WAC 246-341-0640 Individual service record content. A behavioral health agency is responsible for the components and documentation in an individual's individual service record content unless specified otherwise in certification or individual service requirements.

(1) The individual service record must include:

(a) Documentation the individual received a copy of counselor disclosure requirements as required for the counselor's credential.

(b) Identifying information.

(c) An assessment which is an age-appropriate, strengths-based psychosocial assessment that considers current needs and the individual's relevant behavioral and physical health history according to best practices, completed by a person appropriately credentialed or qualified to provide the type of assessment pertaining to the service(s) being sought, which includes:

(i) Presenting issue(s);

(ii) An assessment of any risk of harm to self and others, including suicide, homicide, and a history of self-harm and, if the assessment indicates there is such a risk, a referral for provision of emergency/crisis services;

(iii) Treatment recommendations or recommendations for additional program-specific assessment;

(iv) A diagnostic assessment statement, including sufficient information to determine a diagnosis supported by the current and applicable *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), or *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-5);

(v) A placement decision, using ASAM criteria dimensions, when the assessment indicates the individual is in need of substance use disorder services.

(d) Individual service plan that:

(i) Is completed or approved by a person appropriately credentialed or qualified to provide mental health, substance use, co-occurring, or problem gambling disorder services;

(ii) Addresses issues identified in the assessment and by the individual or, if applicable, the individual's parent(s) or legal representative;

(iii) Contains measurable goals or objectives and interventions;

(iv) Must be mutually agreed upon and updated to address changes in identified needs and achievement of goals or at the request of the individual or, if applicable, the individual's parent or legal representative;

(v) Must be in a terminology that is understandable to the individuals and the individual's family or legal representative, if applicable.

(e) If treatment is not court-ordered, documentation of informed consent to treatment by the individual or individual's parent, or other legal representative.

(f) Progress and group notes including the date, time, duration, participant's name, response to interventions or clinically significant behaviors during the group session, and a brief summary of the individual or group session and the name and credential of the staff member who provided it.

(g) If treatment is for a substance use disorder, documentation that ASAM criteria was used for admission, continued services, referral, and discharge planning and decisions.

(h) Discharge information as follows:

(i) A discharge statement if the individual left without notice; or

(ii) Discharge information for an individual who did not leave without notice, completed within seven working days of the individual's discharge, including:

(A) The date of discharge;

(B) Continuing care plan; and

(C) If applicable, current prescribed medication.

(2) When the following situations apply, the individual service record must include:

(a) Documentation of confidential information that has been released without the consent of the individual under:

(i) RCW 70.02.050;

(ii) The Health Insurance Portability and Accountability Act (HIPAA);

(iii) RCW 70.02.230 and 70.02.240 if the individual received mental health treatment services; and

(iv) 42 C.F.R. Part 2.

(b) Documentation that any mandatory reporting of abuse, neglect, or exploitation consistent with chapters 26.44 and 74.34 RCW has occurred.

(c) If treatment is court-ordered, a copy of the order.

(d) Medication records.

(e) Laboratory reports.

(f) Properly completed authorizations for release of information.

(g) If the individual engages in services or is referred to a new service provider, the individual service record should include documentation that copies of documents pertinent to the individual's course of treatment were forwarded to the new service provider with the individual's consent or if applicable, the consent of the individual's parent or legal representation.

(h) If a report is required by a third-party, a copy of any report required by third-party entities such as the courts, department of corrections, department of licensing, and the department of health, and the date the report was submitted.

(i) Documentation of coordination with any systems or organizations the individual identifies as being relevant to treatment, with the individual's consent or if applicable, the consent of the individual's parent or legal representation.

(j) A crisis plan, if one has been developed or obtained.

[Statutory Authority: RCW 71.24.037, 71.05.560, 71.34.380, 18.205.160, 43.70.080(5), 41.05.750, 43.70.250, and 74.09.520 and chapters 71.05, 71.12, 71.24 and 71.34 RCW. WSR 22-24-091, § 246-341-0640, filed 12/6/22, effective 5/1/23. Statutory Authority: RCW 71.24.037, 71.05.560, 71.34.380, 18.205.160, 71.24.037 and chapters 71.05, 71.24, and 71.34 RCW. WSR 21-12-042, § 246-341-0640, filed 5/25/21, effective 7/1/21. Statutory Authority: 2018 c 201 and 2018 c 291. WSR 19-09-062, § 246-341-0640, filed 4/16/19, effective 5/17/19.]