staff statement in (e) below to date on note of first meeting for service needs evaluation or Admission Note. G: For annual Clients' Rights, compare the previous date of staff statement in (e) below to the date of the most recent staff statement.							3
		I: When reviewing the client record, look at notes which indicate discussion of the case with other people. There must be signed releases for anyone outside of the agency other than the guardian or parent of children. G: There can be no full names of other clients in the identified client's record (except for family). I: For DCFS clients this applies to Section VI, Child Specific Section of the case record per Administrative Procedure 5. G: If no discussion of the case with other people was found, and if there are no full names of other clients found in the record, this standard becomes not applicable for that record.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.142 Clients' Rights									
		G: If any of the client rights have been restricted, there must be evidence of notification sent to the appropriate entities. G: If any rights have been restricted, the clinical record must contain documentation of the reason why and must include a plan with measurable objectives for restoring the client's rights that is signed by the client or the client's parent or guardian, the QMHP and the LPHA. In addition, the client affected by such restrictions, his or her parent or guardian, as appropriate, and any agency designated by the client pursuant to subsection (d)(2) of this section shall be notified of the restriction and given a copy of the plan to remove the restriction of rights.							3
	a) Informed Consent 1) <u>Prior to the initiation of mental health services</u>, the provider shall obtain written or oral consent for these services demonstrating that the client or guardian, as applicable, knows all of the risks and costs involved in the treatment, including the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment 2) Consent must be given by the parent or guardian for a child under 12 years of age, except a child 12 through 17 years of age can consent to treatment for 5 outpatient sessions of no more than 45 minutes in duration. 3) If the client is determined to be in need of crisis intervention services, or if the assessment is court ordered for the client, consent is not required. 4) Legally competent adults who participate in treatment services are deemed to have consented. 5) Oral consent shall also be documented in the record.	G: There must be evidence that all required information was explained to the client/guardian, as evidenced by a staff's signature attesting to having explained those items to the client/guardian. I: Compare date of staff statement to date on first service note to determine if consent was obtained prior to the first mental health service being provided. G: Guardian oral or written consent must be obtained for a client under 18 with the following exception, a child 12 through 17 can consent to treatment for 5 sessions (405 ILCS 5/3-501(a)). G: Client oral or written consent must be obtained if client is 18 or older, unless the client is an adult adjudicated disabled. G: If the client is determined to be in need of crisis intervention services, or if the assessment is court ordered for the client, consent is not required.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.145 General Provisions									
	b) An LPHA shall provide the clinical direction and recommend medically necessary services as documented by his or her dated original signature with credentials on the mental health assessment	G: The mental health assessment report must contain the original dated signature with credentials of the LPHA. G: Pre-typed credentials that are clearly associated with the signature line are acceptable. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act.							9
	b) and ITP.	G: The ITP must contain the original dated signature with credentials of the LPHA. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act.							9

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.145 General Provisions									
	b) In determining whether there is medical necessity for each service under this Part, the LPHA shall consider and document that consideration, among other factors, including: 1) The definition of medical necessity in this Part; 2) The type, severity and chronicity of the client's symptoms; 3) The severity of impairment in the client's role functioning; 4) The risks that a client's symptoms or level of role functioning pose to the safety of the client or to others with whom the client interacts; 5) The expected short-term and long-term outcome of each service needed by the client; 6) Progress made in response to treatment, if the client is currently receiving treatment; and 7) Criteria or guidance published by the public payer for the purposes of defining and evaluating the medical necessity of each service.	G: Do not score this item here. Will be scored as part of the MHA.							
Deemed	c) When discharging a client from services, the provider shall ensure the continuity and coordination of services as provided in the client's ITP. The provider shall: 1) Communicate, consistent with the requirements of Section 132.142, relevant treatment and service information prior to or at the time that the client is transferred to a receiving program of the provider or is terminated from service and referred to a program operated by another service provider, if the client, or parent or guardian, as appropriate, provides written authorization; and 2) Document in the client's record the referrals to other human service providers and follow-up efforts to link the clients to services.	G: If the client has been discharged, the client record must have documentation of referrals, linkages, and follow-up efforts. If there are no referrals, linkages, or follow-up efforts, the client record must document that none were needed. G: If the client has been discharged, the provider must communicate the relevant treatment and service information to the receiving program/staff person before the client is discharged/transferred or at the time the client is discharged/transferred. G: If the client has been discharged/transferred and if relevant treatment and service information was shared, there must be documentation of proper authorization for this specific disclosure(s). I: This standard will need to be reviewed for at least 1 client record.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	a) Mental health assessment service is a formal process of gathering information regarding a client's mental and physical status and presenting problems through face-to-face, video conference or telephone contact with the client and collaterals, resulting in the identification of the client's mental health service needs and recommendations for service delivery. MHA services may be provided without appearing on an ITP.	I: 132.148a) is the definition of Mental Health Assessment service. Points are assessed for compliance with this definition under 132.148a)13)							
	1) An admission note may be used to initiate services prior to the completion of a mental health assessment for a client who is admitted to a specialized substitute care living arrangement; a residential facility designated by the public payer for the purpose of stabilizing a crisis; or ACT prior to the completion of a comprehensive assessment as required in Section 132.150(i)(2)(A). <u>An Admission Note must be completed within 24 hours after a client's admission and is effective for a maximum of 30 days.</u>	G: If an Admission Note is not used in a residential setting, then the timelines for the completion of the MHA apply starting with the MHA must be completed within 30 days of the first face-to-face. This item as well as the other Admission Note items would then be indicated as U.							3
	A) The Admission Note is a written report of an initial assessment and treatment plan and shall include the following: i) Identifying information: name, gender, date of birth, primary language or method of communication, date of initiating assessment; ii) Client's current mental health functioning level; iii) Provisional diagnosis; iv) Pertinent history; v) Precautions (e.g., suicidal risk, homicidal risk, flight risk) and special programming to meet the client's needs; vi) Initial treatment plan, including a list of Part 132 services that will be provided and the staff responsible for those services; and vii) Other relevant information.	G: All areas must be addressed. "None" may be indicated for "Precautions" if there are no precautions. "None" may be indicated for "Other relevant information" if there is no additional relevant information to include on the Admission Note. G: ii) Current mental health functioning level must include a description of the client's presenting problem(s) within the last three months. G: iv) Pertinent history must include a description of the client's placement prior to admission. G: vi) The Admission Note must specify the staff responsible for these services.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	B) An Admission Note shall be completed by at least an MHP following a face-to-face or video conference meeting with the client.	G: The Admission Note, or notation in the record, must indicate that at least an MHP met with the client face-to-face in order to complete the Admission Note.							3
	C) A QMHP shall be responsible for approving the completed Admission Note as documented by the QMHP's dated signature on the Admission Note.	G: The Admission Note must be signed and dated by the QMHP.							3
	2) An HFS approved Healthy Kids mental health screen may be used to initiate services prior to the completion of a mental health assessment by a provider certified under this Part for a client who is under age 21. A) A Healthy Kids screen remains effective for the initiation of services for 60 days from the date the physician completed it as indicated by physician dated signature. B) A Healthy Kids screen may be used by a certified provider for a maximum of 30 days from the initial face-to-face contact with the client while the mental health assessment is being completed.	G: Health Kids Screen may be used for 30 calendar days to initiate services as long as the first face-to-face is completed within 60 calendar days of the physician's signature on the Healthy Kids Screen. G: The MHA must be completed within 30 days of the first face-to-face.							3
	3) A mental health assessment is required prior to the development and implementation of an ITP. A mental health assessment is not required prior to the initiation of psychological evaluation services described in subsection (b) crisis services described in Section 132.150(b) and case management services described in Section 132.165(a)(1).	G: Crisis services and case management services in the 30 days immediately preceding the dated signature of the LPHA on the MHA may be provided prior to the completion of the MHA or an Admission Note.							3
	4) The provider shall complete a mental health assessment report within 30 days after the first face-to-face contact for services not initiated with an Admission Note or Healthy Kids mental health screen. When a client is hospitalized for crisis services, the first face-to-face contact shall be the initial contact following discharge from the hospital.	G: The first face-to-face contact is considered the first face-to-face contact for the purpose of initiating Rule 132 services. G: If more than 30 days elapse between the first face-to-face contact and the completion of the mental health assessment report, the provider must document that the consumer stopped the process of initiating services, e.g., repeatedly cancelled appointments, repeatedly failed to appear for appointments, moved and left no contact information.							9

