CHART AUDIT	Date of Audit:	Client Name:	Client DOB:	Clinician:
INTAKE REVIEW	The Intake is defined as an analysis of a client's needs for mental health services to determine which services a healthcare organization shall provide to the client.			
	Requirements/Guidelines		Complete or Not Complete	Comments
Intake Completion	This client's initial intake was completed within the appropriate timeframe and in accordance with practice policies and procedures.			
Signed and Dated	This initial intake was signed and completed within the appropriate time frame. (when needed by insurance)			
Presenting Problem	There is documentation of symptom description, including onset, duration, frequency, and other relevant information.			
Objective Content	There is evidence that a discussion on informed consent, practice policies, confidentiality and mandated reporting, best contact information, future scheduling, and the no show/late cancellation fee occurred.			
Mental Status	Documentation that current mental status was observed.			
History of Presenting Problems Complete	There is evidence within the intake of the client's presenting problem.			

Past Psychiatric History	Psychiatric history such as hospitalizations, outpatient treatment, and suicidal and self-harm behavior are noted.		
Trauma History	Evidence of trauma history being asked and properly documented. If present, documenting natura of trauma, when the trauma occurred, people involved, and impact on present functioning.		
Medical and Medication	The intake includes documentation of past/current medical history, surgeries, adverse drug reactions, allergies, and disabilities, and current medications.		
Substance Use	Includes history of substances used in the past and present.		
Social History/Family History	Social and family history includes documentation of support systems, family members and description of relationships. Shows hobbies and interests.		
Spiritual/Cultural Factors	Documentation of important spiritual practices and communities, cultural influences, etc.		
Developmental History	A review of developmental history and gestational development, if pertinent		
Family Psychiatric History	An in-depth review of family mental health history along with physical history, if available		

Educational/Vocational History	Documentation of highest level of education, current/past employment, hobbies, leisure activities, etc.		
Legal History	History of arrests/summons, sentencing, DUI occurrences, incarcerations, civil litigations, family court matters, etc. were noted.		
SNAP	Strengths, Needs, Abilities, and Preferences were documented		
Referral Source	Documentation of Referral Source (i.e. Self, IOP, Psychiatrist, etc.)		
Risk Assessment	A risk assessment was completed for SI/HI and substance misuse		
Initial Plan	Frequency and agenda in second session are documented		
Initial diagnosis	There is an initial diagnosis, and the intake is congruent with this diagnostic evidence		
Header Information	All header information is correct and includes client's name, DOB, Payer, Date, Duration, Service Code, Location, and Participants		

Date of Audit:	Client's Name:	Client's DOB:	Clinician's Name:
TREATMENT PLAN	The Treatment Plan is a structured document outlining goals, objectives and interventions, tailored and created in a collaborative effort to an individual's mental health needs, guiding providers in delivering effective and coordinated care.		
	Requirements/Guidelines	Complete or Not Complete	Comments
Treatment Plan Completion	Treatment Plan was created and dated before or at client's second session.		
Required Header Information	All header information is correct and includes client's name, DOB, Payer, Date, Duration, Service Code, Location, and Participants		
Presenting Problem	There is documentation of symptom description, including onset, duration, frequency, and other relevant information.		
Number of Treatment Goals	At least 3 goals with corresponding objectives		
Goals	Goals are broad and summarize what client will achieve in services		
Objectives	At least 2-3 objectives per goal. Objectives must be action-based steps that will be used to complete goals and are **measurable.**		
Interventions	Identify what interventions and modalities will be used with each objective.		

Estimated Date of Completion	An estimated date of completion will be listed under each objective.		
Discharge Criteria	Description of what will be different when treatment is completed, such as proficiency with new skills, additional support, new or changed behaviors		
Treatment Plan Updates	Evidence of treatment plan updates occurring every 90 days (if applicable). Treatment plan updates must occur prior to a session taking place later than 90 days.		

Date of Audit:	Client's Name:	Client's DOB:	Clinician's Name:
PROGRESS NOTES	A Progress Note is a piece of documentation used to record the details of a client's treatment and clinical status over time. Progress Notes will include client's status and symptoms, changes since their last session, treatment and interventions provided, and a plan for future treatment.		
	Requirements/Guidelines	Complete or Not Complete	Comments
Ensure header information is correct	The progress notes are dated, timed, have correct Service Code, lists location and participants, and is signed when applicable		
Current Mental Status Observed	Documentation that current mental status was observed.		
Risk Assessment Completed	A risk assessment was completed for SI/HI and substance misuse		

Medications	A note of most recent medications, dosage, and prescriber is listed.		
Symptom Description and Subjective Report	A detailed account of a client's self-reported symptoms, experiences, and perspectives regarding their condition is documented.		
Objective Content	A report of the measurable and observable information that you obtain during the session. Documentation of conversations or interventions used during the session.		
Interventions Used	A list of interventions used in the session is documented.		
Treatment Plan Progress	There is evidence showing how the treatment plan goals were addressed in session and a subjective measurement of client's progress for each goal.		
Future Plans	Identified the next steps in the treatment process.		
Prescribed Frequency of Treatment	Documentation of recommended frequency of treatment or changes to recommended frequency of treatment.		

MEMBER'S RIGHTS	Requirements/Guidelines	Complete or Not Complete	Comments
HIPAA			
Informed Consent			
No Show/Late Cancellation Policy			
Practice Policies			
Client Information Form			
Client Insurance Form			
Emergency & Other Contacts Form			
Payment Authorization Form			
ROI	Contains all necessary information including name, address, and contact information for agency/person, as well as purpose of contact/coordination.		
ROI's are updated annually			

TERMINATION PROCEDURE	Requirements/Guidelines	Complete or Not Complete	Comments
Termination occurs in accordance with policy	Client's who discontinue contact for three consecutive weeks, unless other arrangements have been made in advance, will be eligible for termination Files must be closed out if a client has not been seen for 60 days.		
Reason for Termination	There is documentation of what precipitated the decision to terminate services (ie Planned pause in treatment, a referral, discontinued contact by client, etc.)		
Chief Complaint	Explanation of client's presenting problems and symptoms that caused client to seek treatment.		
Treatment Modality and Interventions	A list of modalities and interventions used throughout treatment are listed in congruence with treatment plans.		
Treatment Goals and Outcomes	A list of client's most recent treatment plan goals are listed with corresponding outcomes (i.e. Improved, Goal met, Progressing, Maintained, etc.)		