QUALITY ASSESSMENT REVIEW WORKSHEET

EXTENSION/STAY/DISCHARGE REVIEW

Program _____ Admission Date _____ DMC Billing began Date _____ Date of Review _____ Date of Last Review _____ Date MD signed last Stay Review:_____ Stay Review Due Date: _____	____ ODF ____ IOT ____ Extension Review ____ Stay Review ____ D/C or Transfer out ____ Last Corrective Action complete	CLIENT I.D. _____ STATE I.D. #: _____ Primary Counselor's Name_____

NOTE: All items must have a √ or N/A. If an item is missing, circle the line and identify corrective action in bottom section.

MEDICAL/HEALTH REVIEW

Follow-up on MD Orders & Recommendations in chart?
(Client notified) ☐ yes ☐ no ☐ n/a
Client cleared for participation? ☐ yes ☐ no
Annual Health Questionnaire needed? ☐ yes ☐ no

STAY REVIEW

Has QAR reviewed latest Stay Review? ☐ yes ☐ no ☐ n/a
(check previous Review forms for accurate dates)
Stay Review Justification present & signed by MD?
☐ yes ☐ no ☐ n/a
Date MD Signed latest Stay Review _____
(See disallowances below if MD signed later than 6 months)

DISCHARGE

Date of last contact (SanWITS D/C date) _____
Discharge Summary/Plan date (counselor signed) _____
___ Discharge SanWITS completed ___10 Day Notice

LAST QAR FORM

Corrective Action complete: ☐ yes ☐ no ☐ n/a
Comments/Recommendations incorporated in charting?
☐ yes ☐ no ☐ n/a

Note: Corrective Action must be completed, however, not all comments or recommendations must be adhered to. Check with QAR Chair if you have questions.

TREATMENT PLAN(S) TIMELINE

Development Date of **last** Tx Plan reviewed (See **last** QAR Review Form for this date): **1**)_____
Tx Plan due date(s) (90 days from last Tx Plan(s))
2)_____ & **4**)_____
Review of Tx Plan(s) needed? ☐ yes ☐ no
(if no, skip to Progress Note section)
Tx Plan Development date(s): **3**)_____ & **5**)_____
New Tx plan(s) developed in timely manner? ☐ yes ☐ no
Date MD signed Tx Plan(s) _____ & _____
MD signature within 15 days? yes ☐ no ☐ & ☐ yes ☐ no
(If either date is late, see disallowances below)
DSM Dx and ICD-10 Code(s) on all Tx plan(s): # _____
Updated Tx Plan covers Physical Exam: yes ☐ no ☐ n/a ☐
Tx Goals appropriate to client's stage in Tx: ( ) & ( )
Long/Short Term Goals & Target dates identified: ( ) & ( )
Action Steps measurable & attainable: ( ) & ( )
Type of counseling identified in Action Steps ( ) & ( )
Frequency of Counseling is identified in Action Steps
(minimum = 2 times monthly) ( ) & ( )

PROGRESS NOTES

___ **Monthly DMC Eligibility Reports in file**
___ Progress Notes address ALL problems on Tx Plan
___ PN documents CLT progress toward Tx Plan goals
___ Each billing has acceptable documentation
(if not, see disallowances below)
___ **Multiple 2nd Service Billings in File**
___ **ADP 7700 Present**

QAR DETERMINATION

___ Full compliance
___ Corrective Action Required - See Below
___ Approved Discharge

UPCOMING REVIEW DATES

_____ Next Extension Review Date (3 months from now)
_____ Next Stay Review Date (6 months from admit date or last MD signature on Stay Review)
_____ Check this line if D/C review completed today

DMC DENIALS ☐ No Denials noted in this chart

A State auditor would probably deny D/MC funding from _____ through _____. # Visits denied _____
List the dates of visits that would be denied in a State audit:_____
List reason(s) for denied visits _____

CORRECTIVE ACTION REQUIRED (Title 22 related)

☐ **Please give letter to client w/MD orders/recommendations**

QAR COMMENTS & RECOMMENDATIONS:

☐ **Please follow up with client regarding medical tests (letter has already been given to client & is in file)**

QA Reviewer Signature **Date**

Second QA Reviewer Signature **Date**