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	11) For services initiated by an Admission Note or Healthy Kids mental health screen, the provider shall complete a mental health assessment report or a comprehensive assessment for an ACT client within 30 days after the client's admission.	G: If an Admission Note or Healthy Kids mental health screen was used to initiate services, the mental health assessment report must be completed within 30 days after the client's admission.							9
	5) A written mental health assessment report shall be a compilation of the following: B) Reasons for seeking or being referred for current mental health treatment, including symptoms of mental illness; C) DSM-5 or ICD-10-CM diagnosis E) Mental status evaluation; F) Client preferences relating to services and desired treatment outcomes; I) Social adjustment and daily living skills; L) Strengths and resources (e.g., education, and vocational skills, current employment and employment history, interests/hobbies, financial and material resources, and supportive social relationships with family and friends, as well as more intrinsic resources, including hope, motivation, self-confidence and sense of belonging within a community of one's peers); O) Summary analysis and conclusions regarding the medical necessity of services.	G: Sections (B), (C), (E), (F), (I), (L) and (O) are reviewed together here. G: For item (C) to be compliant, documents signed and dated prior to October 1, 2015 must reflect a DSM-IV or ICD-9-CM diagnosis. Documents signed and dated on or after October 1, 2015 must reflect a DSM-5 or ICD-10 diagnosis. G: For (O) to be compliant, there must be an analysis of the findings that establishes the medical necessity for Part 132 services.							9
	A) Identifying information: name, gender, date of birth, primary language and method of communication, name and contact information of client's primary care physician, and guardian; D) Family history, including the history of mental illness in the family; G) Personal history of symptoms of mental illness and mental health treatment, date of most recent psychiatric evaluation, and whether the client has taken or is now taking psychotropic medication; H) History of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence); J) Legal history and status, including guardianship and current court involvement;	G: Sections (A), (D), (G), (H), (J), (K), (M) and (N) are reviewed together here.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	K) Identification of factors in the current environment that may create threats to the client's personal safety (e.g., gang involvement, domestic violence, elder abuse); M) History of and current alcohol or other substance use, abuse or dependence, and any previous substance use treatment/recovery efforts; N) Client's report on general physical health, including date of last physical examination;								Scored Above
	6) If a definitive diagnosis has not been determined per the DSM-5 or the ICD-10-CM by the time the MHA report is completed or a rule out diagnosis is given, the MHA report must contain documentation as to what evaluations will occur in order to provide a definitive diagnosis. A definitive diagnosis shall be determined within 90 days after the completion of the MHA report.	G: If the diagnosis wasn't available at the completion of the MHA, other evaluations needed to provide a definitive diagnosis must be noted in the client record. G: Please see Guideline for item 132.148(a)(5) concerning use of DSM-IV/ICD-9-CM or the DSM-5/ICD-10. G: The definitive diagnosis must be determined within 90 days after completion of the MHA, and the ITP must be modified as necessary based on the definitive diagnosis.							3
	7) A QMHP who has had, at a minimum, one face-to-face or video conference contact with the client shall be responsible for the completed mental health assessment report as documented by his/her dated original signature with credentials on the mental health assessment. MHPs may participate in the mental health assessment.	G: The mental health assessment report must contain the original dated signature with credentials of the QMHP who has had at least one face-to-face meeting with the client. G: Face-to-face meeting must be documented by a signed and dated note on the MHA report or in the record. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	8) The client's family or guardian may participate in the mental health assessment during which the family will be given the opportunity to provide pertinent information or support. Participation by the family and other interested persons must be in accordance with the Confidentiality Act and HIPAA.	I: If the family or other interested persons has participated in the mental health assessment, verify that needed releases are in place. [A release is not necessary for anyone who is a guardian for the client.]							3
	9) The mental health assessment report shall be reviewed and approved by the LPHA as documented by the LPHA's dated original signature with credentials on the mental health assessment. The LPHA shall determine in writing if any additional evaluations are required to assess the client's functioning or service needs.	I: Do not cite lack of LPHA signature here - It is cited under 132.145(e). G: The determination must be in writing and may be in any part of the record.							3
	10) The mental health assessment shall be updated annually by the QMHP who has, at a minimum, one face-to-face contact with the client to complete the updated mental health assessment. The annual update must occur within 12 months after the LPHA's original signature on the mental health assessment report or the previous update. The QMHP shall be responsible for the completed update as documented by his or her dated original signature with credentials on the updated mental health assessment. The LPHA shall review and approve the assessment as documented by the LPHA's dated original signature with credentials on the updated mental health assessment. MHPs may participate in the mental health assessment update.	G: There must be written documentation that includes the LPHA's original dated signature with credentials within 12 months of the LPHA's original signature on the previous MHA report that indicates the MHA was reviewed. G: The mental health assessment report must include the original dated signature with credentials of the QMHP who has had at least one face-to-face meeting with the client. Face-to-face meeting may be documented by a signed and dated note in the record. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	12) The annual update of the mental health assessment shall minimally include all requirements specified under subsection (a)(5) with the exception of requirements listed under subsections (a)(5)(A), (D), (G) and (H). Providers may include requirements under subsections (a)(5)(A), (D), (G) and (H) as medically necessary and clinically indicated as part of the mental health assessment update. Following review of a requirement, providers may also indicate "no change" where applicable on the mental health assessment update if there has been no change in status. B) Reasons for seeking or being referred for current mental health treatment, including symptoms of mental illness; C) DSM-5 or ICD-10-CM diagnosis; E) Mental status evaluation; F) Client preferences relating to services and desired treatment outcomes; I) Social adjustment and daily living skills; L) Strengths and resources (e.g., education, and vocational skills, current employment and employment history, interests/hobbies, financial and material resources, and supportive social relationships with family and friends, as well as more intrinsic resources, including hope, motivation, self-confidence and sense of belonging within a community of one's peers); O) Summary analysis and, conclusions regarding the medical necessity of services.	G: Sections (B), (C), (E), (F), (I), (L) and (O) are reviewed together here. Annual reassessment must include reassessment of each. Providers may also indicate "no change" where applicable on the mental health assessment update if there has been no change in status. G: For item (C) to be compliant, documents signed and dated prior to October 1, 2015 must reflect a DSM-IV or ICD-9-CM diagnosis. Documents signed and dated on or after October 1, 2015 must reflect a DSM-5 or ICD-10 diagnosis. G: For (O) to be compliant, there must be an analysis of the findings that establishes the medical necessity for Part 132 services.							9
	J) Legal history and status, including guardianship and current court involvement; K) Identification of factors in the current environment that may create threats to the client's personal safety (e.g., gang involvement, domestic violence, elder abuse); M) History of and current alcohol or other substance use, abuse or dependence, and any previous substance use treatment/recovery efforts; N) Client's report on general physical health, including date of last physical examination; and	G: Sections (J), (K), (M) and (N) are reviewed together here. Annual reassessment must include reassessment of each. G: If there is evidence in the record of a "change", then "no change" is not an allowable notation.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	13) Specific documentation of the delivery of mental health assessment service must include a description of the time spent with the client or collateral gathering information	G: Documentation of Mental Health Assessment services must meet this standard as well as the service definition in 132.148a)							3
	b) Psychological Evaluation 1) A psychological evaluation service, if recommended, shall: A) Be completed within 90 days after completion of the MHA report and be documented by the provider consistent with the Clinical Psychologist Licensing Act [225 ILCS 15] using nationally standardized psychological assessment instruments; a master's level professional may assist;	I: If a psychological evaluation was done, review the credentials of whoever signs the psychological evaluation to verify that she/he is a licensed clinical psychologist.							3
	B) Be conducted face-to-face or video conference with the client; and	G: If a master's level professional assists with the psychological assessments, there must also be a face-to-face meeting done by the clinical psychologist.							3
	C) Result in a written report that includes a formulation of problems, tentative diagnosis and recommendations for treatment or services.	I: If any one item is missing, indicate lack of compliance with this standard for that record.							3
	2) Specific documentation of the delivery of psychological evaluation service must identify the specific nationally standardized psychological assessment instruments used.	G: Score documentation of Psychological Evaluation services here for compliance with the definition of the service.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	c) Treatment plan development, review and modification service is a process that results in a written ITP, developed with the participation of the client and the client's parent/guardian, as applicable, and is based on the mental health assessment report and any additional evaluations. The ITP may be known also as a rehabilitation treatment plan or a recovery treatment plan. Active participation by the client and the client's parent/guardian, as applicable, is required for all ITP development, whether it is the initial ITP or subsequent reviews and modifications. The client may choose to actively involve collaterals in the ITP process. Participation by the client and the client's parent/guardian, as applicable, shall be documented in the plan and confirmed by the client's and the parent's/guardian's, as applicable, dated original signature on the ITP. In the event that a client or the client's parent/guardian, as applicable, refuses to sign the ITP, the LPHA, QMHP or MHP shall document the reason for refusal and indicate by his or her dated original signature with credentials on documentation in the record that the ITP was developed with the active participation of the client and the client's parent/guardian, as applicable, and that the client or the client's parent/guardian, as applicable, refused to sign the ITP. 1) The initial ITP shall be completed within 45 days after the completion of the mental health assessment as documented by the LPHA's dated original signature with credentials on the ITP. When an Admission Note or Healthy Kids mental health screen was completed to initiate services, the ITP shall be developed, following the completion of a mental health assessment, within 30 days after the client's date of admission.	G: If an Admission Note or Healthy Kids mental health screen was NOT used to initiate services, determine the number of days between the date of the LPHA original signature on the mental health assessment (MHA) report and the date of the LPHA original signature on the ITP. It must be 45 days or less but not prior to the date of the LPHA original signature on the MHA report. G: If an Admission Note or Healthy Kids mental health screen was used to initiate services, the ITP must be completed within 30 days of the client's admission.							9
		G: Active participation by the client/parent/guardian in the development, review and modification of the ITP must be documented on the ITP. The documentation must include the client/guardian input into the development of goals/objectives or must reference, by date and time, the progress notes that describe the client/guardian's input into the development of goals/objectives. G: For DCFS wards, input by the caseworker and/or foster parent is acceptable as parent/guardian input.							9

