

This is a sample form developed by the "CCS Statewide QA/QI Work Group", and is available to CCS sites as a sample for consideration of use, modification, and customization. There is no implicit or explicit guarantee that this document meets the requirements for CCS as outlined in DHS 36, Medicaid, or other applicable laws, rules, or regulations. Individual counties and tribes are responsible for developing their own forms and ensuring adherence to all applicable laws, rules, and regulations. The hope is that this working draft is modified based on the experiences and expertise of state, county, and tribal partners, and as new information becomes available.

Comprehensive Community Services (CCS) File Review Checklist – Comprehensive

Consumer Name:	Consumer ID:	Earliest MA Billing Date:	Admission Date:
Service Facilitator:	Date of Review:	Reviewer:	Discharge Date:

SECTION 1: CONSUMER SERVICE RECORD DHS 36.18.

Each consumer record shall be organized in a consistent format and include: (3)

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	1. A legend to explain any symbol or abbreviation used (3)
<input type="checkbox"/>	<input type="checkbox"/>	2. Results of the assessment including the assessment summary. (3a)
<input type="checkbox"/>	<input type="checkbox"/>	3. Initial and updated service plans, including attendance rosters from service planning sessions. (3b)
<input type="checkbox"/>	<input type="checkbox"/>	4. Authorization of services statements. (3c)
<input type="checkbox"/>	<input type="checkbox"/>	5. Any request by the consumer for a change in services or service provider and the response by the CCS to such a request. (3d)
6. Service delivery information, including all of the following: (3e)		
<input type="checkbox"/>	<input type="checkbox"/>	a. Service facilitation notes and progress notes. (3e)1
<input type="checkbox"/>	<input type="checkbox"/>	b. Records of referrals of the consumer to outside resources. (3e)2
<input type="checkbox"/>	<input type="checkbox"/>	c. Descriptions of significant events that are related to the consumer's service plan and contribute to an overall understanding of the consumer's ongoing level and quality of functioning. (3e)3
<input type="checkbox"/>	<input type="checkbox"/>	d. Evidence of the consumer's progress, including response to services, changes in condition and changes in services provided. (3e)4
<input type="checkbox"/>	<input type="checkbox"/>	e. Observation of changes in activity level or in physical, cognitive or emotional status and details of any related referrals. (3e)5
<input type="checkbox"/>	<input type="checkbox"/>	f. Case conference and consultation notes. (3e)6
<input type="checkbox"/>	<input type="checkbox"/>	g. Service provider notes in accordance with standard professional documentation practices. (3e)7
<input type="checkbox"/>	<input type="checkbox"/>	h. Reports of treatment, or other activities from outside resources that may be influential in the CCS's service planning. (3e)8
7. A list of current prescription medication and regularly taken over the counter medications. Documentation of each prescribed medication shall include all of the following: (3f)		
<input type="checkbox"/>	<input type="checkbox"/>	a. Name of the medication and dosage. (3f)1
<input type="checkbox"/>	<input type="checkbox"/>	b. Route of administration. (3f)2
<input type="checkbox"/>	<input type="checkbox"/>	c. Frequency. (3f)3
<input type="checkbox"/>	<input type="checkbox"/>	d. Duration, including the date the medication is to be stopped. (3f)4
<input type="checkbox"/>	<input type="checkbox"/>	e. Intended purpose. (3f)5
<input type="checkbox"/>	<input type="checkbox"/>	f. Name of the prescriber. The signature of prescriber is also required if the CCS prescribes medication as a service. (3f)6
<input type="checkbox"/>	<input type="checkbox"/>	g. Activities related to the monitoring of medication including monitoring for desired responses and possible adverse drug reactions, as well as an assessment of the consumer's ability to self-administer medication. (3f)7
<input type="checkbox"/>	<input type="checkbox"/>	8. Signed consent forms for disclosure of information and for medication administration and treatment. (3g)

9. Legal documents addressing commitment, guardianship, and advance directives. (3h)

10. Discharge summary and any related information. (3i)

11. Any other information that is appropriate for the consumer service record. (3j)

Notes:

SECTION 2: INITIAL PAPERWORK

Prior to billing Medicaid for services, the following initial paperwork must be completed: A) Prescription for Treatment, B) Application for Services, C) Admission Agreement D) Authorization for Services, and EITHER E) Assessment of Initial Needs (DHS 36.13 (2)(b), DHS 36.14(3)(a), DCTS CCS Frequently Asked Questions, page 16) OR F) Determination of Need for Psychosocial Rehabilitation Services (DHS 36.14(3)(a))

