Care Coordination Organization (CCO) Chart Review Checklist

Care Coordinator should review all charts using this checklist before submitting to their supervisor for review

Youth: _____ Care Coordinator: _____ Supervisor: _____

General Items

Please initial to indicate that you confirmed the documents are included in this youth's chart

Chart
With youth name _____

Referral
With assigned date _____

Intake Paperwork

Please initial to indicate that you confirmed the documents are included in this youth's chart

Intake Checklist
Signed by care coordinator & supervisor _____

Provisional Plan of Care
Signed to match completion date _____

Research or Grant Specific Consents
If applicable _____

Electronic Communications Form
If applicable _____

Consent for Services
Name & date at top of all pages
All medical & team information filled in
Write "minor" if youth did not sign _____

Family Timeline _____

Family Story _____

Releases of Information

*** Every team member listed in the Plan of Care should have a release***

	Organization Name	Exp. Date	Your Initials
School 1			
School 2			
Primary Care Physician			
Dept. of Juvenile Svcs.			
Dept. of Social Services			
Other Release 1 *(Specify)*			
Other Release 2 *(Specify)*			

Behavioral Health Information

Please initial to indicate that you confirmed the documents are included in this youth's chart

Diagnostic Information _____

Assessments _____

Inpatient paperwork _____

Other *(Specify)* _____

Behavioral Health Service Provider Information

	Facility/Org. Name	Clinician's Name	Phone Number
Current Primary Therapist	_____	_____	_____
Current Primary Psychiatrist	_____	_____	_____
Other Provider *(Specify)*	_____	_____	_____

School Information

Current School Name _____

School Contact Person
E.g., Counselor, Teacher, IEP Admin. _____

School Contact Direct Number _____

School Paperwork

Please initial to indicate that you confirmed the documents are included in this youth's chart

Individualized Education Plan _____ **504 Paperwork** _____

Referral/Suspension Paperwork _____ **School Reports** _____

Behavior Charts _____

Legal Information

Please initial to indicate that you confirmed the documents are included in this youth's chart

Custody Paperwork _____ **DJS Paperwork** _____ **Other** *(Specify)* _____

Medical Information

Please initial to indicate that you confirmed the documents are included in this youth's chart

Cover letter to PCP _____ **Immunization Records** _____

Physical Health Records _____ **Other (*Specify*)** _____

Referral Paperwork

	Name of Organization and/or Provider	Initial Referral Date	Your Initials	Follow Up I *Within 7 days of referral*	Your Initials	Follow Up II *Within 7 days of Follow Up I*	Your Initials
Referral 1	_____	_____	_____	_____	_____	_____	_____
Referral 2	_____	_____	_____	_____	_____	_____	_____
Referral 3	_____	_____	_____	_____	_____	_____	_____

Insurance and Staffing Paperwork

Please initial to indicate that you confirmed the documents are included in this youth's chart

Administrative Service Organization (ASO) Authorization _____

Transfer of Staff/CC Form *If applicable* _____

ASO Letter _____

ASO Summary _____

Child and Family Team (CFT) Meeting Documents

Please initial in boxes to indicate that you confirmed the documents are included in this youth's chart
Meeting frequency for each level of care: Level I Every 6 Months | Level II Every 3 Months | Level III Every 45 Days

	Meeting Date	Agenda	**Sign-In Sheet** *Must Contain: All Signatures Meeting Date Youth Name*	**Plan of Care** *Signed on CFT Date by: Youth Guardian Supervisor Team Members *Ensure all medical & team member info is included**	**If CFT is late:** *Provide the reason below **AND** provide your initials to indicate that the reason is documented in the File/Electronic Medical Record*
Meeting 1	_____	_____	_____	_____	_____
Meeting 2	_____	_____	_____	_____	_____
Meeting 3	_____	_____	_____	_____	_____
Meeting 4	_____	_____	_____	_____	_____
Meeting 5	_____	_____	_____	_____	_____
Meeting 6	_____	_____	_____	_____	_____
Meeting 7	_____	_____	_____	_____	_____
Meeting 8	_____	_____	_____	_____	_____
Meeting 9	_____	_____	_____	_____	_____

Electronic Medical Record

CANS
Child and Adolescent Needs and Strengths Ax
Must be on date of intake & every 6 mo. after _____

SBIRT
Screening, Brief Intervention and Referral to Tx
Must be on date of intake & every 3 mo. after _____

CRAFFT
Car, Relax, Alone, Forget, Friends, Trouble Ax
Dated for date of intake _____

Diagnostic Review Form _____

Interim Treatment Plan / Plan of Care Tx Plan
Dated for date of intake _____

Monthly Progress Notes _____

Discharge Paperwork

Discharge Checklist
Signed by CC and Supervisor _____

Discharge Letter to Youth _____

Discharge Letter to Referral Source _____

Discharge Summary _____

Discharge CANS
Must match date of discharge _____

ASO Discharge
Must match date of discharge _____

Care Coordinator's Signature _____ Date Reviewed by Care Coordinator _____

To be completed by the Care Coordinator's Supervisor:

Chart Complete _____ Chart Needs Improvement _____

Notes:

Care Coordinator Supervisor's Signature _____ Date Reviewed by Supervisor _____

Charts requiring corrections or additions should be submitted to supervisors for review within 10 business days of initial review