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
		G: The MHA report must support the goals in the ITP.							3
	2) A written ITP is a compilation of the following: A) The goals/anticipated outcomes of services; B) Intermediate objectives to achieve the goals; C) The specific Part 132 mental health services to be provided; D) The amount, frequency and duration of Part 132 services to be provided; and E) Staff responsible for delivering services.	G: Specific Part 132 services must be identified in relation to each objective or goal/anticipated outcome. G: Amount means the length of a session (e.g., 1 hour, 30 minutes). Frequency means how often the service will be provided (e.g., 3 times per week, 1 time per month). Duration means for what period of time (e.g. 1 month, 6 weeks) the service will be provided. I: A responsible staff person must be listed by name or in another way that indicates a specific person. A title may be used if it is used by only one person.							3
	3) The ITP shall include a definitive diagnosis that has been determined per the DSM-5 or the ICD-10-CM. If the diagnosis cannot be determined by the time the ITP is completed or a rule out diagnosis is given, the client's clinical record must include the diagnosis determined as a result of additional evaluations recommended in the MHA report within 90 days after completion of the MHA report.	G: Documents signed and dated prior to October 1, 2015 must reflect a DSM-IV or ICD-9-CM diagnosis. Documents signed and dated on or after October 1, 2015 must reflect a DSM-5 or ICD-10 diagnosis. G: If the diagnosis wasn't available at the completion of the MHA, other evaluations needed to provide a definitive diagnosis must be noted in the client record. G: The definitive diagnosis must be determined within 90 days after completion of the MHA. G: The ITP must be modified as necessary based on the definitive diagnosis.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	4) Responsibility for development, review and modification of the ITP shall be assumed by a QMHP as documented by his/her dated original signature with credentials on the ITP. MHPs may participate in the development of the ITP. An LPHA shall provide the clinical direction of mental health services identified in the ITP as documented by his/her dated original signature with credentials on the ITP.	G: The QMHP's original dated signature with credentials must be on the ITP. G: Scanned, photocopied, or faxed representations of original signed documents may be used to demonstrate original signature. Original signature is also interpreted to include documents signed by electronic means such as electronic signature pads, or through a compliant electronic signature policy as outlined in Section 132.85 (f). In all cases, documents must be signed following completion and **may not be pre-signed** by staff, clients, or guardians. Signature stamps are also **not** considered compliant with original signature requirements, unless used as part of documented reasonable accommodations in accordance with the Americans with Disabilities Act. G: An MHP may bill for this service if meeting with the client. I: Do not cite lack of an LPHA signature here. Cite that under 132.145(e).							3
	5) The LPHA and the QMHP shall review the ITP no less than once every 6 months from the date of the LPHA original signature on the most recent ITP to determine if the goals set forth in the ITP are being met and whether each of the services described in the plan has contributed to meeting the stated goals. The ITP shall be modified if it is determined that there has been no measurable reduction of disability or restoration of functional level.	G: Six months is measured from the date of the LPHA's original signature on the previous plan to the date of the LPHA original signature on the next full review. G: The entire plan must be reviewed. G: The review documentation must contain the original dated signature of the LPHA and the QMHP. G: The modifications to the ITP must contain the original dated signature of the LPHA and the QMHP. G: See Guidelines above concerning original signature requirements. I: The LPHA and QMHP may be the same person if the LPHA is acting as the QMHP.							9

