

## RESIDENTIAL VENDOR CASE FILE REVIEW

Vendor \_\_\_\_\_ BPA # \_\_\_\_\_

Site \_\_\_\_\_ Counselor/Therapist \_\_\_\_\_

Case Name \_\_\_\_\_ PACTS # \_\_\_\_\_

Reviewer \_\_\_\_\_ Date \_\_\_\_\_

Months Reviewed \_\_\_\_\_

Circle Program Type:            Substance Abuse    Mental Health    Co-Occurring    Sex Offender

Circle Program Modality :    Detox                    Residential

### File Content

#### 1. Program Plan

- |                             |   |   |
|-----------------------------|---|---|
| a. Is Program Plan in file  | Y | N |
| b. Is it signed by offender | Y | N |

#### 2. Amended Program Plan (if applicable)

- |                                    |   |   |     |
|------------------------------------|---|---|-----|
| a. Is Amended Program Plan in file | Y | N | N/A |
| b. Is it signed by offender        | Y | N |     |

#### 3. Authorization to Release Confidential Information

- |                                  |   |   |
|----------------------------------|---|---|
| a. Is Authorization Form in file | Y | N |
| b. Filled out completely         | Y | N |

#### 4. Monthly Treatment Report (MTR)

- |  |   |   |     |
|--|---|---|-----|
| a. All months present in file  | Y | N |     |
| b. Filled out completely   | Y | N |     |
| c. Summarizes offender's activities during month                       | Y | N |     |
| d. Reflects that all authorized services have been provided            | Y | N |     |
| e. Indicates offender progress (adjustment, significant problems etc.) | Y | N |     |
| f. Records urine collection and test results                           | Y | N |     |
| g. Includes co-payment amount billed, collected and owed               | Y | N | N/A |

## 5. Chronological Record

a. Record all offender contacts	Y	N	
b. Record all officer and collateral contacts (Including quarterly psychiatrist contact if applicable)	Y	N	
c. Are they current	Y	N	
d. Is length of session included	Y	N	
e. Is there a clear printed name for each entry	Y	N	
f. Is there a signature for each entry	Y	N	
g. Violation notifications (including no-shows) in file (Fax, email or chrono)	Y	N	N/A

## 6. Urinalysis/Breathalyzer(If Applicable)

a. Is there a minimum of 6 tests per month	Y	N	N/A
b. Are additional tests conducted upon return from passes	Y	N	N/A
c. Are special instructions being followed (if applicable)	Y	N	N/A
d. Does testing appear to be random	Y	N	
e. Is there testing on weekends and holidays	Y	N	
f. Are there back-to-back tests	Y	N	
g. Are there no more than one unobserved test per month	Y	N	
h. Were offenders retested within two hours for invalid samples	Y	N	N/A
h. Were invalid samples reported to USPO	Y	N	N/A
j. Was the majority of testing by NIDT (on-site) devices	Y	N	
k. Was lab testing used appropriately (presumptive positive etc)	Y	N	
l. Were On-Site Testing Records complete and accurate	Y	N	
m. Were Lab Chain of Custody forms complete and accurate	Y	N	N/A

## 7. Reports and Evaluations (if applicable)

a. Comprehensive	Y	N	N/A
b. Incorporates information provided by officers	Y	N	
c. Includes full diagnosis	Y	N	
d. Includes recommendations	Y	N	
e. Is it completed within 10 business days of final interview or test	Y	N	

## 8. Discharge Summaries (if applicable)

a. Is it in the file	Y	N	N/A
b. Was it completed within 15 days after treatment terminated	Y	N	

## 9. Residential Service Level Requirements

a. Are the number of activities/services summarized on the MTR	Y	N	
b. Are activities/services documented in the file (e.g. chrono record)	Y	N	

