BAY MILLS INDIAN COMMUNITY
BEHAVIORAL HEALTH DEPARTMENT
QUARTERLY CHART REVIEW

Clinician’s Name: _______________________________________

Program being reviewed: _______________________________________

Chart Number: ___________________________ Date Reviewed: ________

Substance Abuse Checklist
Chart: OPEN CLOSED

- Patient Registration Form
- Beh. Health Participation Policy
- Consent to Treatment/Services
- Advanced Directive Form
- Releases of Information
- HIPPA Permission to Contact
- Copy of Insurance
- Verification of Tribal Membership
- Orientation Checklist
- Referral/Prescreen
- Assessment
- Integrated Summary
- Treatment Plan
- Treatment Plan Review (if applicable)
- Progress Notes
- Case Management Review Form
- Discharge Summary
- Continuing Care Plan
- Quarterly Medication Review
- Coordination of Care
- Proof of Residency

Mental Health Checklist
Chart: OPEN CLOSED

- Patient Registration Form
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- Coordination of Care

Quality of Service
The service, goals and objectives of the person served were:

1. Based on the results of the assessment:
   - Yes ☐ No ☐
2. Addresses strengths, needs, abilities and preferences:
   - ☐
3. Treatment objectives are measurable:
   - ☐
4. Treatment objectives are achievable:
   - ☐
5. Treatment objectives are time limited:
   - ☐
6. Treatment objectives are realistic:
   - ☐
7. Treatment objectives are specific:
   - ☐
If no, please comment:

Actual services delivered were related to the service goals and objectives: Yes No

Chart is legible and has proper corrections, if applicable: Yes No

**Appropriateness of Service**

Measuring time lines for services:

1. Are services provided for a suitable length of time: Yes No
2. Assessment completed within three sessions: Yes No
3. Assessment is typed within 30 days of completion: Yes No
4. Assessment addresses spirituality: Yes No
5. Assessment has a pain screening completed: Yes No
6. Assessment contains a nutritional screening: Yes No
7. Assessment contains a suicide/risk screening: Yes No
8. Treatment plan completed within 10 days of assessment: Yes No
9. Treatment plan review completed, if applicable: Yes No
10. Are progress notes current: Yes No

If no, please comment:

Persons served were actively involved:

1. Did the client/guardian sign the treatment plan: Yes No
2. Were they informed of choices regarding services they received: Yes No

If no, please comment:

CAFAS and BASIS (Mental Health) ASAM (Substance Abuse)

1. What was the person level of functioning score when entering services: Yes No
2. What was the person level of functioning score upon discharge: Yes No
3. Was there an improvement in the quality of life for the person served: Yes No
4. Was Level of Functioning completed quarterly: Yes No
5. Was Level of Functioning completed at discharge: Yes No
If no, please comment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Continuity of Care**

Discharge:  
1. Discharge plan completed  
2. Discharge completed with 30 days of inactivity  
3. Discharge plan described the expectations that have been established and achieved:

If no, please comment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Administrative Review**

Record Review Committee:
1. Has a chart review been done previously:
2. Has the person been presented in a case management meeting:
3. Was the client billed accurately:
4. Was the client billed in a timely manner:
5. Assessment signed by medical director:
6. Treatment plan signed by medical director:

If no, please comment:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are you responsible for the services being provided to this person?  
Yes  No

Was feedback given to the service provider?  
Yes  No

Reviewer

Date

Behavioral Health Services Coordinator

Date
Clinician's Name: _________________________

Program being reviewed: ATR

Chart Number: _________________________ Date Reviewed: _________________________

ATR Chart Checklist

Chart: OPEN   CLOSED

- Client Registration Form
- Authorization for Use and Disclosure of Protected Health Information
- Your Rights
- Informed Consent for Evaluation/GPRA (3 pages)
- Informed Consent for Peer Recovery Support Services
- Document of Client Choice
- AUDIT
- DAST-10
- Client Screening and Assessment Summary form (2 pages)
- GPRA (17 pages)
- Recovery Support Assessment (6 pages)
- Referral
- Clinical Assessment
- Integrated Summary
- Treatment Plan
- Treatment Plan Review (if applicable)
- Progress Notes
- Case Management Review Form
- Discharge Summary
- Releases of Information
- BMIC Access to Recovery Guidelines

Quality of Service

The service, goals and objectives of the person served were:

1. Based on the results of the assessment:  
   - Yes  
   - No

2. Addresses strengths, needs, abilities and preferences:  
   - Yes  
   - No

3. Treatment objectives are measurable:  
   - Yes  
   - No

4. Treatment objectives are achievable:  
   - Yes  
   - No

5. Treatment objectives are time limited:  
   - Yes  
   - No

6. Treatment objectives are realistic:  
   - Yes  
   - No

7. Treatment objectives are specific:  
   - Yes  
   - No
If no, please comment:

________________________________________________________________________

Actual services delivered were related to the service goals and objectives: Yes  No