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	6) The ITP review shall include continuity of care planning with the client or the client's parent/guardian. The ITP review shall also include an estimated transition or discharge date and identify goals for continuing care.	G: Continuity of care planning is defined as goals related to continued services/natural supports/community involvement to help the client maintain recovery after the client transitions from the current placement/service provider. G: If other documents related to transition/discharge exist in the record, they can be referenced on the ITP review to satisfy this requirement.							3
	7) The results of crisis assessments, reassessments or additional evaluations after the client's ITP is completed shall be incorporated into a modified ITP, if appropriate, within 30 days.	G: If there are re-assessments or additional evaluations after the ITP is completed, and the ITP has not been modified, there must be documentation to explain why.							3
	8) The provider shall explain to the client and/or persons of the client's choosing, which may include a parent/guardian, as applicable and as evidenced by a signed and dated statement by the provider and the client or parent/guardian, the process for the development, review and modification of the contents of the ITP.	G: Documentation must be in record that the process for the development, review and modification of the contents of the ITP has been explained to the client/parent/guardian and persons of the client's choosing.							3
	9) The ITP and all its revisions shall be signed by the parent or guardian if the client is under 12 years of age. If the client is 12 through 17 years of age, the ITP shall be signed by the client and by the parent/guardian, as applicable, unless the client is an emancipated minor. A client 18 years of age or older or an emancipated minor shall sign the ITP. If the client is 18 years of age or older and has been adjudicated as legally incapable, the ITP shall be signed by the legally appointed guardian.	G: The provider must be able to show a good faith effort in trying to obtain the required signatures. Good faith effort may include fax confirmation and mail receipt confirmation. Good faith effort must include a minimum of three attempts during the three months after the ITP is in effect.							3
	10) Pursuant to the Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110], a copy of the signed ITP shall be given to the client and the client's parent/guardian, as applicable. The ITP and documentation that the signed ITP has been provided to the client or parent/guardian shall be incorporated into the client's clinical record.	G: Any client who was not given a copy of their ITP due to clinical contraindication must have been given a copy of their ITP within 30 days of the effective date of the revised rule.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.148 Evaluation and Planning									
	11) Commencement of Services A) Mental health services may be provided concurrently with ITP development if: i) The mental health assessment report is completed, signed and dated by the LPHA or the Admission Note is signed and dated by the QMHP or a Healthy Kids mental health screen completed by a physician is in the client record; ii) The specific Part 132 service is recommended as medically necessary on the completed mental health assessment or Admission Note or Healthy Kids mental health screen; and iii) The specific Part 132 services provided are included in the completed ITP, signed by an LPHA as required by this Part. B) If services are provided prior to completion of the ITP, and the client terminates services before the ITP is completed and signed, the provider must complete the ITP and document that the client terminated services and was unavailable to sign the ITP.	G: This item is scored for services that are provided BEFORE the initial ITP is signed and dated by the LPHA. G: If an ITP is not completed on the same day as the MHA, recommendations for specific Part 132 services must be included in the MHA or those services are not authorized until the ITP is completed. G: Do NOT cite here if the ITP is not completed within the required timeframe. That is cited elsewhere.							9
	12) Specific documentation of delivery of treatment plan development, review and modification service must include a description of the time spent with the client or collateral developing, reviewing or modifying the ITP.	G: Documentation of Individual Treatment Plan Development, Review and Modification services must meet this standard as well as the service def. in 132.148c)							3
Section 132.150 Mental Health Services									
	a) All services defined in this Section shall be provided and terminated in accordance with the following criteria unless exceptions are noted: 1) The services shall be provided: A) Following a mental health assessment or Admission Note, as applicable, and consistent with the client's ITP or Admission Note, as applicable; B) Through face-to-face, video conference or telephone contact as permitted under each specific service; C) To clients, and their families or collaterals, at the client's request or agreement; with groups of clients; or with the client's family or collaterals as it relates to the primary benefit and well being of the client and when related to an assessed need and goal on the client's ITP; and D) Services may be provided on- or off-site, as indicated under the specific service.	G: This item is scored for services that are provided AFTER the initial ITP is signed and dated by the LPHA.							9

