EXAMPLE 3 **Families CARE __ Parent Peer Support (PPS) __ Transitional Youth Advocate Programs (TYAP)**
Record Audit for Non-Residential Services (Non-Accredited)

Service Location: Kearney **Reviewer:** Melinda Dulitz **Audit Date(s):** **Page ___ of ___** ___ **Units Needed** ___ **Units Claimed** ___ **Units Found**

Participant Name:	**Participant SS #:**
MONTH(S) CLAIMED	**MONTH(S) DOCUMENTED**
Month:	Month:

Strength(s):

Blue font =TYAP

(P) Programmatic **EXCEPTION CODES FOR NON-RESIDENTIAL SERVICES**

EXCEPTION	CODE	SPECIFIC REASON FOR EXCEPTION
Note: Each circled/blank box equals an exception		
Admission Documentation	□ 28	Includes Referral Form (RF).
	□ 29	Ensure RF includes referral source.
	□ 30	Ensure RF verifies participant is a resident of Region 3.
	□ 31	RF verifies participant either has an official diagnosis or specific behavior health needs. (PPS)
	□ 32	Ensure RF participant risks are identified (Baseline Strengths - Baseline Stress/Risk") (electronic)
	□ 33	Ensure RF includes staff signature.
	□ 34	Copy of completed attestation form (proof of citizen) is in participant file (DIQ).
	□ 35	Copy of signed Release to Treat (Release to Treat form) (hardcopy).
	□ 36	Release to Treat form includes Parent Peer Support signature.
	□ 37	Ensure Notice of Privacy Practices is provided. (R&R) (purple form)
Rights & Responsibilities form (P) .	□ a	Includes orientation documentation. (Orientation/R&R)
	□ b	Acknowledgement of offer regarding Voter registration in participant file. (R&R)
	□ c	Includes participant rights documentation. (R&R)
	□ d	Participant expectations clearly defined. (R&R)
	□ e	Includes grievance procedures documentation. (R&R)
Authorization of Disclosure of Information (AODOI)	□ 38	Copy of Authorization of Disclosure of Information (AODOI) (aka ROI) included in participant file.
	□ 39	AODOI includes the name of the person or agency to which the information is to be disclosed.
	□ 40	AODOI includes the purpose of the disclosure.
	□ 41	AODOI includes the specific information to be disclosed.
	□ 42	AODOI includes the date the consent was signed.
	□ 43	AODOI includes participant and/or parent/guardian signature, as applicable.
	□ 44	AODOI includes specification of the period of time the consent is valid. (1 year)
Financial Eligibility Worksheet for NBHS Funded Services (FEWFS)	□ 45	Eligibility Worksheet for NBHS Funded Services (EWFS) is located in participant file.
	□ 46	EWFS includes annual income, monthly income & family size which are consistent with co-pay w/in the appropriate Region 3 fee schedule.
	□ 47	Provider billed Region 3 after the denial of insurance benefit was received (service was deemed to be not covered by insurance or the consumer's deductible not being met). Denial was not due to provider error or failure to submit required information (as evidenced by EOB) (as applicable).
	□ 48	All services billed were submitted to the insurance company within 30 working days after the date of service and the date of submission has been documented for subsequent review and tracking (as applicable).
	□ 49	A person 18 yrs old or older may consent to MH services w/out the consent of his/her parent or guardian in accordance w/ revised NE Statute 43-2101; or (3) according to Federal statute 42 CFR 2.14, a minor may obtain SU treatment w/out the knowledge or consent of the minor's parents. Parent/guardian info will not be used under these circumstances.
	□ 50	If the participant is under the age of 19 and has not been designated by a court as emancipated, the custodial parent(s) alimony, wages, tips or other money received is used to determine financial eligibility. Participant copayment has been determined as is indicated on EWFS.
	□ 51	Copay charge falls w/in the range of allowable copayment on the appropriate Region 3 fee schedule.
	□ 52	EWFS includes appropriate personnel signature.
	□ 53	EWFS includes participant and/or parent/guardian signature, as applicable.
	□ 54	Provider completes EWFS re-verification process annually, or when known changes occur.

Screening (P)	□ 55	Includes screening and recommendations for trauma (Families CARE Trauma Screening Tool).
	□ 56	Include Medical/Self Care Information form.
	□ 57	Includes Dr/clinic name/phone # and emergency contact name/phone #. (Medical/Self Care Information form)
	□ 58	Includes medical history (items f-k) are included within the Medical/Self Care form.
	□ 59	Medical/Self Care form include check boxes for referral for medical care.
	□ f	Includes whether screened for HIV/AIDS.
	□ g	Includes whether screened for Tuberculosis.
	□ h	Includes whether screened for pregnancy.
	□ i	Includes whether screened for IV drug use.
	□ j	Includes whether screened for Hepatitis B.
	□ k	Includes whether screened for Hepatitis C.
	□ l	Ensure referral is made & Interim Services packet is provided, if screening (items f-k) indicates need.
Service Expectations	□ 60	A mental health or Substance Use Disorder assessment describing the service needs of the consumer, completed by a licensed clinician authorized to perform this service, must have been completed prior to initiating peer support services. A copy of the assessment(s) should be found in the consumer's peer support file; if unable to obtain, documentation will be found describing efforts to obtain.
Month of Srvc	□ 61	Month(s) of service indicated in participant file.
Date of Service	❑ 62	Date of service indicated in participant file
	❑ 63	Date of service in file agrees with date claimed
Length of Service	❑ 64	Length of service indicated in participant file (CA)
	❑ 65	Length of service in file agrees with time claimed (CA)
Units	❑ 67	Units claimed agree with units documented in participant file or attendance log
Direct Contact Notes (DCN)	□ 68	DCN in participant file. (electronic)
	□ 69	DCN is legible/complete/sufficient to determine nature/content of srvcs/indiv participation & progress.
	□ 70	DCN completed within required timeframe.
	□ 71	DCN identifies appropriate staff.
Program Plan must include item #'s 71 thru 81	□ 72	WRSP Peer support service interventions to support individuals on their recovery journey include Person centered-strength based planning.
	□ 73	System navigation, accessing community resources, and engagement with formal and informal resources and supports through coaching/mentoring.
	□ 74	Assist individuals in accessing resources and to locate and join existing self-help groups.
	□ 75	Education about topics such as healthy personal boundaries, individual rights, self-management, and the significance of shared decision making.
	□ 76	Self-advocacy activities that enhance problem solving abilities and improve health and well-being.
	□ 77	For Family Peer support, provide education to family to support building parenting skills & understanding trauma.
	□ 78	Collaborate and serve as a valuable member of the individual/family/guardian's care team.
	□ 79	Clinical consultation between a licensed provider and the peer support provider must occur every 90 days or as often as necessary to update progress or revise the WRSP.
	□ 80	Clinical Consultation shall be available to provide consultation on various situations that arise to the level of "crisis" with the individual and/or family.
	□ 81	Caseloads for peer support providers must not exceed 1:25.
	□ 82	Groups are a minimum of three and a maximum of 12 participants. Revised: 8/31/22