**Section 132.100 Clinical Records**

The Client's clinical record shall contain, but is not limited to the following:

a) Identifying information, including Client's name, Medicaid recipient identification number, address and telephone number, gender, date of birth, primary language, method of communication, and documentation of how anything other than verbal English communication needs were accommodated, name and phone number of emergency contact, date of initial contact and initiation of mental health services, third party insurance coverage, marital status, and source of referral;

b) Documentation of consent for or refusal of mental health services;

c) Assessment and reassessment reports;

d) A single consolidated ITP within a Provider organization. The ITP must be current;

e) Admission Note or Healthy Kids screen, if applicable;

f) Documentation concerning the prescription and administration of psychotropic medication as specified in Section 132.150(c)(1);

g) Documentation of missed appointments;

h) Documentation of Client referral or transfer during any active service period to or from the Provider's programs or to or from other providers;

i) Documentation to support services provided for which reimbursement is claimed shall be in the format specified by the Public Payer, shall be legible, shall support the amount of time claimed, and shall include, but not be limited to, the following elements:

1) The specific service, including whether the service was rendered in a group, individual or family setting and a note in the periodic report indicating the specific Part 132 mental health services billed by name or code;

2) The date the service was provided;

3) The start time and duration for each service;

4) The original signature, name and credential of the staff providing the service;

5) The site or, if off-site, the specific off-site location where services were rendered; and

6) Written documentation of each service provided as described in Section 132.148, 132.150 or 132.165;

j) ITP reviews describing the Client's overall progress;

k) A written record of the Client's major accidents or incidents that occurred at the site, whether self-reported or observed, and resulting in an adverse change in the Client's physical or mental functioning; and

l) Discharge summary documenting the outcome of treatment and, as necessary, the linkages for continued services.

(Source: Amended at 38 Ill. Reg. 15550, effective July 1, 2014)