

INTEGRATING FAMILY SERVICES

Client Record Review Form

COVER SHEET

File Review Date: Click here to enter text. File

Reviewer Name: Click here to enter text.

Agency/Service Provider: Click here to enter text.

Client Identifier (*choose one from below*):

Record #: Click here to enter text. OR BFIS ID#: Click here to enter text.

Client DOB: Click here to enter text. Open Date: Click here to enter text. Closed Date: Click here to enter text.

Type of File (*select one*): Full R Brief contact/consultation: Click here to enter text. Visits/contacts (indicate #)

KEY

◇ = see accompanying Instructional Guide for more information (e.g. specific requirements)

Shaded areas = where the element is truly a present/not present and doesn't have a quality component. In other words, it could not be rated as better or worse; it just is or is not there.

NOTES TO REVIEWERS

- When you indicate that something needs attention, please explain your response in the “comments” section.
- Please direct any questions or suggestions regarding this form to Cheryle Bilodeau, Director, Integrating Family Services (IFS): Cheryle.Bilodeau@vermont.gov or 802-760-9171

IFS Chart Review Form

IFS Quality Measure #	Standard/Guideline	Minimum Standard			Comments
		Present (1)	Not Present (0)	N/A	
GENERAL					
General Information					
	1. Record of access/disclosure form (Paper chart only)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	2. Signed authorization by parent/guardian to release information form ◇	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	3. Signed client rights form	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	4. Intake documents ◇	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	5. Referral documents (if applicable) ◇	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	6. Orientation checklist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	7. Consent to evaluation & treatment/services signed by client	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	8. Evidence that client received information regarding grievances & appeals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	9. Medical home/PCP identified or evidence thereof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	10. Dental home identified or evidence thereof	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
A) Financial Information					
	1. Permission to bill insurance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
	2. Patient payment responsibility/fees form is present	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Click here to enter text.
SECTION I SCORE					

IFS Quality Measure #	Standard/Guideline	Minimum Standard			Quality Review				Comments
		Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
II. CLINICAL EVALUATION, ASSESSMENT AND/OR SCREENING ◇									
A) Presenting Issues, Symptoms and History									
E1	1. Assessment is completed within required days: *intake/referral or re-evaluation must be completed annually (0-6 years old) *within 2 years (6+ years old)	<input type="checkbox"/>	Click here to enter text.						
E3-1	2. Clear indication of clients hopes and dreams	<input type="checkbox"/>	Click here to enter text.						
E3-2	3. History of presenting issues/target symptoms from multiple informants, where appropriate, and described in multiple settings (home, community, school)	<input type="checkbox"/>	Click here to enter text.						
E3-3	4. Clear indication of client's strengths, abilities, interests, assets, resources, skills and capabilities.	<input type="checkbox"/>	Click here to enter text.						
E3-7	5. Developmental history and needs	<input type="checkbox"/>	Click here to enter text.						
E3-5	6. Medical history	<input type="checkbox"/>	Click here to enter text.						
E3-4	7. Psychosocial history ◇	<input type="checkbox"/>	Click here to enter text.						
E3-6	8. Complete mental status exam ◇	<input type="checkbox"/>	Click here to enter text.						
E2	9. At least one standardized screening/assessment tool is used to assess clients' functioning and/or care/treatment needs ◇	<input type="checkbox"/>	Click here to enter text.						

		Minimum Standard			Quality Review				
IFS Quality Measure #	Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
A) Presenting Issues, Symptoms and History (cont'd)									
	10. Inventory current services: Is child/youth/family receiving other supports/services? Who else is or should be part of this child/youth/family's team? ◇ (needs to be moved so it is not tied to the assessment)	<input type="checkbox"/>	Click here to enter text.						
Formulation Interpretive Summary									
E3-9	1. DSM 5 or ICD Diagnosis is consistent with evaluation findings	<input type="checkbox"/>	Click here to enter text.						
E-3-10	2. Clinical formulation or interpretive summary that uses the information gathered, is developmentally sensitive, and identifies strengths and needs.	<input type="checkbox"/>	Click here to enter text.						
E3-11	3. Clear and specific treatment/supports/services recommendations that address presenting issues and target symptoms	<input type="checkbox"/>	Click here to enter text.						
	4. Treatment/supports/services recommendations reflect best practices ◇	<input type="checkbox"/>	Click here to enter text.						
	5. Qualified provider's name and credential are present (see guidance document for specific requirements)	<input type="checkbox"/>	Click here to enter text.						
SECTION II SCORE:									

