DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

PNMI Exit Sheet

General Information **5%**	**1***	**Full Name of Child/Youth**
	2*	**Gender**
	3*	**DOB**
	4*	**Link PID #**
	5*	**EMS #**
	6*	**Admission Date**
	7*	**Actual Discharge Date**
Authorization and Evaluation **15%**	**8***	**Reason for Placement (from face sheet)**
	9o	**Psychosocial History** must be completed and signed within the first 30 days from admission
	10*	**CANS Information**: Registration/Referral form
	11*	**CANS Information**: Level of Care
	12*	**CANS Information**: Referral packet w/ DSM dx.
	13*	**CANS Information**: Reauthorization forms from Beacon Health.
Treatment Planning **40%**	**14**	**Initial Treatment Plan:** *(written no later than the DOA & authorized by a LCP).
	15	**30-day Treatment Plan:** Name, Signature, Date, Title of LCP.
	16	**90-day Treatment Plan:** And all subsequent quarterly treatment plans
	17	**Treatment Planning Participation**: Signature page for all participants.
	18	**Sourcing the Goals**: Statement specifying the source if the info which the goal is based.
	19	**Goals & Objectives:** All treatment plans have appropriate Goals & Objectives.
	20	**Clinical & Milieu Services**: Individual, Group and Family Therapy, Psycho-education Group, Therapeutic Recreation, Daily Proactive Coaching, etc. ***Intervention-staff implementing the intervention, linked to the objective, aimed at youth goals.**
	21	**Clinical & Milieu Services**: Documentation requirements (frequency & duration).
	22	**Reauthorization of the Treatment Plans:** Treatment plan is reviewed, reauthorized as necessary and appropriate, signed, dated by LCP within 90-days of admission.
	23	**Detailed Progress Review:** Beginning with first 90-day plan for each Goal & Objective there is a written statement of progress.
	24	**Discharge Plan within the Plan:** Beginning with the 30-day plan, to include date, caregiver, optional-concurrent, projected services needed at discharge, indication if there are any barriers for discharge and if so, steps to address them.
Service Delivery And Progress Documentation **40%**	**25**	**Service Delivery & Progress Documentation**: Clinical Services: per session, one note unless same person wrote notes, ***includes frequencies and session duration from the treatment plan.** 75% or higher is required for each service.
	26	**Service Delivery & Progress Documentation-Progress Notes**: Type of service, session duration as written in treatment plan ***(never prefill duration, actual duration should be noted, entered in record no later than 30-days after service, but ideally right after session.**
	27	**Service Delivery & Progress Documentation-Progress Note**: Each note must specify the date the service was provided.
	28	**Service Delivery & Progress Documentation-Progress Note**: Printed name, signature, date, title of person providing the service ***(the same person who provides the service must be the same person writing the note).** 95% of the notes required to meet.
	29	**Service Delivery & Progress Documentation-Progress Note**: Each progress note specifies the treatment plan Goal & Objective addressed during the session.

Service Delivery And Progress Documentation, continued **40%**	**30**	**Service Delivery & Progress Documentation-Progress Notes**: Progress towards Goals & Objectives *(must include information on progress toward achieving the goals/objectives including psych/med management notes, outside providers delivering services in support of the treatment plan.
	31	**Daily Milieu Proactive Services**: Teaching or coaching on a **useful skill** using the treatment plan indications, **proactively implemented**, in a **planned manner**, where the program seeks out the youth. If a service is not given, a progress note must be written explaining why the service was not given. There must be a milieu progress note written each day. If the youth is not at the program for a day or a period of time and there is no note documenting each day of their absence from the program, the days cannot be eliminated from the QSR compliance calculation. 75% or higher is required.
	32*	**Monthly Treatment Plan and Progress Report (MTPPR):** Monthly progress report in record for each month youth is in placement.
	33	**Monthly Treatment Plan and Progress Report (MTPPR):** Information on the number, (frequency) of clinical sessions given is on the MTPPR to include: ***individual, group & family therapy and documentation of the frequency of services provided in the MTPPR must be consistent with the actual services provided as documented in the progress notes.** If the period under review includes only one (1) MTPPR, that MTPPR there can be no discrepancies in reporting; if the period under review includes two (2) MTPPRs there can be no more than one (1) discrepancy in reporting.
	34	**Monthly Treatment Plan and Progress Report (MTPPR):** MTPPR addresses progress made toward Goals & Objectives of the individual treatment plan (ITP). ***Begin documentation of the treatment plan in the Symptomatology box, continue documentation in the Recovery and Resiliency box.**
	35*	**Monthly Treatment Plan and Progress Report (MTPPR):** documentation that the monthly summary has been sent to the area office designee, (this is the same as having submitted it to Beacon Health).

* Standards denoted with an asterisk, if not found during the PNMI Review, can be resolved prior the completion of the review.

° Standards denoted with a superscript circle, Standard 9, can be resolved prior to the completion of the review if the document was written and signed no later than 30 days following admission but was not found in the record initially during the review.