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	2) Service termination criteria shall include: A) Determination that the client's acute symptomatology has improved and improvement can be maintained; B) Determination that the client's level of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated; or C) Documentation in the client's clinical record that the client terminated participation in the program.	G: If services to the client have been terminated, there must be documentation in the client record of the reason for termination. G: The reason must be one of these. G: This does not apply to clients leaving one Part 132 service and still participating in other Part 132 services.							3
	b) Crisis intervention services include interventions to stabilize a client in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. A crisis is defined as a deterioration in the level of role functioning of the client within the past 7 days or an increase in acute symptomatology. 1) Crisis intervention services shall be provided to clients who are experiencing a psychiatric crisis and acute symptomatology. For a child or adolescent, a crisis may include events that threaten safety or functioning of the client or extrusion from the family or the community. Children in psychiatric crisis who are believed to be in need of admission to a psychiatric inpatient facility and for whom public payment may be sought, shall be provided with crisis intervention pre-hospitalization screening. The child shall be screened for inpatient psychiatric admission and shall have his or her mental health need assessed, according to the requirements of the SASS (Screening, Assessment and Support Services) Program (59 Ill. Adm. Code 131). 2) Crisis intervention services may be provided prior to a mental health assessment and prior to a mental health diagnosis.	G: The provider's crisis intervention is terminated when the client is hospitalized or is transferred to another setting.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	3) Crisis intervention services shall include an immediate preliminary assessment that includes written documentation in the clinical record of presenting symptoms and recommendations for remediation of the crisis. Crisis intervention services may also include, if appropriate, brief and immediate mental health services or referral, linkage and consultation with other mental health services.	G: There must be documentation identifying who is having a crisis, what the crisis is, and what is going to be done about it. If it is not the client, it is not a billable crisis service. I: A crisis episode may be associated with multiple billings, at least 1 of which must include personal contact with the client unless the crisis is the threat of extrusion of a child or adolescent from the family or community.							3
	4) The preliminary assessment shall be incorporated into the mental health assessment and ITP, as applicable.	G: If a client enters the service system through a crisis, the preliminary assessment must be incorporated into the ITP.							3
	5) Crisis intervention services shall be delivered by at least an MHP with access to a QMHP who is available for immediate consultation and clinical supervision.	G: The notes documenting the crisis intervention services must be signed and dated by at least an MHP. If services are provided by an MHP, there must be an on-call list of QMHP(s) available 24 hours/day, 7 days/week.							3
	6) During regular hours of operation, the provider shall be able to provide immediate face-to-face or video conference crisis intervention services. Outside regular hours of operation, the provider shall be able to provide, at a minimum, crisis assessment and referral to mental health services, as necessary.	G: If the provider does not have its own 24-hour response capability, there must be a written agreement with another provider certified under Part 132 for this capability. I: Ask the provider how they respond to a crisis outside normal business hours.							1
	7) Specific documentation of the delivery of crisis service must include a preliminary assessment, a description of the intervention and the client response to service.	G: Only score here the description of the intervention and the client response. Score description of preliminary assessment above in 150b)3.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	c) Psychotropic medication services 1) Documentation requirements A) If prescribed by a physician or an advanced practice nurse, employed by or on contract with the provider, there shall be evidence that psychotropic medication has been prescribed by the physician or advanced practice nurse per the collaborative agreement that includes physician-delegated prescription authority.	I: If psychotropic medications are prescribed by an advanced practice nurse employed by or on contract to the provider, verify that the nurse's collaborative agreement with a physician authorizes prescribing. G: Section 132.150(c)(1)(A) - (C) requirements apply only when the physician or advanced practice nurse is employed by or is on contract to the provider. G: Provider must have a copy of the collaborative agreement.							3
	B) If a physician is employed by or on contract with the provider, there shall be evidence that psychotropic medication is reviewed at least every 90 days by a physician or advanced practice nurse.	G: There must be a note, describing the review of the psychotropic meds, signed and dated by the physician or advanced practice nurse every 90 days. The client need not be present.							3
	C) Notations shall be made in the client's clinical record regarding psychotropic medication and other types of medication. Notations shall include: i) All medication prescribed for the client; ii) Current psychotropic medication: name, dosage, frequency and method of administration; iii) Any problems with psychotropic medication administration and changes implemented to address these problems; iv) A statement indicating that the client has been informed of the purpose of the psychotropic medication ordered and the side effects of the medication; and v) Assessment of the client's ability to self-administer medications.	G: All medications, psychotropic and non-psychotropic, taken by the client, must be listed in the client's record. G: For each psychotropic medication, each element must be noted. For method of administration, if noted as # of tablets, it is presumed to be oral medication. G: If any problems are noted with any of the psychotropic medications, the provider must have documentation of activities implemented to address them. G: There must be a statement for each psychotropic medication taken, by name of the specific medication. A new statement is not needed when a specific medication dosage is being adjusted. G: There must be a statement in the record of the client's ability to self-administer medications. G: The physician, advanced practice nurse or designated staff is responsible for the conditions stated in Section 132.150(c)(1)(C).							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	2) Psychotropic and other medication shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security and in accordance with the Department of Public Health's rules at 77 Ill. Adm. Code 300.1640.	G: This condition applies only when medications are stored at a certified site. I: Verify compliance during site inspections.							3
	3) Psychotropic medication administration service A) Psychotropic medication administration consists of preparing the client and the medication for administration, administering psychotropic medications, observing the client for possible adverse reactions, and returning the medication to proper storage. B) Psychotropic medication administration services must be provided face-to-face.	G: For the purposes of Part 132 services, medication administration relates only to psychotropic medication. G: Drawing blood per a specified protocol (related to psychotropic medication) may be permitted as medication administration. G: Documentation must meet the service definition indicated here.							3
	C) Psychotropic medication shall be administered by personnel licensed to administer medication pursuant to the Nurse Practice Act [225 ILCS 65] or the Medical Practice Act of 1987 [225 ILCS 60].	I: If done by an LPN, check for RN supervision (e.g., organizational chart).							3
	D) Specific documentation of the delivery of psychotropic medication administration service must include a description of the activity.	G: Documentation is scored above in 150c)3).							
	4) Psychotropic medication monitoring services A) Psychotropic medication monitoring includes observation and evaluation of target symptom response, adverse effects, including tardive dyskinesia screens, and new target symptoms or medication. This may include discussing laboratory results with the client. B) Psychotropic medication monitoring may be provided face-to-face or using videoconferencing, with one exception. Phone consultation is allowed for psychotropic medication monitoring when a client is experiencing adverse symptoms from psychotropic medication and phone consultation with another professional is necessary.	G: Telephone contact between professionals is acceptable. G: This does not include watching a client self-administer his/her medications or determining whether a client has taken medication. G: Group psychotropic medication monitoring is not permitted. G: Score documentation of this service here.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	C) Psychotropic medication monitoring shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement. The authorized staff shall not provide the service prior to the date of the signature.	G: If a physician, RN or LPN does not do the medication monitoring, the provider must have a written list of staff, by name, authorized to do medication monitoring, signed and dated by the physician or advanced practice nurse. This physician/advanced practice nurse does not have to be the same as the one prescribing the service. I: If the written list of staff is signed by the advanced practice nurse, the collaborative agreement between the physician and the advanced practice nurse must specify the advanced practice nurse has the authority to delegate this responsibility.							3
	D) Specific documentation of the delivery of psychotropic medication monitoring service must include a description of the intervention.	G: Documentation is scored above in 150c)4)A).							
	5) Psychotropic medication training service A) Psychotropic medication training includes training the client or the client's family or guardian to administer the client's medication, to monitor proper levels and dosage, and to watch for side effects. B) Psychotropic medication training may be provided face-to-face or using video conferencing.	G: Psychotropic medication training can be provided in a group setting. G: Psychotropic medication training is limited to psychotropic medication.							3
	C) Psychotropic medication training shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement.	G: If a physician, RN or LPN does not do the medication training, the provider must have a written list of staff, by name, authorized to do medication training, signed and dated by the physician or advanced practice nurse. The authorized staff may not provide the service prior to the date of the signature. This physician/advanced practice nurse does not have to be the same as the one prescribing the service.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	D) Psychotropic medication training shall be provided to clients in the following areas: i) Purpose of taking psychotropic medications; ii) Psychotropic medications, effects, side effects and adverse reactions; iii) Self-administration of medications; iv) Storage and safeguarding of medications; v) Communicating with professionals regarding medication issues; or vi) Communicating with family/caregivers regarding medication issues.	G: When documented, discussions with a client regarding any of these topics pertaining to psychotropic medication are considered medication training.							3
	E) Services may be provided individually or in a group setting. F) Specific documentation of the delivery of psychotropic medication training service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response, and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3
	d) Therapy/counseling service is a treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Services shall be provided face-to-face, by telephone or videoconference. 1) Therapy/counseling services may be provided to: A) An individual client; B) A group of 2 or more clients; or C) A family, including parents, spouses and siblings (client need not be present).	G: The terms "therapy" and "counseling" can be used interchangeably or jointly. G: Activities of daily living skill training are not billable as therapy/counseling. (See community support - individual services (132.150(e) or psychosocial rehabilitation services (132.150(i).)							3
	2) Therapy/counseling services shall be provided by at least an MHP.	G: All notes must be signed by at least an MHP.							3
	3) Specific documentation of the delivery of therapy/counseling services must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	e) Community Support − CS service 1) Community Support − Services are mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. CS services help clients develop and practice skills in their home and community. 2) Service activities and interventions shall include: A) Assistance with identifying, coordinating and making use of individual strengths, resources, preferences and choices in natural settings; B) Assistance with identifying and developing existing and potential natural support persons and teams; C) Assistance with the development of crisis management plans; D) Assistance with identifying risk factors related to relapse, developing wellness plans and strategies and incorporating the plans and strategies into daily routines in one's natural environments; E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning and facilitating learning to do this for oneself; F) Support and consultation to the client or his/her collaterals that is directed primarily to the well-being and benefit of the client; G) Skill building and identification and use of adaptive and compensatory strategies to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness;. H) Assistance with applying skills and strategies learned from provider-based services and interventions to life activities in natural settings; and I) Identification and assistance with modifying habits and routines to improve and support mental health, resiliency and recovery.	G: Natural supports are generally persons identified by the client who are not paid to provide support, e.g., family, friends, pastor. G: Community resources are generally organizations identified and used by the client outside the provider that are also used by persons who are not clients, e.g., church, YMCA, library.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	3) Program requirements A) CS services shall be provided face-to-face, by telephone or by video conference. B) CS services may be provided to: i) An individual client; ii) A group of 2 to 15 clients; or iii) A family, including parents, spouses and siblings (client need not be present).	G: There must be a roster of clients participating in each group. Group size cannot exceed 15 clients.							3
	C) A minimum of 60% of all Community Support services must be delivered in natural settings. This requirement will be monitored in the aggregate for a provider for an identified billing period separately for community support individual and community support group, but will not be required for each individual.	G: Score community support individual here.							9
		G: Score community support group here.							9
	D) CS services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community involvement.	G: Points will be deducted when evidence is seen in the file that clients are taken out of natural activities, e.g., work, school, to participate in community support services.							3
	4) Staffing requirements CS services shall be delivered by at least an RSA.								3
	5) Specific documentation of the delivery of community support service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	f) Community Support − Residential (CSR) service 1) Community Support − Residential services consist of mental health rehabilitation services and supports for children, adolescents and adults necessary to assist individuals in achieving rehabilitative, resiliency and recovery goals. The service consists of interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources for individuals who reside in sites designated by the public payer. 2) Interventions shall include those described in subsection (e) and (f).	I: Only covers interventions listed in subsection e) as follows: 1) Community Support − Services are mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. CS services help clients develop and practice skills in their home and community. 2) Service activities and interventions shall include: A) Assistance with identifying, coordinating and making use of individual strengths, resources, preferences and choices in natural settings; B) Assistance with identifying and developing existing and potential natural support persons and teams; C) Assistance with the development of crisis management plans; D) Assistance with identifying risk factors related to relapse, developing wellness plans and strategies and incorporating the plans and strategies into daily routines in one's natural environments; E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning and facilitating learning to do this for oneself; F) Support and consultation to the client or his/her collaterals that is directed primarily to the well-being and benefit of the client;							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
		G) Skill building and identification and use of adaptive and compensatory strategies to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness;. H) Assistance with applying skills and strategies learned from provider-based services and interventions to life activities in natural settings; and I) Identification and assistance with modifying habits and routines to improve and support mental health, resiliency and recovery.							Scored above
	3) CSR services shall be provided face-to-face, by telephone or by video conference in group or individual settings. Groups shall be composed of no more than 15 clients. 4) Eligibility criteria − Individuals eligible for CSR shall include individuals whose mental health needs require active assistance and support to function independently as developmentally appropriate within home, community, work and/or school settings and who are in public payer designated residential settings.	G: For DCFS, this service is provided in a DCFS approved living arrangement as evidenced by a CFS906 in the client record. G: For DMH, this service may be provided only in CILA (program code 620), 24-hour supervised (program code 830) and crisis (program code 860) residential sites. G: There must be a roster of clients participating in each group. Groups shall be composed of no more than 15 clients.							3
	5) Staffing requirements − CSR services shall be delivered by at least an RSA.								3
	6) Specific documentation of the delivery of community support – Residential service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	g) Community Support − Team (CST) service 1) Community Support − Team services consist of mental health rehabilitation services and supports available 24 hours per day and 7 days per week for children, adolescents, families and adults to decrease hospitalization and crisis episodes and to increase community functioning in order for the client to achieve rehabilitative, resiliency and recovery goals. The service consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources. 2) Interventions shall include those described in subsections (d) and (e)(2).	G: Natural supports are generally persons identified by the client who are not paid to provide support, e.g., family, friends, pastor. G: Community resources are generally organizations identified and used by the client outside the provider that are also used by persons who are not clients, e.g., church, YMCA, library. G: 132.150e) contains the following examples of activities and interventions provided in this service and are not all required to be provided to each client. 2) Service activities and interventions shall include: A) Assistance with identifying, coordinating and making use of individual strengths, resources, preferences and choices in natural settings; B) Assistance with identifying and developing existing and potential natural support persons and teams; C) Assistance with the development of crisis management plans; D) Assistance with identifying risk factors related to relapse, developing wellness plans and strategies and incorporating the plans and strategies into daily routines in one's natural environments; E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning and facilitating learning to do this for oneself; F) Support and consultation to the client or his/her collaterals that is directed primarily to the well-being and benefit of the client;							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
		G) Skill building and identification and use of adaptive and compensatory strategies to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness;. H) Assistance with applying skills and strategies learned from provider-based services and interventions to life activities in natural settings; and I) Identification and assistance with modifying habits and routines to improve and support mental health, resiliency and recovery. G: 24/7 may be demonstrated through written staffing schedules, written interagency/program agreements, notification to clients of crisis alternatives, etc.							Scored above
	3) Program requirements A) CST services shall be provided face-to-face, by telephone or by video conference to an individual or family member; B) A minimum of 60% of all Community Support Team services must be delivered in natural settings. This requirement will be monitored in the aggregate for a provider for an identified billing period but will not be required for each individual client.	I: From an MIS printout of CST services provided on-site and off-site, determine that off-site services are at least 60% of the total services provided for the preceding 12 months.							9
	C) CST services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community involvement;	G: Points will be deducted when evidence is seen in the file that clients are taken out of natural activities, e.g., work, school, to participate in community support services.							3
	D) CST shall maintain a client-to-staff ratio of no more than 18 clients per full time equivalent staff;	I: Get a staffing roster listing percent of work time dedicated to CST. Get a list of clients served in CST. Compare to verify that there are no more than 18 clients to 1 FTE staff.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	E) Documentation shall demonstrate that more than one member of the team is actively engaged in the direct service to the individual.	G: Provider is compliant if at least 2 CST staff have written notes documenting the provision of CST services during the review period.							3
	F) The CST shall conduct organizational staff meetings at least one time per week at regularly scheduled times, according to a schedule established by the team leader.	G: The team leader shall maintain meeting minutes that include participant names, date of meeting and topics of discussion. G: Provider will maintain and share with team members the meeting schedule.							3
	4) Eligibility criteria Individuals eligible for CST services are those who require team-based outreach and support for their moderate to severe mental health symptoms and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services. A less intensive service must have been tried and failed or must have been considered and found inappropriate at this time. The individual must exhibit 3 or more of the following, or must currently be residing in a DMH residential setting or in a DCFS residential substitute care living arrangement from which transition to a less restrictive setting is imminent and, were it not for living in one of these settings, be reasonably expected by history to exhibit 3 or more of the following: A) Multiple and frequent psychiatric inpatient readmissions, including long term hospitalization; B) Excessive use of crisis/emergency services with failed linkages; C) Chronic homelessness; D) Repeat arrest and re-incarceration; E) History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow-through, taking medications, following a crisis plan, or maintaining housing; F) High use of detoxification services (e.g., 2 or more episodes per calendar year); G) Medication resistance due to intolerable side effects or the individual's illness interfering with consistent self-management of medications;	G: The client's record will document that at least 3 of the items in this list have been exhibited or that the client is currently residing in a DMH residential setting or in a DCFS residential substitute care living arrangement from which transition to a less restrictive setting is imminent and, were it not for living in one of these settings, be reasonably expected by history to exhibit 3 or more of the items in the list.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	H) Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated and supportive interventions; I) Because of behavioral health issues, the child or adolescent is at risk of out-of-home placement, is currently in out-of-home placement and reunification is imminent, is currently in out-of-home placement and at risk of residential placement, or is in residential placement and transition to a less restrictive placement is imminent; J) Clinical evidence of suicidal ideation or gesture in the last 3 months; K) Ongoing inappropriate public behavior within the last 3 months, including public intoxication, indecency, disturbing the peace, etc.; L) Self-harm or threats of harm to others within the last 3 months; or M) Evidence of significant complications such as cognitive impairment, behavioral problems or medical problems.								Scored Above
	6) Staffing requirements CST services shall be delivered by: A) A team approved by the public payer or its designee; B) A full-time team leader who is at least a QMHP and serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; C) An RSA or MHP who works under the supervision of the QMHP and who works on the team in sufficient full-time equivalents to meet the required client-to-staff ratio; D) At least one member of the team who is a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP) in a program for children and adolescents. This staff person is a fully integrated CST member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making; and E) No fewer than 3 full-time equivalent staff meeting the required team components (shall include the team leader) and no more than 6 full-time equivalent staff totaling no more than 8 different staff.	I: Have provider produce documentation of public payer or designee approval of team. G: On list of CST staff, there must be at least 1 full-time QMHP designated as the team leader. G: There must be CST service notes in the client records signed by the designated QMHP team leader. G: There must be at least 2 other FTE staff designated as members of the team. G: The provider must have at least one member of the team who is a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP) in a program for children and adolescents by February 1, 2014, for existing staff and 12 months after hire for new staff.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	7) Service exclusions When a client is receiving CST, CSI and CSR shall not be provided except under the following conditions: A) In accordance with an ITP to facilitate transition to and from CST services; or B) While a client is receiving services in a residential facility designated by the public payer for the purpose of stabilizing a crisis.								3
	8) Specific documentation of the delivery of community support – Team service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3
	h) Assertive Community Treatment (ACT) 1) ACT is an intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medications as well as restore personal care, community living and social skills. 2) Interventions The ACT team shall assume responsibility for assisting the client to achieve improved community functioning, by providing: A) Comprehensive assessment; B) Individualized treatment and recovery planning; C) Service coordination; D) Crisis assessment and service;								3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	3) Program requirements A) ACT shall be provided face-to-face, by telephone or by video conference. B) ACT services shall be available 24 hours per day, seven days per week, with emergency response coverage, including psychiatric coverage. Crisis services shall be available 24 hours per day, seven days per week.	G: All ACT notes must be signed by an ACT team member unless transition is documented. G: Provider must have documentation of on-call coverage 24/7.							3
	C) A minimum of 75 percent of all team contacts shall occur in natural settings.	I: From and MIS printout of ACT services provided on-site and off-site, determine that off-site services are at least 75% of the total services provided for the preceding 12 months.							9
	D) A minimum of three contacts per week shall be provided to most ACT clients and all clients shall receive a minimum of four face-to-face contacts per month.	G: 51% of ACT clients receive 3 or more ACT service incidents/week for the preceding 12 months. G: In records reviewed for clients receiving ACT services, verify that 4 face-to-face contacts have been made for each month in the preceding 12 months.							9
	E) The ACT team shall conduct organizational staff meetings at least four times per week at regularly scheduled times, according to a schedule established by the team leader.	I: Must see a sign-in sheet and meeting notes for each meeting.							1
	4) Eligibility criteria A) Adults who require assertive outreach and support in order to remain connected with necessary mental health and support services and to maintain stable community living and who have not benefitted from traditional services and modes of delivery as evidence by any of the following: i) Multiple and frequent psychiatric inpatient readmissions;	G: All clients in ACT must have written authorization from DHS for participation in ACT.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	ii) Excessive use of crisis/emergency services with failed linkages; iii) Chronic homelessness; iv) Repeat arrests and incarcerations; v) Client has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers; vi) Client exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or vii) Client has persistent or severe psychiatric symptoms, serious behavioral difficulties, a mentally ill/substance abuse diagnosis, and/or high relapse rate. B) DHS shall authorize ACT services for eligible individuals.								Scored Above
	5) Staff qualifications A) Each ACT team shall be approved by the public payer or its designee. B) Each ACT team shall consist of a least six full-time equivalent staff. The psychiatrist and program assistant shall not be counted toward meeting the 6 full-time equivalent requirement. All teams are required to minimally consist of: i) A full-time leader who is the clinical and administrative supervisor of the teams and also functions as an ACT clinician. The team leader shall be a licensed clinician. ii) A psychiatrist who works on a full or part-time basis for a minimum of ten hours per week with the ACT team for up to 60 enrolled clients. With a waiver by the public payer, an Advanced Practice Nurse may substitute for up to half of the psychiatrist's time;	I: Have provider produce documentation of public payer or designee approval of team. G: List of ACT team members must show at least 6 FTE staff in addition to a psychiatrist and program assistant. G: Look for team leader's license in personnel file. G: Look at list of clients enrolled in ACT and verify documentation that psychiatrist works at least 10 hours for every 60 clients on the list. G: If an advance practice nurse substitutes, look for written waiver from DMH or its agent. G: A nurse must be a team member and there must be ACT service notes signed by the nurse as the deliverer of service.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	iii) A full-time registered nurse who provides services to all ACT team enrollees and who works with the ACT team to monitor each client's clinical status and response to treatment. The registered nurse functions as a primary practitioner on each ACT team for a caseload of clients. Existing ACT providers may use an LPN with two years experience in mental health services as part of an ACT team until July 1, 2007. After that date, a registered nurse is required as a member of the ACT team. New ACT providers shall be required to utilize an RN on all ACT teams. iv) Four full-time staff who work under the supervision of a licensed clinician and function as primary practitioners for a caseload of clients and who provide rehabilitation and support functions; and v) A program/administrative assistant who is responsible for organizing, coordinating and monitoring all non-clinical operations of ACT.									Scored Above
	C) At least one of the members of the core team shall have special training and certification in substance abuse treatment and/or treating clients with co-occurring mental health and substance abuse disorders.	I: Have team leader indicate which member of the team has special training or certification. G: The team member specified for (B), (C) and (D) may be the same person. G: Evidence of special training OR certification is acceptable.							3
	D) At least one of the members of the team shall be an individual qualified as a Certified Recovery Support Specialist (CRSS). This staff person: i) is a fully integrated ACT team member who provides consultation to the ACT team and highly individualized services in the community, and who promotes self-determination and decision making; and. ii) as of January 1, 2012, shall have six months to become certified as a CRSS, if not already certified.	I: Have team leader indicate which member of the team is an individual in recovery. G: Self-disclosure is sufficient documentation. G: The team member specified for (B), (C) and (D) may be the same person. G: Certified Recovery Support Specialist (CRSS) will need to be part of the ACT team by February 1, 2014, for existing staff and 12 months after hire for new staff.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	E) At least one member of the core team shall have special training in rehabilitation counseling, including vocational, work readiness and educational support.	I: Have team leader indicate which member of the team has special training. G: Evidence of training in any vocational area is acceptable.							3
	F) Each team shall be expected to maintain a staff to client ratio of no more than one full time staff per ten clients, which shall not include the psychiatrist and program assistant. As the number of clients increase, ACT teams shall add staff to maintain the required ratio.	G: Each client receiving ACT services must be assigned to a specific team. I: Compare staff team lists and client team lists for each team to determine ratio.							1
	6) Services may be provided following a determination of eligibility for ACT services and may commence prior to the completion of a mental health assessment and the ITP when immediate assistance is needed to obtain food, shelter or clothing.								1
	7) Service exclusions When a client is receiving ACT, other Part 132 services shall not be provided except under the following conditions: A) In accordance with an ITP to facilitate transition to and from ACT services; and B) While a client is admitted to a residential facility designated by the public payer for the purpose of stabilizing a crisis for a maximum of 30 days.	I: If billings indicate service billed in addition to ACT, verify that they were billed in accordance with (A) or (B). G: An ACT identified client may not be provided non-ACT mental health case management services.							1
	8) Specific documentation of the delivery of ACT service must include a description of intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							**3**

