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SAN BERNARDINO COUNTY

Department of Behavioral Health
Alcohol and Drug Services

Quality Assurance Review (Perinatal Specific)

Today's Date:	☐ **Initial**	☐ **Initial + Discharge Review**
Client Name:	**Client ID #:**	**Provider ID #:**
☐ **Medi-Cal**	☐ **Block Grant**	☐ **CalWORKs** ☐ **Perinatal** ☐ **CFS**

Section 1 Admission Documentation		
☐ **Admission Criteria Completed**	☐ **ASI Completed**	
Admission Date:	**Date ITP completed:**	**Date client signed ITP:**
☐ The MD determined the services in the initial treatment plan are medically necessary, and typed or legibly printed their name, and signed and dated the treatment plan within **15** calendar days of signature by the therapist or counselor.		
☐ Counselor/Therapist, Client, and MD's names are typed or legibly printed, signed and dated		
☐ All serious problems identified on ASI are addressed on the ITP		
☐ Problems to be addressed	☐ Random UA's planned	
☐ Goals to be reached	☐ Primary counselor assigned	
☐ Action steps to be taken	☐ MD's DSM IV / ICD-10 code on ITP	
☐ Target dates	☐ Goal to obtain Physical Exam is on ITP	
Counseling services MUST be provided at a minimum of **3** hours per day for **3** days per week:		
☐ Individual counseling provided and the frequency thereof	☐ Group counseling provided and the frequency thereof	
☐ Child Care is Cooperative	☐ Child Care is Licensed	
☐ Children's needs assessment completed.	☐ Transportation (SUD services; employment; Primary medical/pediatric care)	
☐ Therapeutic interventions for children (Developmental needs; sexual abuse; physical abuse; neglect)		
☐ Continued Stay Review needed? Date signed by MD: _____ Coordinator signed: _____		

Section 2 Progress Documentation	
☐ Counselor completed, typed or legibly printed name, signed and dated progress note within **7** days of service	
☐ Topic of session present in note	☐ Description of progress toward problems, goals, action steps, referrals
☐ Date of session present in note	☐ Start and end time of session in note
☐ UA's meet contractual minimum requirements	☐ Individual counseling meets contractual minimum requirements
ITP and client's progress are reviewed as follows:	
☐ Residential (**30** days or less) – Within **10** days of initial ITP and no later than every **10** days thereafter	
☐ Residential (**31** days or more) - Within **14** days of initial ITP and no later than every **14** days thereafter	
☐ Outpatient - Within **30** days of initial ITP and no later than every **30** days thereafter	
☐ Documentation of Case Management (Primary medical/pediatric care; Therapeutic interventions for children)	
☐ Evidenced Based Curriculum (Relationships; sexual and physical abuse; Parenting)	

Section 3 Program Funding Forms		
☐ Episode Opening/CalOMS	☐CalOMS Annual Update (if applicable)	☐Referral form (if applicable)
☐Admission Request Form (if applicable)	☐Checking Medi-Cal eligibility monthly	

Section 4 Physical Status Documentation				
☐ MD reviewed client's personal, medical, substance abuse history within **30** calendar days of admission to TX				
☐ MD confirmed DX within **30** days of admission	☐ Proof of pregnancy w/ Estimated Due Date	☐ Verification of prenatal care ☐Verification of Delivery date (last date of pregnancy)		
Choose (1) Option- ☐ Physical exam reviewed ☐ Physical exam performed ☐ Goal of Physical exam on ITP				
☐ TB Education	☐ TB Screened	☐ TB Referred	☐ TB Tested	☐ AIDS/HIV Education

Section 5 Consent Forms				
☐ Consent to TX	☐ Confidentiality	☐ Personal/Civil Rights	☐ Consent to Follow-up	☐ Fair Hearing
☐ Program Rules	☐ Consent to release PHI properly completed		☐ Fee payment agreement	

Section 6 Discharge Documentation	
Was the discharge involuntary? YES ☐ NO ☐	If YES, date Fair Hearing NOA was mailed:
If NO, was the Discharge Plan completed correctly? YES ☐ NO ☐	Date it was completed:
Was the Discharge Summary completed correctly? YES ☐ NO ☐	Date it was completed:
☐ CalOMS Closing completed?	Discharge Status Standard ☐ Administrative ☐ Discharge Code

☐ Client file in full compliance	☐ Corrective action required	☐ Discharge approved
Corrective actions required:		

Next Individual Treatment Plan due date:	**Next QAR date for this chart:**
Next Justification to Continue Services (Stay Review) is due no sooner than five (5) months and no later than six (6) months from client's admission to treatment date or the date of completion of the most recent justification to continue treatment services. Due between and .	