

**CHILDREN, YOUTH AND FAMILIES DEPARTMENT  
FAMILY SERVICES • COMMUNITY AND BEHAVIORAL HEALTH SERVICES BUREAU • LCA**

**CLIENT RECORD REVIEW : BEHAVIORIAL MANAGEMENT SERVICES** [ref Cert Stds 3/29/02] form v.9/10/02

Agency: \_\_\_\_\_ Client: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

BMS Worker: \_\_\_\_\_ Guardian:  CYFD SW \_\_\_\_\_ Reviewer (init): \_\_\_\_\_

DX: \_\_\_\_\_

Medications: \_\_\_\_\_

(note with "☒" if no informed consent present)

<b>Admission, Consent, Rights, Initial Screening, Initial Treatment Plan</b>	<b>C</b>	<b>P</b>	<b>D</b>	<b>N A</b>	<b>N R</b>
<b>22.F (1)</b> Date of admission documented, consistent <span style="float:right"><b>DOA:</b></span>					
<b>22. C Client Rights</b> explained; written explanation given to parent/legal guardian upon admission.					
(3) (a) Record contains all applicable <b>consents</b> for <input type="checkbox"/> treatment, incl. <input type="checkbox"/> emergency medical treatment <input type="checkbox"/> informed consent for Rx medication taken during program hrs and/or prescribed by program Dr.					
(c) Consent forms complete prior to being signed by a client or guardian.					
(4) At admission, <b>orientation</b> of the client and parents/legal guardians is documented in the client's record. Orientation incl. <input type="checkbox"/> basic expectations of the clients, <input type="checkbox"/> rules for client conduct/bx.					
(5) Written <b>grievance/complaint procedure</b> reviewed w/ client & parent/legal guardian at admission; documented.					
<b>23.D (1) Initial Screening @</b> admission to determine need for tx, need for further assessment: <i>Date:</i> <input type="checkbox"/> physical, <input type="checkbox"/> psychological, <input type="checkbox"/> social functioning Identifies risk of dangerous behavior, incl. need for special supervision or intervention.					
<b>28. C (1)(e)</b> Agency works in partnership with other agencies/individuals involved in the client's care to implement the discharge plan and link the client to aftercare, as indicated;					
(f) A staff-to-client ratio of 1:1 is maintained at all times.					
<b>28. C (1)</b> Agency (a) Conducts clin. assessm't, or acquires (similar) info to guide development of Service Plan; (b) Documents clinical review of this information prior to comprehensive treatment plan; <i>Date:</i>					
<b>23.D (2) EPSDT</b> within 30 days unless within 12 months prior <i>Date:</i>					
<i>See assessment reference info; p. 2</i>					
<i>Please duplicate as 2-sided form</i>					
<b>Key: C: Compliant</b> or mostly compliant in this record. <b>P: Partially</b> compliant and partially non-compliant in this record. <b>D: Significant Deficiency</b> noted. <b>N/A:</b> Standard <b>not applicable</b> to this record. <b>N/R:</b> Standard <b>not reviewed/evaluated</b> in this record. Use "☒" to indicate item missing/deficient; "T" if present. <input type="checkbox"/> <b>Check here if add'l info is noted on back of sheet.</b> →					

Assessment	C	P	D	N A	N R
<b>23. D</b> <input type="checkbox"/> Clinical decisions made by qualified clinical personnel.					
Assessment incl: <input type="checkbox"/> physical, <input type="checkbox"/> emotional, <input type="checkbox"/> cognitive, <input type="checkbox"/> educational, <input type="checkbox"/> social development; <input type="checkbox"/> nutrition					
<b>28. C (1)</b> Agency (a) Conducts clin. assessm't, or acquires (similar) info to guide development of Service Plan;					
(b) Documents clinical review of this information prior to comprehensive treatment plan; <i>Date:</i>					
<b>23.D (2)</b> EPSDT within 30 days unless within 12 months prior <i>Date:</i>					
<i>Assessment elements below may be evaluated in terms of 28.C (1) (a) above.</i>					
Involves active participation of the family or guardian,					
<b>23.D (3) (a)</b> includes client=s personal, family, medical and social history, including:					
(i) prev. records/collateral info. <i>Placements/omissions:</i>					
<b>23.D (6)</b> assessment is amended as collateral becomes available					
<b>23.D (3) (a) (ii)</b> Relevant family and non-familial custodial history & guardianship;					
(iii) Client and family abuse of substances;					
(iv) <input type="checkbox"/> Medical history, <input type="checkbox"/> medications;					
(v) History as victim of physical/sexual abuse, neglect, trauma;					
(vi) History as a perpetrator of physical or sexual abuse					
(vii) client's/ family=s perception of his or her current need for services and priorities					
(viii) client's/ family=s strengths and resources;					
(ix) current mental status.					
<b>23.D (3) (b) Psychosocial evaluation</b> of client=s status and needs relevant to					
(i) Psychological functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(ii) Intellectual functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(iii) Educational/vocational functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(iv) Social functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(v) Developmental functioning; <input type="checkbox"/> status <input type="checkbox"/> needs					
(vi) Substance abuse; <input type="checkbox"/> status <input type="checkbox"/> needs					
(vii) Culture; <input type="checkbox"/> status <input type="checkbox"/> needs					
(viii) Leisure and recreation. <input type="checkbox"/> status <input type="checkbox"/> needs					
(c) Evaluation of high risk behaviors or potential for such;					
(d) a summary / clinical formulation including underlying dynamics					
(5) Assessment processes include the following:					
(a) educational evaluation /IEP, or evidence of satisfactory school performance (30 days);					
(b) a psychiatric evaluation when indicated					
(c) a psychological evaluation when indicated					
<b>23.D (6)</b> Assessment reviewed and updated as indicated; updated annually as addendum					
<b>23.D.</b> Reassessment is conducted when significant changes occur in condition or dx					
<i>Assessment notes, incl. issues to track in Service Plan:</i>					