IFS Quality Measure #	Standard/Guideline	Minimum Standard			Quality Review				Comments
		Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
Plan of Care									
E-1	1. If the initial plan fell under the period under review it was completed within 45 days of client initiating services. For prenatal to age 6, the plan must be completed within 45 days of referral ◊	<input type="checkbox"/>	Click here to enter text.						
E-1	2. If the plan is an update, it was completed within the last year. For prenatal to age 6, a plan update must happen every 6 months.	<input type="checkbox"/>	Click here to enter text.						
POC - 1	3. Goals/outcomes are meaningful to and have been developed in partnership with client and families, as evidenced by ◊	<input type="checkbox"/>	Click here to enter text.						
POC-2	4. Goals reflect evaluation and/or other assessments, or recent progress notes if the plan is an update.	<input type="checkbox"/>	Click here to enter text.						

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III. Plan of Care (cont'd)									
POC-2	5. Plan includes at least one client goal ◊	<input type="checkbox"/>	Click here to enter text.						
	6. Goals have realistic, measurable action steps that clearly define the work and expectations between service provider and family	<input type="checkbox"/>	Click here to enter text.						
	7. Client's plan is accessible and easy to understand for the consumer.	<input type="checkbox"/>	Click here to enter text.						
	8. Type of intervention or service, frequency and time frame are identified	<input type="checkbox"/>	Click here to enter text.						
	9. CIS services are provided primarily in the home or in programs with typically developing children.	<input type="checkbox"/>	Click here to enter text.						
	10. Documentation shows who will provide services (an identified name is preferred, but at least a title or position is required).	<input type="checkbox"/>	Click here to enter text.						
	11. Signature of qualified provider on treatment plan (see standards/guidelines for service-specific requirements)	<input type="checkbox"/>	Click here to enter text.						

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III. Plan of Care (cont'd)									
POC-2	<p>12. Signature of psychiatrist/psychiatric nurse practitioner is required only if any of the following conditions are present:</p> <ul style="list-style-type: none"> * The client has enduring or complex mental illness * Child/youth receiving psychiatric and/or medication management services * Child/youth returning directly from a psychiatric inpatient setting <p>Child/youth who has a co-occurring physical health and emotional/behavioral condition for whom the supervising clinician determines a review and consultation is needed</p>	<input type="checkbox"/>	Click here to enter text.						
	13. Physician's signature required on completed One Plans for children receiving CIS early intervention services.	<input type="checkbox"/>	Click here to enter text.						
SECTION III SCORE:									

		Minimum Standard			Quality Review ◇				
IFS Quality Measure #	Standard/Guideline	Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	Comments
IV. SERVICE DELIVERY & DOCUMENTATION									
General									
	1. Weekly or monthly summary of services provided and major content or intervention themes.	<input type="checkbox"/>	Click here to enter text.						
	2. Intervention content is consistent with client's plan goals.	<input type="checkbox"/>	Click here to enter text.						
Prog 2	3. Interagency coordination is evident if appropriate (as demonstrated by e.g.: One Plan (CIS), Coordinated Services Plan, releases to disclose information, documentation in progress notes).	<input type="checkbox"/>	Click here to enter text.						
	4. Evidence of adherence to best practice as defined by content experts. ◇	<input type="checkbox"/>	Click here to enter text.						
Medical Care									
E3 - 5	1. Medical History is explored with a summary of health issues/events and allergies (could be included in intake evaluation, discharge summary, psycho-social evaluation, psychiatric evaluation, or noted separately).	<input type="checkbox"/>	Click here to enter text.						
	2. If appropriate, there is documentation of integration or collaboration with primary care.	<input type="checkbox"/>	Click here to enter text.						
SECTION IV SCORE									

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		Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
V. PERIODIC REVIEW & ASSESSMENT OF PROGRESS									
Prog 1	1. A standardized screening or assessment tool is used to periodically assess progress on goals.	<input type="checkbox"/>	Click here to enter text.						
	2. Assessment timelines met based on assessment rules/guidelines.	<input type="checkbox"/>	Click here to enter text.						
	3. Information from this screening/assessment tool and progress notes are used to inform client Plan goals and service delivery as appropriate.	<input type="checkbox"/>	Click here to enter text.						
	4. The notes reflect observations of the client or their response to the intervention.	<input type="checkbox"/>	Click here to enter text.						
	5. Evidence of assessment of progress towards client Plan goals.	<input type="checkbox"/>	Click here to enter text.						
	6. Documentation of ongoing need for continuing intervention and next steps in care and/or treatment.	<input type="checkbox"/>	Click here to enter text.						
SECTION V SCORE									