Chart is legible and has proper corrections, if applicable: Yes  No

**Appropriateness of Service**

Measuring time lines for services:

1. Are services provided for a suitable length of time: Yes  No
2. Assessment completed within three sessions: Yes  No
3. Assessment is typed within 30 days of completion: Yes  No
4. Assessment addresses spirituality: Yes  No
5. Assessment has a pain screening completed: Yes  No
6. Assessment contains a nutritional screening: Yes  No
7. Assessment contains a suicide/risk screening: Yes  No
8. Treatment plan completed within 10 days of assessment: Yes  No
9. Treatment plan review completed, if applicable: Yes  No
10. Are progress notes current: Yes  No
If no, please comment:

________________________________________________________________________

________________________________________________________________________

Persons served were actively involved:

1. Did the client/guardian sign the treatment plan: Yes  No
2. Were they informed of choices regarding services they received: Yes  No
If no, please comment:

________________________________________________________________________

________________________________________________________________________

**CAFAS and BASIS (Mental Health)**

1. What was the person level of functioning score when entering services: __________
2. What was the person level of functioning score upon discharge: __________
3. Was there an improvement in the quality of life for the person served: Yes  No
4. Was Level of Functioning completed quarterly: Yes  No
5. Was Level of Functioning completed at discharge: Yes  No
If no, please comment:

________________________________________________________

________________________________________________________

Continuity of Care
Discharge:
1. Discharge plan completed 
2. Discharge completed with 30 days of inactivity 
3. Discharge plan described the expectations that have been established and achieved:
If no, please comment:

________________________________________________________

________________________________________________________

Administrative Review
Record Review Committee:
1. Has a chart review been done previously: 
2. Has the person been presented in a case management meeting: 
3. Was the client billed accurately: 
4. Was the client billed in a timely manner: 
5. Assessment signed by Program Coordinator: 
6. Treatment plan signed by Program Coordinator: 
If no, please comment:

________________________________________________________

________________________________________________________

Are you responsible for the services being provided to this person? 
Yes No

Was feedback given to the service provider?
Yes No

Reviewer

________________________________________________________

Date

Behavioral Health Services Coordinator

________________________________________________________

Date
Substance Abuse Checklist

Chart: OPEN  CLOSED

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Mental Health Checklist

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- Progress Notes
- Case Management Review Form
- Discharge Summary
- Quarterly Medication Review
- Coordination of Care

Quality of Service

The service, goals and objectives of the person served were: Yes  No

1. Based on the results of the assessment:
   - D D
2. Addresses strengths, needs, abilities and preferences:
   - D D
3. Treatment objectives are measurable:
   - D D
4. Treatment objectives are achievable:
   - D D
5. Treatment objectives are time limited:
   - D D
6. Treatment objectives are realistic:
   - D D
7. Treatment objectives are specific:
   - D D
Actual services delivered were related to the service goals and objectives: Yes  No

Chart is legible and has proper corrections, if applicable: Yes  No

**Appropriateness of Service**

Measuring time lines for services: Yes  No

1. Are services provided for a suitable length of time: □  □
2. Assessment completed within three sessions: □  □
3. Assessment is typed within 30 days of completion: □  □
4. Assessment addresses spirituality: □  □
5. Assessment has a pain screening completed: □  □
6. Assessment contains a nutritional screening: □  □
7. Assessment contains a suicide/risk screening: □  □
8. Treatment plan completed within 10 days of assessment: □  □
9. Treatment plan review completed, if applicable: □  □
10. Are progress notes current: □  □

If no, please comment:

Person served were actively involved: Yes  No

1. Did the client/guardian sign the treatment plan: □  □
2. Were they informed of choices regarding services they received: □  □

If no, please comment:

CAFAS and BASIS (Mental Health) ASAM (Substance Abuse)

1. What was the person level of functioning score when entering services: __________
2. What was the person level of functioning score upon discharge: __________
3. Was there an improvement in the quality of life for the person served: Yes  No
4. Was Level of Functioning completed quarterly: Yes  No
5. Was Level of Functioning completed at discharge: Yes  No
If no, please comment:  

Continuity of Care  
Discharge:  
1. Discharge plan completed  
2. Discharge completed with 30 days of inactivity  
3. Discharge plan described the expectations that have been established and achieved:  
If no, please comment:  

Administrative Review  
Record Review Committee:  
1. Has a chart review been done previously:  
2. Has the person been presented in a case management meeting:  
3. Was the client billed accurately:  
4. Was the client billed in a timely manner:  
5. Assessment signed by medical director:  
6. Treatment plan signed by medical director:  
If no, please comment:  

Are you responsible for the services being provided to this person?  
Was feedback given to the service provider?  

Reviewer  

Behavioral Health Services Coordinator  

Yes  |  No  
---|---

Date  

Date