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	i) Psychosocial Rehabilitation service 1) Psychosocial rehabilitation services (PSR) are facility-based rehabilitative skill-building services for adults age 18 and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The PSR interventions focus on identification and use of recovery tools and skill building to facilitate independent living and adaptation, problem solving and coping skills development. The service is intended to assist clients' ability to: A) Live as independently as possible; B) Manage their illness and lives with as little intervention as possible; and C) Achieve functional, social, educational and vocational goals.	G: Facility-based means all PSR services are provided at the provider's certified sites. If any PST services are provided off-site no points are awarded for this standard. G: PSR is an adult only service.							3
	2) Psychosocial rehabilitation services shall include the following service interventions and activities to assist the client in achieving improved community functioning: A) Identification and use of strengths and recovery tools and strategies to overcome challenges, improve mental health and develop skills; B) Individual or group skill building interventions that focus on the development of skills to be used by clients in their living, learning, social and working environments, which includes: i) Socialization, communication, adaptation, problem solving and coping; ii) Self-management of symptoms or recovery; iii) Concentration, endurance, attention, direction following, planning and organization; and iv) Establishing or modifying habits and routines; C) Cognitive behavioral intervention; D) Interventions to address co-occurring psychiatric disabilities and substance abuse; E) Promotion of self-directed engagement in leisure, recreational and community social involvement; and F) Client participation in setting individualized goals and assisting his or her own skills and resources related to goal attainment.								3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	3) Program requirements A) Psychosocial rehabilitation services shall be provided in an organized program through individual and group interventions;	G: There must be a schedule or calendar of program activities available.							1
	B) Services may be provided during day, evening and weekend hours;								1
	C) Each psychosocial rehabilitation services provider shall designate a staff member to assist in assessing client needs and progress toward achievement of treatment goals and objectives.	I: Ask supervising or directing Q who has been designated to do this.							1
	4) Staff qualifications A) Each psychosocial rehabilitation program shall have a clinical supervisor or program director who is at least a QMHP;								1
	B) PSR services shall be provided by at least an RSA.								1
	C) The clinical supervisor or program director shall be on-site at least 50 percent of the time. If a provider has multiple sites, the clinical supervisor or program director must be able to document a consistent schedule that includes on-site time at each location; D) When the clinical supervisor is not physically onsite, the clinical supervisor or designated QMHP shall be accessible to psychosocial rehabilitation staff;	I: Review schedule for Q. I: Obtain statement of # of hours program operates and compare to the Q's schedule to verify 50% of time spent on-site. I: Verify that the schedule includes time at all sites for which the Q is responsible and that the schedule is followed. Documentation may be a sign-in sheet, a note describing what was done on-site, etc. G: There must be an on-call policy and schedule.							1
	E) Each psychosocial rehabilitation program shall include at least one staff person with documented experience or training to provide services and interventions to clients with co-occurring psychiatric and substance abuse disorders; and	I: Look for evidence that indicates that at least one PSR staff person has training or experience.							1
	F) The staffing ratio for groups shall not exceed one full-time equivalent staff to 15 clients.	G: There must be a roster of clients and staff participating in each group.							1
	5) Service exclusions Psychosocial rehabilitation services shall not be provided in combination with any of the following services: A) Intensive outpatient; or B) Hospital-Based Psychiatric Clinic Service Type B.	I: If billings indicate Intensive Outpatient billed in addition to PSR, cite violation here and disallow billings for Intensive Outpatient.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.150 Mental Health Services									
	6) Specific documentation of the delivery of psychosocial rehabilitation service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.	G: Score the intervention, the client's response and progress here. G: Progress statement must include an assessment of progress toward the goal/objective that was worked on during the service as well as the reason for that assessment.							3
	j) Mental health intensive outpatient services are scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week.	G: There must be a written schedule of sessions available at least 4 hours per day, 5 days per week. This does not mean the client must be in programming all that time. If a provider is certified for PSR and intensive outpatient services, each service must have a separate and distinct schedule.							1
	1) Mental health intensive outpatient services are for clients at risk of, or with a history of, psychiatric hospitalization who currently have ITP objectives to reduce or eliminate symptoms that have, in the past, led to the need for hospitalization.	G: For "at risk" there must be evidence in the client record that without this service the client would be hospitalized.							3
	2) Services shall be provided by at least a QMHP.	G: All notes must be signed by at least a QMHP.							3
	3) Mental health intensive outpatient services shall be provided with a staff to client ratio that does not exceed 1:8 for adults and 1:4 for children and adolescents. For purposes of this subsection (l) only, a child or adolescent is defined as any individual who is 17 years of age or younger. 4) Services shall be provided on a face-to-face or video conference basis.	G: Groups may not have more than 8 adults per staff person or 4 children or adolescents per staff person. G: Service cannot be provided by telephone.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.165 Case Management Services									
	a) **Mental health case management** services include assessment, planning, coordination and advocacy services for clients who need multiple services and require assistance in gaining access to and in using mental health, social, vocational, educational, housing, public income entitlements and other community services to assist the client in the community. Case management activities may also include identifying and investigating available resources, explaining options to the client and linking them with necessary resources. 1) Mental health case management services shall be provided following a mental health assessment and be authorized consistent with the client's ITP or Admission Note, with the following exceptions: A) Case management provided during the 30 days immediately preceding completion of the assessment. B) The client has refused all other appropriate services under this Part.	G: The client does not have to be physically present G: Case management services during the 30 days immediately preceding the dated signature of the LPHA on the MH assessment report may be provided prior to the completion of the mental health assessment report or, if applicable, an Admission Note. I: If case management is provided and is not on the ITP, it must meet one of these criteria.							3
	2) Mental health case management services shall be provided by at least an RSA.	G: All notes must be signed by at least an RSA.							3
	3) Specific documentation of the delivery of mental health case management service must include a description of the activity.	G: Documentation is scored above in 165a).							
	b) **Client-centered consultation** services are individual client-specific professional communications among provider staff, or between provider staff and staff of other agencies who are involved with service provision to the client. The professional communication shall include offering or obtaining a professional opinion regarding the client's current functioning level or improving the client's functioning level, discussing the client's progress in treatment, adjusting the client's current treatment, or addressing the client's need for additional or alternative mental health services.	G: Professional foster parents who are staff members can be included in client-centered consultation services, provided that the documentation of the consultation with the professional foster parents meets all requirements in 132.165b)1-4) [consulted as professionals not as parents].							3
	1) Services must be provided in conjunction with one or more mental health services identified in this Part and in accordance with the ITP. 2) Client-centered consultation does not include advice given in the course of clinical staff supervision activities, in-service training, treatment planning or utilization review and may not be billed as part of the assessment process. 3) Client-centered consultation services shall be provided by at least an RSA.	G: This service must be included in the ITP. There is no allowance for provision of the service prior to its inclusion in the ITP. G: At least one other service listed in Section 132.150 must be included in the ITP.							3