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		Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
VI. TRANSITION & DISCHARGE PLANNING									
TDP 1	1. If the client transitions from one IFS/CIS service to another and a transition plan is required, or the client is no longer receiving IFS/CIS services, a transition or Discharge Plan was developed at least 30 days prior to the change in or termination of services.	<input type="checkbox"/>	Click here to enter text.						
	2. Qualified provider signature and date.	<input type="checkbox"/>	Click here to enter text.						
	3. Required timeline(s) met.	<input type="checkbox"/>	Click here to enter text.						
	4. Evidence of proper transition/exit planning documentation and notifications. ◊	<input type="checkbox"/>	Click here to enter text.						
SECTION VI. SCORE									

Supplemental Components

IFS Quality Measure #	Standard/Guideline	Minimum Standard			Quality Review ◊				Comments
		Present (1)	Not Present (0)	N/A	Needs Attn. (1)	Meets Std. (2)	Exceeds Std. (3)	N/A	
	I. GENERAL								
	A) General Information								
Developmental Services	1. Emergency fact sheet for children/youth who are receiving care in an agency contracted foster or developmental home.	<input type="checkbox"/>	Click here to enter text.						
All CIS Services	2. Required authorized signature(s) to initiate services.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	3. Every practitioner providing billable substance abuse services shall be under the supervision of a Vermont certified Licensed Alcohol and Drug Counselor (LADC) or a physician with an American Society of Addiction Medicine (ASAM) certification.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	4. Any pregnant woman seeking substance abuse services is seen and begins treatment within 48 hours of request for services.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	5. If there is a waitlist for substance abuse services, intravenous (IV) drug users must be placed at the top of the waitlist.	<input type="checkbox"/>	Click here to enter text.						

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	II. CLINICAL EVALUATION, ASSESSMENT AND/OR SCREENING								
	A) Presenting Issues, Symptoms and History								
Mental health	1. If client is admitted to hospital or hospital diversion, is there evidence of discharge planning and participation from the designated agency (DA) or social services agency (SSA)?	<input type="checkbox"/>	Click here to enter text.						
Developmental Services	2. For children/youth who are receiving care in an agency contracted foster/developmental home, chart should include: <ul style="list-style-type: none"> * Immunization record * Medication administration records * Medication Prescription * Annual physical * Semi-annual dental hygiene visit * Seizure record * Quarterly psychiatric medication checks and Tardive dyskinesia (TD) checks 	<input type="checkbox"/>	Click here to enter text.						

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	I. CLINICAL EVALUATION, ASSESSMENT AND/OR SCREENING (Cont'd)								
	A) Presenting Issues, Symptoms and History								
Substance Abuse	3. Qualified provider used American Society of Addiction Medicine (ASAM) criteria to document risk rating across all 6 dimensions.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	4. Substance use history, current use & amounts documented.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	5. If client screens positive for substance use, a risk assessment is completed within the next 3 days of service or 30 days.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	6. Re. clients with criminal justice involvement, assessment documents required elements. ◇	<input type="checkbox"/>	Click here to enter text.						
	B) Formulation Interpretive Summary								
Substance Abuse	1. Interpretive summary includes substance use issues when appropriate.	<input type="checkbox"/>	Click here to enter text.						

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	II. Plan of Care								
Mental Health	1. Special status situations, such as imminent risk of harm, suicidal/homicidal ideation, are actively considered and integrated into the plan of care.	<input type="checkbox"/>	Click here to enter text.						
Mental Health	2. A Pro-Active Crisis Plan clearly identifies triggers, strategies and resources ◇ There should be a pro-active crisis plan if any of the following is present: <ul style="list-style-type: none"> · Are there multiple crisis contacts? · Has client had a recent (within last six months) hospital or crisis bed stay? · Has the client recently (within last six months) stepped down from a residential level of care? · Has client recently had a traumatic or significant life event or stressor that might indicate need for pro-active crisis planning? 	<input type="checkbox"/>	Click here to enter text.						

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	III. Plan of Care (cont'd)								
Developmental Services	3. For children who have developmental disabilities who have direct support staff supporting them, the chart should include: a) Behavior support/safety plan, if the child/youth exhibits challenging behavior b) Communication plan, if the child/youth has significant challenges with communication c) Special medical care procedures plan, if the child has specialized procedures that must be followed	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	4. If client diagnosed with substance use disorder, plan includes substance treatment goal(s).	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	5. IFS grantee providing medication-assisted therapy for opioide dependence must demonstrate compliance with VT Dept of Health medication-assisted therapy opioide dependence rule.	<input type="checkbox"/>	Click here to enter text.						

