Provider Documentation Standards – Mental Health

I. Purpose

This exhibit establishes record and treatment expectations and standards regarding mental health documentation responsibilities including intake, assessment, treatment planning, progress notes, suicide prevention, reassessment, and discharge. These standards apply to all individuals receiving mental health services to ensure quality care, continuity of services, and regulatory compliance.

II. Provider Responsibilities

All Network Service Providers are expected to maintain an individualized, accurate, and current participant record. Providers must update information at intake or with significant changes, and document all services provided. Providers must ensure that documentation reflects participant-centered goals, progress, and outcomes and is completed in a timely manner according to best practice timeframes.

III. Documentation components

Basic Client Record / Demographics

The Network Service Provider must develop and maintain a record for each individual for which it provides mental health services that includes the following information:

- Participant name, address, telephone number, date of birth, sex, race, marital status, address, telephone number, and financial eligibility information
- Guardian contact for minor clients or emergency contact information, if applicable
- Referral source and legal status
- Staff name who has primary responsibility of client
- Consent for services
- Time-specific, signed, and dated Releases of Information (ROI's) for pertinent contacts such as primary care physician, referral source, emergency contact, and/or family/ support person (specifying relationship to the individual)

Screening and Intake Procedures

The Network Service Provider must have written screening and intake procedures which minimally assure that:

- Upon initial request for services, an evidence-based screening tool is utilized by specifically trained staff, to determine the immediacy of the individual’s needs and to ascertain the appropriateness of the agency’s services to meet the needs of the individual.
- For cases determined to be non-emergency, initial intake services are offered as immediately as appropriate to meet the individual’s needs.
- When the services offered by the agency are found to be inappropriate to the needs of a potential individual served, the agency shall ensure a timely referral for the person to a more appropriate agency or service provider and make all reasonable efforts to confirm that the individual has been accepted for service.

- During the intake process, all potential individuals served will be provided with a documented orientation that describes to them the nature of the services offered, the procedures, expectations, fees, confidentiality, time involved, as well as a description of the participant's rights, choices, and responsibilities while in treatment.

Comprehensive Assessment

The comprehensive assessment must be completed within 30 days after intake and include the following with client input:

- Description and evaluation of the client's current and potential strengths and presenting problems, the client's family and friends, pertinent agencies with whom the client has been involved, and other social support systems that may contribute to the course of treatment.
- Information from the intake and evaluation

***Clinical Assessment Components*:** Comprehensive mental health assessment including history, trauma, current symptoms, mental status exam, and diagnostic impressions (DSM-5/ICD-10)

- Risk assessment (suicide, self-harm, aggression)
- Functional and psychosocial assessment
- Integrated summary including details regarding safety risks and observations of symptoms that demonstrate the client meets the criteria for the diagnosis given.

All assessment elements must be documented clearly, signed by the qualified professional on the date of completion, and include a record of participant involvement. If the individual drafting the assessment is a registered intern, the assessment must be countersigned by the intern's supervisor within 10 days of completion.

Treatment Plans

Master Treatment Plans must be individualized, developed collaboratively with the participant, and completed within 30 days of intake. Plans should be reviewed at least every 6 months, or sooner to document any significant changes.

Treatment Plan Requirements:

- Incorporate needs and strengths from the comprehensive assessment
- Include measurable, achievable, and observable goals and objectives
- Identify actions needed to obtain the goals and the staff responsible for each action
- Include one goal for each treatment domain
- Link participants to external resources when the service is unavailable within the agency
- Record progress, setbacks, and next steps
- Plans must be signed by the participant and the assigned clinician. For minor clients, the parent or caregiver must sign for the participant as well.
- Staff who are registered interns must have the plan countersigned by their supervisor within 10 days of completion.

Progress Notes / Contact Documentation

Progress notes shall be prepared at least monthly for those individuals with a service or treatment plan, unless the plan indicates less frequent need. All contacts, outreach attempts, and referrals must be documented within the client record by way of a progress note or status update.

Progress Notes Requirements:

- Indicate progress or lack thereof relative to the goals and objectives on the service or treatment plan
- Modifications to the treatment or service plan based on participant needs, resources, findings, etc.
- Contact dates with client, family, friends, or service agencies

Suicide Prevention and Safety Planning

Providers must follow suicide prevention protocols appropriate to their role and scope of practice. Screenings should be completed at intake, every 90 days, or sooner based on risk level or if risk is observed.

- Conduct comprehensive risk assessments
- Administer evidence-based screening tools (PHQ-9, ASQ, C-SSRS)
- Develop, monitor, and update safety plans that include warning signs, triggers, coping skills, support systems, and limiting access to lethal means
- Provide a signed copy of the safety plan to the participant and maintain a copy in the record. For minor clients, provide a copy of the completed safety plan to the parent or caregiver.
- Provide clinical interventions and referrals as indicated

Annual Review

At least once per year, the following must be reviewed and updated with the participant:

- Comprehensive Assessments
- Safety plan
- Orientation materials and participant understanding

Discharge / Termination

Discharge documentation must be completed in the client record within four weeks of service completion or official discharge. If there is no contact for over ninety (90) days, the client file must be closed unless the treatment plan indicates less frequent contact. Any attempts to contact the individual prior to discharge must be documented via progress notes within the client record.

Termination Report Requirements:

- Reason for termination
- An evaluation of impact of the agency's services on the client's goals and objectives

- If there is a recommendation for additional services or referrals, a reason for the referral must be noted
- Date and signature of the individual preparing the report.

References:

http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/0394PARTIVContentsIndex.html

Senate Bill 1620 (2025) https://www.flsenate.gov/Session/Bill/2025/1620

https://laws.flrules.org/2025/184

LSF Provider Contract Documents Attachment I:

https://www.lsfhealthsystems.org/wp-content/uploads/2023/08/Network-Service-Provider-Attachment-I-FY-23-24.pdf