A. PRESCRIPTION FOR TREATMENT (MA requirement, not a DHS 36 requirement)

Yes	No	Initial Completion Date:	Updates (if applicable):
<input type="checkbox"/>	<input type="checkbox"/>	1. A prescription for treatment is present	
<input type="checkbox"/>	<input type="checkbox"/>	2. Includes client name, date of birth, date of order, and diagnosis.	
<input type="checkbox"/>	<input type="checkbox"/>	3. Includes Physician's certification/license number (recommended, not required)	
<input type="checkbox"/>	<input type="checkbox"/>	4. Diagnosis on initial functional screen matches the diagnosis on the prescription (recommended, not required)	
<input type="checkbox"/>	<input type="checkbox"/>	5. Signed and dated by prescribing physician	
		6. Physician is enrolled as a participating Medicaid provider	
<input type="checkbox"/>	<input type="checkbox"/>	7. The prescription must be "current". The DCTS FAQ document references Section 49.46(2)(b)6. Lm – "A current prescription is one that has not expired. The physician will determine the expiration date for the prescription for each member."	

Notes:

B. APPLICATION FOR SERVICES (DHS 36.13)

Yes	No	Completion Date:	Due date for Assessment and Plan (30 days):
<input type="checkbox"/>	<input type="checkbox"/>	1. An Application for services is present	
<input type="checkbox"/>	<input type="checkbox"/>	2. Includes date of receipt	

Notes:

C. ADMISSION AGREEMENT (DHS 36.13 (1m)/ DHS 36.19)

Yes	No	Completion Date:	
<input type="checkbox"/>	<input type="checkbox"/>	1. An Admission Agreement is present, and includes all of the following:	
<input type="checkbox"/>	<input type="checkbox"/>	a. The nature of the CCS including the hours of operation (1m) a	
<input type="checkbox"/>	<input type="checkbox"/>	b. How to obtain crisis services during hours in which the CCS does not operate (1m) a	
<input type="checkbox"/>	<input type="checkbox"/>	c. Staff member titles and responsibilities (1m) a	
<input type="checkbox"/>	<input type="checkbox"/>	d. Consumer Rights, including: (1m) b	
<input type="checkbox"/>	<input type="checkbox"/>	e. Patient rights and grievance resolution procedures in s. 51.61, Stats., and ch. DHS 94.19 (1)	
<input type="checkbox"/>	<input type="checkbox"/>	f. Choice in the selection of recovery team members, services, and service providers. DHS 94.19 (1a)	
<input type="checkbox"/>	<input type="checkbox"/>	g. The right to specific, complete and accurate information about proposed services DHS 94.19 (1b)	
<input type="checkbox"/>	<input type="checkbox"/>	h. For Medical Assistance consumers, the fair hearing process under s. DHS 104.01 (5). For all other consumers, how to request a review of a CCS determination by the department. DHS 94.19 (1c)	

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|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 2. The service facilitator shall ensure that the consumer understands the options of using the formal and informal grievance resolution process in s. DHS 94.40 (4) and (5). DHS 94.19 (2) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. An acknowledgement of receipt and understanding of the information received (1m) c |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Signed AND dated by consumer and parent/guardian (if needed). (1m) |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Completed same day as application (1m) |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. HIPAA information (Medical Assistance Requirement) |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Releases of Information (Medical Assistance Requirement) |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Written consent for Functional Screen if consumer is a minor (Medical Assistance Requirement) |

Notes:

D. AUTHORIZATION OF SERVICES (DHS 36.15)

Yes No Completion Date:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Signature of mental health professional indicating they have (1) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Reviewed and attest to the applicant's need for psychosocial rehabilitation services and medical and supportive activities to address the desired recovery goals (1a) |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Authorized the proposed psychosocial rehabilitation services (1b) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. If the applicant has or may have a substance abuse disorder, a substance abuse professional shall also sign the authorization for services. (2) |

Notes:

E. ASSESSMENT OF INITIAL NEEDS (DHS 36.13(2)(b))

DHS 36.14(3)(a) If the department-approved functional screen cannot be completed at the time of the consumer's application, the CCS shall conduct an assessment of the applicant's needs pursuant to s. DHS 36.16 (3) and (4). An assessment conducted under s. DHS 36.16 (3) and (4) may be abbreviated if any one of the conditions under s. DHS 36.16 (5) applies.