Pts U =	**Pts =**

Deemed	STANDARD	GUIDELINES & INSTRUCTIONS	F	S	M	N	U	Pts	Tot
Section 132.165 Case Management Services									
	4) Specific documentation of the delivery of mental health client-centered consultation service must include a description of the consultation that occurred, the professional consulted, and the resulting recommendations.	G: Score here if the documentation included the professional that was consulted and the recommendations that were made.							3
	c) **Transition linkage and aftercare** services shall be provided to assist in an effective transition in living arrangements consistent with the client's welfare and development. This includes discharge from inpatient psychiatric care (in Institutions for Mental Diseases (IMD), general hospitals and nursing facilities), transition to adult services, and assisting the client or the client's family or caretaker with the transition. 1) Transition linkage and aftercare services may consist of: A) Planning with staff of a client's current or receiving living arrangements (including foster or legal parents as necessary); B) Locating placement resources; C) Arranging/conducting pre- or post-placement visits; D) Developing an aftercare services plan; or E) Planning a client's discharge and linkage from an inpatient psychiatric facility, including an IMD or nursing facility, for continuing mental health services and community/family support.	I: Notes must indicate what transition is occurring, e.g., problem-solving issue with the client, client's caretaker, family members, or collaterals regarding the transition; visits to college and independent living arrangements. G: Activities must be related to client transition. G: Transition linkage and aftercare may be provided based on the treatment plan of the referring agency/facility.							3
	2) Transition linkage and aftercare services shall be provided by at least an MHP.	G: All notes must be signed by at least an MHP.							3
	3) Specific documentation of the delivery of mental health transition linkage and aftercare service must include a description of the activity.	G: Documentation is scored above in 165c).							

Pts U =	**Pts =**

Summary

Total of all Possible Points _____
- Total Points for U ____ _____
Total Points Available for This Survey = _____
Total Points Awarded _____
Percent Compliance _____ (Total Points Awarded / Total Points Available x 100 = % Compliance)
Level Award for this Survey Level _____

Level 1 = 90 - 100% compliance; Level 2 = 75 - 89% compliance; Level 3 = 50 - 74% compliance; Level 4 = below 50 % compliance

F = Full Compliance (policy is there = 1 point; Records, all reviewed complied) = 3 points (or 9 pts. if standard is worth 9 pts.)
S = Substantial Compliance (51% - 99% of records reviewed complied) = 2 points (or 4 pts. if standard is worth 9 pts.)(Note the number of the record of non-compliant records alongside standard)
M = Minimal Compliance (1% - 50%) = 1 point (Note the number of the record of non-compliant records alongside standard)
N = Non-Compliant (For policy, is not there; For records, none compliant) = 0 points
U = Standard or issue is not applicable
Pts = Points awarded for level of compliance
Tot = Total points possible for full compliance

Staff Records - 10 will be chosen for review.
Client Records - 10 or more will be chosen for review.

(When a citation is made that was also made during the most recent full survey, points will be awarded according to the next lower level, i.e., if no repeat - 4 pts, repeat - 1 pt.; if no repeat 1 pt, repeat - 0 pts.)

Points assigned to standards: 1 point when standard requires a policy, written document, etc. that a provider will either have or not have; 3 points when client or staff records are used to determine compliance with a standard to allow for partial compliance; and 9 points when a client records are used to determine compliance and the standard is critical to the overall provision of services.

Pts U =	**Pts =**