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	III. Plan of Care (cont'd)								
Substance Abuse	6. Plan is modified to reflect changes in treatment being prescribed.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	7. Client and/or guardian dated signature if required.	<input type="checkbox"/>	Click here to enter text.						
All CIS Services	8. Initial One Plan meeting is within 45 days of referral, not necessarily completed.	<input type="checkbox"/>	Click here to enter text.						
	IV. SERVICE DELIVERY & DOCUMENTATION								
	A) General								
Mental Health	1. If progress is not being made, the notes reflect a change in clinical direction.	<input type="checkbox"/>	Click here to enter text.						
Mental Health	2. If there are crisis screenings, are the screening forms easy to identify/ access?	<input type="checkbox"/>	Click here to enter text.						

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	IV. SERVICE DELIVERY & DOCUMENTATION (cont'd)								
	A) General (cont'd)								
Mental Health	3. If there are crisis screenings, does the screening form include the following: a) A clear description of the situation b) Safety issues are identified if present and a plan to address them c) If the situation is easily resolved, is there a description of resolution and a follow-up plan identified if appropriate.	<input type="checkbox"/>	Click here to enter text.						
Mental Health	4. If a full screening is appropriate, there is a mental status exam, consultation w/ MD or psychiatrist, the level of care needed is identified, resources are explored, and resolution described with follow-up plan identified.	<input type="checkbox"/>	Click here to enter text.						
Developmental Services	5. Division of Disability and Aging Services (DDSD) flexible family funding.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	6. Co-signature of Licensed Alcohol and Drug Counselor (LADC) or eligible MD when required. ◇	<input type="checkbox"/>	Click here to enter text.						

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	IV. SERVICE DELIVERY & DOCUMENTATION (cont'd)								
	A) General (cont'd)								
Substance Abuse	7. Use of seclusion or restraint is recorded and reported as a critical incident. ◊	<input type="checkbox"/>	Click here to enter text.						
	B) Medical & Psychiatric Care								
Mental Health	1. If the child receives psycho-pharmacologic supports from the DA, the medications are documented with dosage, route and schedule. There is a list of medication changes, start dates and refills.	<input type="checkbox"/>	Click here to enter text.						
Mental Health	2. Medication use or benefits are reflected as well as medical/psychiatric information changes.	<input type="checkbox"/>	Click here to enter text.						
Mental Health	3. If medication management is provided by private provider, there is evidence of coordination and input in treatment planning.	<input type="checkbox"/>	Click here to enter text.						

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	V. PERIODIC REVIEW & ASSESSMENT OF PROGRESS								
Mental Health	1. If client is receiving services through residential care, there must be ongoing DA participation in treatment and discharge planning.	<input type="checkbox"/>	Click here to enter text.						
	VI. TRANSITION & DISCHARGE PLANNING								
All CIS Services	1. All children exiting Children’s Integrated Services (CIS) services receive timely transition planning including a One Plan with steps and services.	<input type="checkbox"/>	Click here to enter text.						
Early Intervention	2. Required documentation and copies of notification to local education agency (LEA) and the State early intervention office of child potentially eligible for Part B special education services, needs to be sent between 6 months and 90 days prior to child’s 3rd birthday.	<input type="checkbox"/>	Click here to enter text.						
Early Intervention	3. All children who are potentially eligible for Part B special education and exiting early intervention receive a timely transition conference not more than 9 months prior to a child’s 3rd birthday.	<input type="checkbox"/>	Click here to enter text.						

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	VI. TRANSITION & DISCHARGE PLANNING (cont'd)								
Early Intervention	4. Transition planning and conference completed at least 90 days prior to a child turning three.	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	5. A discharge summary is completed within 15 days following discharge date that is signed and dated by the counselor and includes required elements. ◇	<input type="checkbox"/>	Click here to enter text.						
Substance Abuse	6. A written aftercare plan for planned discharges developed with the person served for all planned discharges or transitions from the program that is signed by the client or appropriate guardian and includes required elements. ◇	<input type="checkbox"/>	Click here to enter text.						

Qualitative Information:

This file was exemplary in the following areas:

Click here to enter text.

Careful consideration needs to be paid to the following areas of this file:

Click here to enter text.

The following needs immediate attention:

Click here to enter text.