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|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. An assessment of initial needs |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Not applicable – Functional Screen completed at time of consumer's application DHS 36.14(3)(a) |

Notes:

F. CRITERIA FOR DETERMINING THE NEED FOR PSYCHOSOCIAL REHABILITATION SERVICES (DHS 36.14)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Completion of a department-approved functional screen (DHS 36.14) <ul style="list-style-type: none"> a. Written consent for Functional Screen if consumer is a minor (Medical Assistance Requirement) b. Documentation of functional eligibility for CCS |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has a diagnosis of a mental disorder or a substance use disorder |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Has a functional impairment that interferes with or limits one or more major life activities and results in needs for services that are described as ongoing, comprehensive and either high-intensity or low-intensity. Determination of a qualifying functional impairment is dependent upon whether the applicant meets one of the following descriptions: <ul style="list-style-type: none"> a. Group 1'. Persons in this group include children and adults in need of ongoing, high-intensity, comprehensive services who have diagnoses of a major mental disorder or substance-use disorder, and substantial needs for psychiatric, substance abuse, or addiction treatment. b. Group 2'. Persons in this group include children and adults in need of ongoing, low-intensity comprehensive services who have a diagnosed mental or substance-use disorder. These individuals generally function in a independent and stable manner but may occasionally experience acute psychiatric crises. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. If an applicant is determined to not need psychosocial rehabilitation services, no additional psychosocial rehabilitation services may be provided to the applicant by the CCS program. |

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|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. The applicant shall be given written notice of the determination and referred to a non-CCS program. |
| <input type="checkbox"/> | <input type="checkbox"/> | b. The applicant may submit a written request for a review of the determination to the department. (3b) |

Notes:

G. FINANCIAL FORM(S) (For MA verification, not a CCS requirement)

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Specific financial forms by County |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Completed same day as admission agreement (recommended) |

Notes:

SECTION 3: RECOVERY TEAM, ASSESSMENT, PLANNING

A. RECOVERY TEAM (DHS 36.16(7))

- | Yes | No | Dates of Recovery Team Meetings: |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Documentation that the consumer was asked to participate in identifying members of the recovery team (7)(a) |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Documentation that the recovery team includes all of the following (7am): |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Consumer (7am)1 |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Service Facilitator (7am)2 |
| <input type="checkbox"/> | <input type="checkbox"/> | c. A mental health professional or substance abuse professional, or both (7am)3 |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Service providers, family members, natural supports and advocates shall be included on the recovery team, with the consumer's consent (7am)4 |
| <input type="checkbox"/> | <input type="checkbox"/> | e. If the consumer is a minor or is incompetent or incapacitated, a parent or legal representative of the consumer (7am)5 |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Documentation that the recovery team participated in the assessment process and in service planning (7b)1 |

Notes:

B. COMPREHENSIVE ASSESSMENT PROCESS (DHS 36.16)

- | Yes | No | Completion Date: | Dates Updated (should coincide with updates to the recovery plan): |
|--------------------------|--------------------------|--|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Completed in 30 days from date of signed application (2a) | |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. If not completed in 30 days from date of signed application, the specific reason was documented | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Documentation that the assessment process was explained to the consumer (2a) | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Substance use diagnosis established by substance abuse professional (2c) | |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Assessment of the consumer's substance abuse, strengths and treatment needs conducted by a substance abuse professional. (2c) | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Assessment process incorporates consumer's unique perspective and own words about how they view their recovery, experience, challenges, strengths, resources and needs in each of the 15 domains included in the assessment process (listed below) (2d) | |
| <input type="checkbox"/> | <input type="checkbox"/> | a. Life Satisfaction (4a) | |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Basic Needs (4b) | |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Social Network and Family Involvement (4c) | |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Community Living Skills (4d) | |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Housing Issues (4e) | |

<input type="checkbox"/>	<input type="checkbox"/>	f. Employment (4f)
<input type="checkbox"/>	<input type="checkbox"/>	g. Education (4g)
<input type="checkbox"/>	<input type="checkbox"/>	h. Finances and Benefits (4h)
<input type="checkbox"/>	<input type="checkbox"/>	i. Mental Health (4i)
<input type="checkbox"/>	<input type="checkbox"/>	j. Physical Health (4j)
<input type="checkbox"/>	<input type="checkbox"/>	k. Substance Use (4k)
<input type="checkbox"/>	<input type="checkbox"/>	l. Trauma and Significant Life Stressors (4l)
<input type="checkbox"/>	<input type="checkbox"/>	m. Medications (4m)
<input type="checkbox"/>	<input type="checkbox"/>	n. Crisis Prevention and Management (4n)
<input type="checkbox"/>	<input type="checkbox"/>	o. Legal Status (4o)
<input type="checkbox"/>	<input type="checkbox"/>	p. Any other domain identified by CCS (4p) (Suggested "Cultural" domain based on 36.16 (3) or (7b)2)
<input type="checkbox"/>	<input type="checkbox"/>	7. Include assessment for co-existing mental health disorders, substance use disorders, physical or mental impairments and medical problems (3a)
<input type="checkbox"/>	<input type="checkbox"/>	8. Updated as new information becomes available (3b)
<input type="checkbox"/>	<input type="checkbox"/>	9. Address the strengths, needs, recovery goals, priorities, preferences, values and lifestyle of the consumer (3c)
<input type="checkbox"/>	<input type="checkbox"/>	10. Address age and developmental factors (3d)
<input type="checkbox"/>	<input type="checkbox"/>	11. Identifies the cultural and environmental supports (3e)
<input type="checkbox"/>	<input type="checkbox"/>	12. Identifies preferred methods for achieving the identified goals (3e)
<input type="checkbox"/>	<input type="checkbox"/>	13. Identifies consumer's recovery goals (3f)
<input type="checkbox"/>	<input type="checkbox"/>	14. Documents consumers understanding of options for treatment, psychosocial rehabilitation services and self-help programs to address their goals (3f)
		15. Additional information required by Forward Health Bulletin 2014-42, Attachment 3 (not a DHS 36 requirement)
<input type="checkbox"/>	<input type="checkbox"/>	a. Includes information about past treatment, such as where it occurred, for how long, and by whom (clinical findings).
<input type="checkbox"/>	<input type="checkbox"/>	b. Includes mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression).
<input type="checkbox"/>	<input type="checkbox"/>	c. Includes biopsychosocial history, which may include, depending on the situation, educational or vocational history, developmental history, medical history, significant past events, religious history, substance abuse history, past mental health treatment, criminal and legal history, significant past relationships and prominent influences, behavioral history, financial history, and overall life adjustment (clinical findings).
<input type="checkbox"/>	<input type="checkbox"/>	d. Includes psychological, neuropsychological, functional, cognitive, behavioral, and/or developmental testing as indicated (studies ordered).
<input type="checkbox"/>	<input type="checkbox"/>	e. Includes current status, including mental status, current living arrangements and social relationships, support system, current activities of daily living, current and recent substance abuse usage, current personal strengths, current vocational and educational status, and current religious attendance (clinical findings).

Notes:

C. ABBREVIATED ASSESSMENT (if necessary) DHS 36.16(5)

Yes	No	Completion Date:	Date Comprehensive Assessment Due (3 months from date of application):
<input type="checkbox"/>	<input type="checkbox"/>	1. Must have signed admission agreement and one of the following three conditions: (5a)	
<input type="checkbox"/>	<input type="checkbox"/>	a. Consumers health or symptoms are such that only limited information can be obtained immediately (5a)1	
<input type="checkbox"/>	<input type="checkbox"/>	b. The consumer chooses not to provide information necessary to complete a comprehensive assessment at the time of application (5a)2	
<input type="checkbox"/>	<input type="checkbox"/>	c. The consumer is immediately interested in receiving only specified services that require limited information (5a)3	

<input type="checkbox"/>	<input type="checkbox"/>	2. An abbreviated assessment conducted shall meet the requirements of the comprehensive assessment to the extent possible that precluded the comprehensive assessment (5b)
<input type="checkbox"/>	<input type="checkbox"/>	3. Assessment summary must include specific reason that an abbreviated assessment was necessary (5c)
<input type="checkbox"/>	<input type="checkbox"/>	4. An abbreviated assessment is valid for up to 3 months from the date of application (5d)
<input type="checkbox"/>	<input type="checkbox"/>	5. Upon the expiration date a comprehensive assessment needs to be completed to continue psychosocial rehabilitation services (5d)
<input type="checkbox"/>	<input type="checkbox"/>	6. If a comprehensive assessment can't be conducted when the abbreviated assessment expires, the applicant shall be given notice of a determination that the consumer does not need psychosocial rehabilitation services (5d)

Notes:

D. ASSESSMENT SUMMARY DHS 36.16(6)

<input type="checkbox"/>	<input type="checkbox"/>	1. Includes the period of time within which the assessment is conducted with meeting dates. (6a)
<input type="checkbox"/>	<input type="checkbox"/>	2. Includes the information on which outcomes and service recommendations are based. (6b)
<input type="checkbox"/>	<input type="checkbox"/>	3. Includes desirable outcomes and measurable goals desired by the consumer. (6c)
<input type="checkbox"/>	<input type="checkbox"/>	4. Includes the names and relationships to the consumer of all individuals that participated in the process. (6d)
<input type="checkbox"/>	<input type="checkbox"/>	5. Includes significant differences of opinion not resolved among members of the recovery team. If no significant differences identified, please notate that there was no significant difference identified' (6e)
<input type="checkbox"/>	<input type="checkbox"/>	6. Includes reason(s) why consumers are not working on a goal that corresponds to an identified need (recommended, not a DHS 36 requirement)
<input type="checkbox"/>	<input type="checkbox"/>	7. Includes signatures of the persons present at the meetings being summarized. (6f)
<input type="checkbox"/>	<input type="checkbox"/>	8. Includes a diagnostic (case) formulation (recommended, not a DHS 36 requirement)

Notes:

E. SERVICE PLANNING AND DELIVERY PROCESSES DHS 36.17

Yes	No	Initial Completion Date:	Dates Updated: (minimum every 6 months):
<input type="checkbox"/>	<input type="checkbox"/>	1. Completed within 30 days of receipt of an application for services (2)	
<input type="checkbox"/>	<input type="checkbox"/>	2. if the Service Plan was not completed within 30 days, the specific reason was documented	
<input type="checkbox"/>	<input type="checkbox"/>	3. Documentation that the planning process was facilitated by the service facilitator in collaboration with the consumer and recovery team	
<input type="checkbox"/>	<input type="checkbox"/>	4. Documentation that the planning process was explained to the consumer (2c)	
<input type="checkbox"/>	<input type="checkbox"/>	5. The plan addresses the needs and recovery goals identified in the assessment (2d)	
<input type="checkbox"/>	<input type="checkbox"/>	6. Discharge criteria ("Discharge from the CCS shall be based on the discharge criteria in the service plan" (5)(a))	
<input type="checkbox"/>	<input type="checkbox"/>	7. The service plan includes a description of all of the following: (2m)	
<input type="checkbox"/>	<input type="checkbox"/>	a. The service facilitation activities that will be provided (2m) ¹	
<input type="checkbox"/>	<input type="checkbox"/>	b. The psychosocial rehabilitation and treatment services to be provided to or arranged for the consumer, including the schedules and frequency of services provided. Psychosocial rehabilitation and treatment services are: (2m) ²	
<input type="checkbox"/>	<input type="checkbox"/>	I. Provided in the most natural and least restrictive manner and most integrated settings practicable (4a)	
<input type="checkbox"/>	<input type="checkbox"/>	II. Delivered with reasonable promptness (4a)	
<input type="checkbox"/>	<input type="checkbox"/>	III. Build upon the natural supports available in the community (4a)	
<input type="checkbox"/>	<input type="checkbox"/>	IV. Provided with sufficient frequency to support achievement of goals identified in the service plan. (4b)	
<input type="checkbox"/>	<input type="checkbox"/>	V. Documentation of the services are included in the service record of the consumer. (4c)	
<input type="checkbox"/>	<input type="checkbox"/>	c. The service providers and natural supports who are or will be responsible for providing the consumer's treatment, rehabilitation, or support services and the payment source for each. (2m) ³	

<input type="checkbox"/>	<input type="checkbox"/>	d. Measurable goals and type and frequency of data collection that will be used to measure progress toward desired outcomes. (2m)4. Include start date of services (suggested, not required by DHS 36)
<input type="checkbox"/>	<input type="checkbox"/>	8. The completed service plan is signed by the consumer, a mental health or substance abuse professional, and the service facilitator. (2mc)
<input type="checkbox"/>	<input type="checkbox"/>	9. The service plan has been reviewed/updated at least every 6 months. The reviews include: (3)
<input type="checkbox"/>	<input type="checkbox"/>	a. An assessment of the progress toward goals (3)
<input type="checkbox"/>	<input type="checkbox"/>	b. Consumer satisfaction with services (3)
<input type="checkbox"/>	<input type="checkbox"/>	c. Original, updated, and partially completed service plans are maintained in the consumer's service record
<input type="checkbox"/>	<input type="checkbox"/>	d. Authorization of services by a Mental Health Professional and Substance Abuse Professional if substance abuse services will be provided. (MA Requirement – ForwardHealth update June 2014-42, pg. 15)