<b>A. Substance Abuse Residential</b>			N/A
1. Minimum of 2 individual sessions per week	Y	N	
2. Minimum of 7 hours of group per week	Y	N	
3. At least 1 manualized cognitive behavioral group	Y	N	
4. Minimum of four 12-Step groups per week	Y	N	
5. Minimum of 6 hours of structured activities per weekday	Y	N	
6. Minimum of 2 hours of structured activities per day on weekends	Y	N	
7. Family Counseling	Y	N	N/A
<b>B. Co-Occurring Residential</b>			N/A
1. An initial mental health assessment and/or psychiatric or psychological evaluation	Y	N	
2. Minimum of 2 individual clinical counseling sessions per week	Y	N	
3. Minimum of 3 hours of group counseling per weekday	Y	N	
4. Family Counseling	Y	N	N/A
6. 12-Step Dual Diagnosis Groups	Y	N	
7. On-site Psychiatric Visits	Y	N	
8. Individual and/or Group Counseling by licensed clinician	Y	N	
9. Minimum of 6 hours of structured activities per weekday	Y	N	
10. Minimum of 2 hours of structured activities per day on weekends	Y	N	
<b>10. Document Congruency</b>			
a. Are dates, times and services consistent between documents (invoices, MTRs, DTLs, notes, testing records, reports)	Y	N	

**Comments/Notes/Recommendations**

**Residential Facility Inspection**

**YES NO N/A**

**V. PHYSICAL PLANT**

A. Does the provider maintain a facility that meets all applicable Federal, State and local regulations building codes?

— — —

B. Does the facility adequately provide for the integrity of the confidential relationship between the client and program staff?

————— — —

C. In Residential Programs:

1. Code Compliance

a. Is contractor complying with all building, sanitation, health, fire, electrical, zoning laws, ordinances and codes?

— — —

b. Can contractor provide documentation upon request regarding compliance with Sub-Section A (above)?

— — —

SUMMARY/FINDINGS:

2. Sleeping and Bathroom Facilities

a. Is contractor providing well-lighted and ventilated sleeping quarters with toilet, wash basin and bathing facilities?

— — —

SUMMARY/FINDINGS:

3. Emergency Plans

a. Does contractor have written emergency and evacuation plans for (fire, natural disaster and severe weather) that are communicated to each arriving resident, posted in the facility and reviewed or revised annually?

— — —

b. Does the contractor conduct quarterly evacuation drills and train its facility personnel in emergency and evacuation plans?

— — —

SUMMARY/FINDINGS:

	YES	NO	N/A
<b>4. <u>Safety Precautions</u></b>			
a. Does the contractor provide at least two means of exit at each floor level?	_____	___	___
b. Are smoke detectors located on each floor?	___	___	___
c. Are exit signs electrically lighted with backup battery powered emergency lighting?	___	___	___
d. Are portable fire extinguishers throughout the the facility appropriately rated, classed and located at least every 75 feet?	___	___	___
e. Can contractor provide documentation that fire inspections and testing of fire equipment are conducted at least semi-annually by equipment representative?	___	___	___

SUMMARY/FINDINGS:

<b>5. <u>General Food Service Standards</u></b>			
a. Is contractor keeping food free from spoilage and/or other contamination?	_____	___	___
b. Not store food containers under exposed and unprotected sewer or water lines?	___	___	___
c. Not permit persons to work in any other capacity in food service if they are infected with a communicable disease, have boils, infected wounds or acute respiratory infections?	_____	___	___
d. Require employees to thoroughly clean their hands and exposed portions of their arms with soap and water before and during work?	_____	___	___
e. Keep garbage and refuse in durable, easily cleanable insect and rodent-proof containers?	_____	___	___

SUMMARY/FINDINGS:

<b>6. <u>Emergency Medical Service</u></b>			
a. Is contractor maintaining basic first aid supplies, and training at least one staff member on each shift in emergency first aid?	___	___	___
b. Ensuring by written agreement that emergency 24-hour medical service is available with a licensed general hospital, private physician or clinic?	_____	___	___