

UM Child PCP Checklist

Consumer:

Clinical Home Submitting

Qualified Professional:

Date Checklist Initially Completed:

Assessments/Attachments

Done	Not Done	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CALOCUS/LOCUS completed and supports level of care or explanation listed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASAM Completed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CCA completed (must be within last 30 days for Level III + Level IV)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Neuropsych (Required for TBI/MR services/PRTF)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IEP/504 plan or other school documents (Required for Day Treatment)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Court Order (when plan states service is "court ordered")
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CON (Required for PRTF)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ICPC Form (Required for Out of State Placement)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Informed Consent Form (Required for Out of State Placement)

Clinical Justification for Services

Done	Not Done	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Axis I-V completed and accurate.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clear clinical justification for Services and Frequency Being Requested
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Explanation as to why lower levels of care are not clinically appropriate- including previous services tried, when these were tried and outcomes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of Prior Hospitalizations (Dates and Reasons)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of current behaviors and symptoms and frequency of these
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Service request meets all service definition criteria
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Information including: Medication, Dosages, current and historical, start/end dates, response, prescribing provider and specialty
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were natural supports identified and included in pcp planning or reasons for not including documented.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of family involvement in treatment now and historically Please identify relationship of guardian to consumer
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Areas of need in School addressed (suspensions, expulsions, EC services)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of coordination with primary care and date of last visit
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goals are relevant to consumer's diagnosis and services requested support those goals.

- Goals support the need for the requested service.
- Measurable Step-down/ transition plan included, with anticipated date of discharge
- Service frequency listed is consistent throughout the PCP and associated TAR.
- DSS, Court, Probation/Parole requirements are addressed in plan.
- EPSDT justification is included for child/adolescent plan requesting services outside standard guidelines.

Signature Requirements

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signature page completed (<input type="checkbox"/> Legally Responsible Person, <input type="checkbox"/> QP/LP, <input type="checkbox"/> Service order, <input type="checkbox"/> Consumer/Guardian, <input type="checkbox"/> Minor signature for SA services) |

Health and Safety

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Services in the PCP reflect assessed risk factors |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crisis Plan completed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Relapse Prevention Plan |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Restrictive Intervention Plan/ Prone Restraint Plan |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Explanation of clinical need for Residential Treatment |