<b>Service/Discharge Plan, Reviews, BMS Service Provision and Documentation</b>	<b>C</b>	<b>P</b>	<b>D</b>	<b>N A</b>	<b>N R</b>
<b>28. C (1) (c)</b> Agency develops a BMS service plan within 14 days of admission. <i>Date:</i>					
Plan includes: client needs;					
measurable goals;					
interventions;					
Discharge plan w/: <input type="checkbox"/> Bx/clinical criteria;					
<input type="checkbox"/> Barriers to DC;					
<input type="checkbox"/> Level of care;					
<input type="checkbox"/> Living situation;					
<input type="checkbox"/> Projected DC date					
28. C (2) (a) BMS participates in the development of BMS service plan					
(d) Agency reviews service plan every 30 days and revises as necessary;					
<i>Review Dates:</i>					
<b>23.F (2)</b> If elements of review are documented in place other than Tx plan review,					
(a) <input type="checkbox"/> All required elements are documented <input type="checkbox"/> in a timely manner <input type="checkbox"/> by qualified clinical personnel;					
(b) client's record contains evidence of participation of tx team members					
<b>28. C (2) (b)</b> BMS implements the service plan to include teaching of behavior enhancing skills;					
(c) BMS documents each client contact, including:					
date;					
time;					
duration;					
client's progress/response to interventions each day; stated in terms of goals and objectives					
<i>Contact dates:</i>					
<b>28.B (1) (b)</b> BMS demonstrates the ability to independently implement and document the outcome of the goals, measurable objectives and interventions as defined in a Behavioral Management Skills Development service plan.					
<b>22.F (2)</b> <input type="checkbox"/> Entries identify writer; <input type="checkbox"/> Late entries correctly documented					
<b>22.F (2)</b> Client record entries are <input type="checkbox"/> accurate; <input type="checkbox"/> objective; <input type="checkbox"/> factual; <input type="checkbox"/> legible; <input type="checkbox"/> timely; <input type="checkbox"/> clinically-based					
28.C (2) (d) BMS coordinates with the family and school personnel, if appropriate, to assist the client to achieve and/or to maintain appropriate behavior management.					

Discharge	C	P	D	N A	N R
<b>23. I. Non-emergency discharge</b> occurs in accordance with the client's discharge plan.					
(1) The agency evaluates appropriateness of release to parent/guardian;					
(2) agency provides that discharge occurs in a manner that provides for a safe and orderly transition;					
(3) agency provides for adequate pre-discharge notice, including specific reason for discharge.					
<b>23. G Aftercare</b> involves <input type="checkbox"/> client, <input type="checkbox"/> case mgr, <input type="checkbox"/> parent/guardian, or GAL (if appl.) in arranging identified needs.					
<b>22. H. A written discharge summary</b> is placed in record within 15 days of termination of services; includes:					
(1) Clinical and safety status;					
(2) Medications being taken at discharge;					
(3) Documentation of notification to Primary Care Physician;					
(4) Specification of referrals/appointments made with specific names;					
(5) Target behaviors addressed;					
(6) Services provided;					
(7) Progress attained, or lack thereof;					
(8) Description of interventions to which the client did and did not respond, including medications;					
(□) Recommendations for continued treatment and services.					
<b>23. H. Emergency Discharge</b> (1) The agency follows P&P for mgt of child who is danger to self or others or presents likelihood of serious harm to self or others.					
(a) Agency makes all appropriate efforts to manage child's bx prior to proposing emergency discharge;					
(b) Agency takes all appropriate action to protect health & safety of others who are endangered.					
(2) In the event of a proposed <b>emergency discharge</b> , the agency provides, at a minimum, procedural due process including written notice to the family/legal guardian, GAL and Department, if applicable.					
(a) Agency documents prov/ participation of parent/guardian & GAL in emerg DC process, when possible.					
(b) A conference is held incl. all interested persons to discuss the proposed emerg DC when possible.					
(3) If parent/guardian is unavailable, agency does not DC the child until safe DC is effected.					