Notes:

F. ATTENDANCE ROSTER DHS 36.17 (2mb) and DHS 36.18 (3b)

<input type="checkbox"/>	<input type="checkbox"/>	1. The consumer's record shall include attendance rosters from service planning sessions (DHS 36.18(3b))
<input type="checkbox"/>	<input type="checkbox"/>	2. An attendance roster shall
<input type="checkbox"/>	<input type="checkbox"/>	a. Be signed by each person, including recovery team members in attendance at each service planning meeting (2mb)
<input type="checkbox"/>	<input type="checkbox"/>	b. Include the date of the meeting (2mb)
<input type="checkbox"/>	<input type="checkbox"/>	c. Include the name, address, and telephone number of each person attending the meeting (2mb)
<input type="checkbox"/>	<input type="checkbox"/>	d. Signatures from everyone present (2mb)

Notes:

G. CRISIS PLAN (This is not a CCS requirement, this is a Chapter 34 rule (DHS 34.23(7)))

<input type="checkbox"/>	<input type="checkbox"/>	1. A crisis plan has been completed
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Notes:

SECTION 4: DISCHARGE (DHS 36.17(5))

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. Discharge from CCS shall be based on the discharge criteria in service plan (5) unless one of the following conditions: (5a)
<input type="checkbox"/>	<input type="checkbox"/>	a. Consumer no longer wants psychosocial rehabilitation (5a)1
<input type="checkbox"/>	<input type="checkbox"/>	b. The whereabouts of the consumer are unknown for at least 3 months despite diligent efforts to locate the consumer (5a)2
<input type="checkbox"/>	<input type="checkbox"/>	c. The consumer refuses services from the CCS for at least 3 months despite diligent outreach efforts to engage the consumer (5a)3
<input type="checkbox"/>	<input type="checkbox"/>	d. The consumer enters a long-term care facility for medical reasons and is unlikely to return to community living (5a)4
<input type="checkbox"/>	<input type="checkbox"/>	e. The consumer is deceased (5a)5
<input type="checkbox"/>	<input type="checkbox"/>	f. Psychosocial rehabilitation services are no longer needed (5a)6
<input type="checkbox"/>	<input type="checkbox"/>	2. When a consumer is discharged from the CCS program, the consumer shall be given written notice of the discharge. The notice shall include all of the following (5am)
<input type="checkbox"/>	<input type="checkbox"/>	a. A copy of the discharge summary (5am)1
<input type="checkbox"/>	<input type="checkbox"/>	b. Written procedures on how to re-apply for CCS services. (5am)2

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| <input type="checkbox"/> | <input type="checkbox"/> | c. If a consumer is involuntarily discharged from the CCS program and the consumer receives Medical Assistance, the fair hearing procedures prescribed in s. DHS 104.01 (5). For all other consumers, information on how the consumer can submit a written request for a review of the discharge to the department. (5am)3 |
|--------------------------|--------------------------|--|
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- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 3. The CCS shall develop a written discharge summary for each consumer discharged from psychosocial rehabilitation services. The discharge summary shall include all of the following: (5b) |
|--------------------------|--------------------------|---|
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|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | a. The reasons for discharge. (5b)1 |
|--------------------------|--------------------------|-------------------------------------|
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- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | b. The consumer's status and condition at discharge including the consumer's progress toward the outcomes specified in the service plan. (5b)2 |
|--------------------------|--------------------------|--|
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- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | c. Documentation of the circumstances, as determined by the consumer and recovery team, that would suggest a renewed need for psychosocial rehabilitation services (5b)3 |
|--------------------------|--------------------------|--|
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- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | d. For a planned discharge, the signature of the consumer, the service facilitator, and mental health professional or substance abuse professional. With the consumer's consent, this summary shall be shared with providers who will be providing subsequent services. (5b)4 |
|--------------------------|--------------------------|---|
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Notes:
