**Provider Monitoring Review Questionnaire**

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| **Provider Name:**  |  | **Region:** |  | **Review Dates:** |  | **Reviewers:** |  |
| **Name of Person Completing Form:** |  | **Phone Number:** |  |

 **Please answer the questions by rating the review process using the scale provided.**

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| --- | --- | --- | --- | --- | --- |
| **Number** | **Item** | **3: Agree** | **2: Neutral** | **1: Disagree** | **0:** **N/A** |
| 1. | You received an initial phone call from the Collaborative Training Coordinator a week (5 business days) prior to the scheduled review. |  |  |  |  |
| 2 | Information regarding the review process that was given to you prior to the review was sufficient to prepare for the review. |  |  |  |  |
| 3. | During the entrance conference, the reviewers provided detailed information regarding the on-site review process. |  |  |  |  |
| 4. | The reviewers included you, when necessary, to help locate documents required for review of the clinical records. |  |  |  |  |
| 5. | The reviewers were professional and conducted themselves in a courteous manner with staff, as well as clients/consumers, when applicable. |  |  |  |  |
| 6. | During the exit conference, the reviewers provided enough information to allow for a clear understanding of the review results. |  |  |  |  |
| 7. | As an agency, you utilize the Illinois Mental Health Collaborative website to locate monitoring tools and information. |  |  |  |  |

Please complete this questionnaire and mail to:

Attn: Charles Hopkins

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