January-22

UnitedHealthcare Community Plan (UHCCP)

NY CFTSS Record Tool

			Yes	No	NA
General Documentation					
	01	Each member has a separate record.			
	02	The record is clearly legible to someone other than the writer.			
	03	Each record includes the member's address, telephone numbers including emergency contacts, relationship or legal status, and guardianship information if relevant.			
Admission and Assessment					
	04	Outreach is made to child/youth and family/caregiver to establish initial contact and engage in scheduling face to face appointment.			
	05	An appointment is made in the established time per service and per service type, in accordance with agency standards and requirements AND Contact is maintained and continued engagement efforts are made with the child/youth and family/caregiver until the appointment occurs.			
	06	The scope of services to be rendered and service guidelines are clearly described to the child/youth and family/caregiver. This information is provided verbally and in writing in a language/format that is understandable to the child/youth and family/caregiver.			
	07	The child/youth, family/caregiver and collaterals are provided with the information necessary to contact the appropriate service provider for both routine follow-up and immediate access in times of crisis.			
	08	All communication with referral sources, family/caregivers, the multidisciplinary team and other collaterals is HIPAA compliant and documented in the child/youth's case record.			

	09	Provider's assessment and interventions acknowledge, respect and integrate the child/youth's and family/caregiver's beliefs, cultural values and practices.			
	10	The assessment is relevant to the child's age/developmental stage.			
	11	Information is gathered to assess the strengths, needs and preferences of the child/youth related to the delivery of the CFTSS.			
	12	Safety issues for the child/youth are identified through the assessment and provider protocols are followed if indicators of risk arise.			
	13	Linkage to appropriate service is expedited if indicated by clinical presentation and/or need for medication and/or medical intervention			
	14	The supporting documentation (including frequency, scope and duration) that substantiates the need for the specific service is maintained in the child/youth's record			
Service Provision					
	15	Services are delivered in a trauma informed, culturally and linguistically competent manner.			
	16	The record documents missed appointments and there is evidence of consistent follow-up on missed appointments.			
	17	The record documents that scheduling is flexible and includes evenings and weekends.			
	18	Barriers to participation in services are identified and addressed with child/youth and family/caregiver.			

	19	Services settings are determined by the multidisciplinary team and include the child/youth and family/caregiver's preferences, make full use of natural environments and supports and is conducive to the provision of services in meeting treatment goals/objectives			
	20	Services are provided in accordance with the treatment plan			
Treatment Planning					
	21	The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and includes desired goals and outcomes.			
	22	The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and identifies the scope, frequency and duration of service			
	23	The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and includes criteria to indicate the child/youth's readiness for discharge.			
	24	The plan is individualized to the circumstances and preferences of the child/youth and family/caregiver and includes signatures of child/youth and/or family/caregiver to ensure their participation and demonstrate agreement.			
	25	Child/youth and family/caregiver are assisted in implementing a written, individualized safety/crisis plan that contains at least the following elements: identification of triggers, warning signs of increased symptoms, management techniques of self-regulation, contact information for supportive persons and plan to get emergency help as needed; a copy is provided.			
	26	Treatment plan review occurs regulalrly and reflects ongoing coordination with the multidisciplinary team as well as active participation with the family, to review progress of the child/youth toward goals/objectives.			
Progress Notes					
	27	All progress notes include who rendered services, their job title, incluiding any relevant licensure/certifications and are dated and signed (including electronic signature for EMR systems) where appropriate.			

	28	All progress notes include the date of service.			
	29	All progress notes include the time of service provided.			
	30	All progress notes document the length of service rendered.			
	31	All progress notes include who is present for services.			
	32	Progress notes are directly linked to goals and objectives by summarizing the services provided, interventions utilized, the child/youth and family caregiver's response, and evidence of progress made toward goals.			
	33	Progress notes include any significant information impacting services, including child/youth and family caregivers' preferences, coordination with the multidisciplinary team, and consideration of the need for changes to the plan.			
	34	The setting of the service is clearly documented and is the least-restrictive most natural environment.			
	35	Ethnic, religious and cultural identities are integrated into the treatment plan as needed.			
Discharge and Transfer					
	36	The discharge plan is part of the treatment/service plan and is developed at the start of service delivery and is regularly reviewed and amended as needed.			
	37	Discharge plan considers the child/youth and family/caregiver's circumstances and preferences and the record reflects thaty decision making occurs with the child/youth, family/caregiver and collaterals regarding readiness for discharge and needed follow up services.			

	38	Discharge summaries are completed that identify services provided, the child/youth's response, progress toward goals, circumstances of discharge and efforts to re-engage if the discharge was not planned.			
	39	If the recipient transferred/discharged from the service, there was evidence the transition was coordinated with other appropriate agencies and/or supports and linkage to services is facilitated (e.g., identification of alternative providers, assistance with obtaining appointments, contact names and numbers provided, etc.).			
	40	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.			
	41	Treatment records are completed within 30 days following discharge.			
	42	Treatment Services are provided by the appropriately credentialed staff.			
	43	There is evidence of supervisory oversight of the treatment record. (Records are reviewed on a regular basis with appropriate actions taken).			