NY Treatment Records

Effective Date: December 5, 2025

General Documentation

Question	
01	Each member has a separate record.
02	Treatment record that includes the member's address, telephone numbers including emergency contacts, birth and/or identified gender, relationship and legal status, and guardianship information, if relevant.
03	All entries in the record include the responsible clinician's name, professional degree/licensure/certification, and relevant identification number, if applicable, and dated and signed (including electronic signature for EMR systems) where appropriate.
04	For children and adolescents the record includes legal documents (court mandates, parental custody, ACS/CPS custody, orders of protection, termination of parental rights etc.) confirming a child's legal custodian AND legal guardian (if different).

Initial Assessment

Question	
05	The initial assessment for outpatient services is completed within 30 days of the member's request for services; any exceptions to this time frame are clearly documented (must be scored for all outpatient services).
06	A complete clinical case formulation is documented in the record (e.g., DSM primary treatment diagnosis, medical conditions, psychosocial and environmental factors and functional impairments).
07	The member's reasons for seeking treatment are documented.
08	A behavioral health history is in the record and includes the following information: dates and providers of previous treatment, family behavioral health history information and therapeutic interventions and responses.
09	There is documentation that recent providers of services have been contacted to obtain discharge summaries and other pertinent information.
10	A medical history is in the record and includes the following information: known medical conditions, dates and providers of previous treatment, current treating clinicians, and current therapeutic interventions and responses and family medical history information AND this health information is reviewed by a physician, NP, RN or PA.
11	Was a current medical condition identified? This is a non-scored question.
12	If a medical condition was identified, there is documentation that communication/collaboration with the treating medical clinician occurred. This is a non-scored question.
13	If a medical condition was identified, there is documentation that the member/guardian refused consent for the release of information to the treating medical clinician. This is a non-scored question.
14	A complete mental status exam is in the record, documenting the member's affect, speech, mood, thought content, judgment, insight, attention or concentration, memory, and impulse control.
15	The record documents a risk assessment appropriate to the level of care and population served which may include the presence or absence of suicidal or homicidal risk and any behaviors that could be considered a danger toward self or others.
16	If a risk issue is identified, a safety plan is documented in the record.
17	The record includes documentation of previous suicidal or homicidal behaviors, (dates, method, and lethality) as well as any behaviors that could be considered a danger toward self or others.
18	The behavioral health history includes an assessment of any abuse the member has experienced or if the member has been the perpetrator of abuse.
19	For children and adolescents the assessment includes and assessment of bullying the member has experienced or if the member has been the perpetrator of bullying.
20	The behavioral health history includes an assessment of any trauma the member has experienced.

21 For Adolescents: The assessment documents a sexual behavior history to include sexual identity, orientation, activity status, unsafe/risky situations and practices.

22 For children and adolescents, prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual, living arrangements, custody, and academic), are documented.

23 The initial screen includes an assessment for depression.

24 For members 12 and older, a substance abuse screening occurs using a standardized screening instrument and clinical assessment as needed. Documentation includes past and present use of alcohol and/or illicit drugs as well as prescription and over-the-counter medications.

25 For members 12 and older, the substance abuse screening includes documentation of past and present use of nicotine.

26 For active smokers, the substance abuse screening includes documentation of the member's readiness to reduce or quit using tobacco.

27 For active smokers, every 3 months the member's nicotine use is reassessed.

28 For members under the age of 18, the substance abuse screening includes documentation of nicotine, alcohol or substance use by anyone living in the member's place of residence.

29 If the screening indicates an active alcohol or substance use problem, there is documentation that an intervention for substance abuse/dependence occurred.

30 The substance identified as being misused was alcohol. This is a non-scored question.

31 The substance(s) identified as being misused were substance(s) other than alcohol. This is a non-scored question.

32 The substances identified as being misused were alcohol and other substance(s). This is a non-scored question.

33 The assessment documents the spiritual and cultural variables that may impact treatment

34 An educational assessment appropriate to the member's age is documented (including identification of any literacy needs).

35 The record documents the presence or absence of relevant legal issues of the member and/or family.

036 There is documentation that the member was asked about community resources (support groups, social services, school based services, other social supports) that they are currently utilizing.

37 There is documentation that indicates the member understands and consents to the medication used in treatment.

38 For children and adolescents documentation indicates the responsible family member or guardian understands and consents to the medication used in treatment.

39 Each record indicates what medications have been prescribed, the dosages of each, and the dates of initial prescription or refills.

40 The presence or absence of drug allergies and food allergies, including adverse reactions, is clearly documented.

41 The member's previous medication history is documented in the record.

42 The clinician uses a Consent for Treatment or Informed Consent form with all members; this document should be signed by the member and/or legal guardian.

43 For children and adolescents, there is documentation that the legally authorized decision maker for the child understands and consents to treatment.

Coordination of Care

Question

44 Does the member have a medical physician (PCP)? This is a non-scored question.

45 The record documents that the member was asked whether they have a PCP. Y or N Only

046 If the member has a PCP there is documentation that communication/collaboration occurred.

47 If the member has a PCP, there is documentation that the member/guardian refused consent for the release of information to the PCP.

48 Is the member being seen by another behavioral health provider (e.g. psychiatrist and social worker, psychologist and substance abuse counselor). This is a non-scored question.

49 The record documents that the member was asked whether they are being seen by another behavioral health provider. Y or N Only

50 If the member is being seen by another behavioral health provider, there is documentation that communication/collaboration occurred.

51 If the member is being seen by another behavioral health provider, there is documentation that the member/guardian refused consent for the release of information to the behavioral health provider.

Treatment Planning

Question

52 For Outpatient Services Only: The treatment plan is completed within 30 days of admission or prior to the 4th visit.

53 An initial treatment plan with goals, treatment priorities, and milestones for progress is in the record.

054 There is evidence that the assessment is used in developing the treatment plan and goals.

55 At the time of the initial assessment and throughout treatment, potential barriers or difficulties to participating in treatment are identified and addressed.

56 If member receiving services from collateral organizations or providers (such as: probation, family court, domestic violence support, etc.) there is evidence that, when agreed upon by the member, that communication occurs as needed.

57 The treatment plan is signed by clinician per regulations.

58 The treatment plan is co authored by member/ and supports as appropriate.

59 For children only, the treatment plan is co authored by the legally authorized decision maker member/ and supports as appropriate.

60 The treatment plan is consistent with the diagnosis.

61 There is evidence that the treatment plan is developed with the individual, family, collaterals and supports as appropriate and is signed by the clinician.

62 Measurable and attainable steps toward the achievement of goals are identified.

063 The treatment plan has estimated time frames for goal attainment.

64 Treatment plan goals, objectives, and services reflect the assessment and include the individual's/family's preferences and priorities.

65 The treatment plan is updated when goals are achieved or new goals are identified.

66 For Outpatient Services Only:The treatment plan is reviewed and updated as needed as determined by the individual/family and the treating clinician, but no less than annually.

67 When applicable, the treatment record, including the treatment plan, reflects discharge planning.

68 If a member is receiving services in a group setting, there is evidence of an individualized assessment, treatment planning, and progress notes in response to identified member needs.

69 The treatment record documents and addresses biopsychosocial needs.

70 The treatment record indicates the member's involvement in care and service.

71 When appropriate, the treatment record indicates the family's involvement in the treatment process, including care decisions.

Progress Notes

Question	
72	For all Outpatient Services: All progress notes document the start and stop times or duration for each session when a timed code is used.
73	For all Outpatient Services: All progress notes document clearly who is in attendance during each session.
074	For all Outpatient Services: All progress notes include documentation of the billing code that was submitted for the session.
075	The progress note indicates the type of intervention that was used for the session
076	The progress notes reflect reassessments when necessary.
77	The progress notes reflect on-going risk assessments (including but not limited to suicide, homicide, and dangerous behaviors) and monitoring of any at risk situations.
78	Documentation in the record reflects that safety plans are reviewed and updated when clinically indicated.
079	The progress notes describe/list member strengths and limitations and how those impact treatment.
80	Progress notes are linked to goals and objectives by summarizing services provided, the interventions utilized, the recipient's response, and progress toward goals.
81	The progress notes document any referrals made to other clinicians, agencies, and/or therapeutic services when indicated.
82	If the member is on medication, there is evidence of medication monitoring in the treatment record. (physicians and nurses)
83	When a primary care physician is identified, there is evidence the prescriber coordinated care within 14 calendar days after initiation of a new medication. This is a non-scored question.
84	When lab work is ordered, there is evidence the lab results were received and reviewed by the prescribing clinician.
85	When lab work is ordered, there is evidence that the provider reviewed the results with the member.
86	The progress notes document the dates of follow up appointments AND when members miss appointments.
087	When a member misses an appointment, there is documentation of outreach efforts (phone calls, missed appointment letters) the provider makes to reengage the member in treatment.

Transitions Planning

Question	
88	Was the member transferred/discharged to another clinician or program? This is a non-scored question.
89	If the member was transferred/discharged to another clinician or program, there is documentation that communication/collaboration occurred with the receiving clinician/program.
90	If the member was transferred/discharged to another clinician or program, there is documentation that the member/guardian refused consent for release of information to the receiving clinician/program.
91	The reason for discharge is clearly identified.
92	The discharge plan summarizes the reason(s) for treatment and the extent to which treatment goals were met.
093	The discharge/aftercare plan describes specific follow up activities.
94	When a member discontinues services, a full review of the case, including an assessment of the level of risk, is completed and efforts are made to reengage the member in services.
95	The discharge summary completed within three business days of discharge.
96	When a case is closed as a result of the member discontinuing services, written correspondence is sent to the member indicating they are encouraged and welcome to reengage in services at any time.

Treatment Records

Question	
97	Treatment records are completed within 30 days following discharge from services.
098	The record is clearly legible to someone other than the writer.
099	When appropriate there is evidence of supervisory oversight of the treatment record.

Education

Question	
100	There is documentation that the provider offers education to members/families about care options, participation in care, coping with behavioral health problems, prognosis and outcomes.
101	There is documentation that the risks of not participating in treatment are discussed with the member.

Interpreter Services

Question	
102	If the member has limited English proficiency, there is documentation that interpreter services were offered.

Recovery and Resiliency

Question	
103	The member is given information to create psychiatric advance directives. This is a non-scored question.
104	The patient is offered with referrals to peer support services. This is a non-scored question.

Inpatient/RTC/PHP/IOP

Question	
105	For inpatient and residential treatment, the record documents functional impairments preventing completion of activities of daily living, assessment of fall risk, and elopement risk.
106	There is evidence of patient monitoring appropriate to their level of acuity.
107	There is clear documentation of medication dispensing and/or administering, as appropriate.
108	For Detox Services, there is evidence of consistent documentation of vital signs throughout treatment.
109	There is evidence of progress documented by the physician/addictionologist at regular intervals, appropriate to the rendered service.
110	For eating disorder treatment, there is evidence of medical monitoring at appropriate intervals to the level of care throughout treatment.