**ATTACHMENT F: File Audit Review Form**

**STATE OF MISSOURI**

**DMH** - **DIVISION OF DD** - **REGIONAL OFFICES TRANSFER FORM**

Date Submitted:

**Transfer Type:**  Services

Case Management Only

Name:       DMH ID Number:

Date of Birth: Medicare Number:

      Medicaid Number:

      ISP date:       Guardian Status:

**Individual's New Address** (Include City, State, Zip Code):

**County:**       **Telephone Number:**

**Parent/Guardian/Best Informant/Name** & **Address** (Include City, State, and Zip Code):

**Parent/Guardian/Best Informant Phone (Include area code):**

**Transfer FROM (RO/TCM):**

**Funding Source:**

**Principle Diagnosis w/ code:**

**Transfer TO (RO/TCM):**

**Services Authorized and/or projected:**

**Medicaid Waiver Slot#:**

Was individual on the Waiting List: (provide date placed on Waiting List, PON Score, and service(s) needed:

**Brief Update** (i.e. Reason for moving, concerns/issues receiving area should know about):

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

File Audit Checklist:

Admission Documents

Legal Documents

Diagnosis Information (including ICD-0 codes and collateral)

All available Assessments (including MOCABI/Vineland)

Current Individual Support Plan

Waiver Choice Statement

Provider Choice Statements

Budgetary Documents (approved UR/ISL budgets)

PON and UR Recommendation form

Last 6 months of monthly/ quarterly reviews

File Audit Completed by: Transition Meeting Date:

Date File Audit Completed: Transfer Effective Date: