

Newaygo County Community Mental Health
A member of
Community Mental Health Affiliation for Mid-Michigan

**CONTRACT PROVIDER PERFORMANCE MONITORING
 REPORTS SUMMARY**

Contract Provider Name: _____

Reporting Period: ____/____/____ **to** ____/____/____ **Report Date:** _____

Check all items used to monitor provider performance during the reporting period. Attach reports/documentation for each item checked.

	Frequency of Monitoring	Date Completed
<input type="checkbox"/> Customer Satisfaction Surveys	Annually by CEI	
<input type="checkbox"/> Site Reviews (Q & C)	Annual	
<input type="checkbox"/> Contract Compliance Reviews	Annual – Random	
<input type="checkbox"/> Medicaid Billing Verification	Annual	
<input type="checkbox"/> Peer Review	As applicable	
<input type="checkbox"/> DCIS Licensing Certification Reports	Annual/bi-annual	
<input type="checkbox"/> Recipient Rights Reports (IR's, Complaints, etc)	Annual	
<input type="checkbox"/> Other (list)	As applicable	

Comments on above check items: _____

PERFORMANCE SUMMARY

Provider Strengths: _____

Provider Improvement Needs: _____

RECOMMENDATIONS

Provider Recommended for Continued Contractual Services:

- YES
- NO

Comments/Stipulations: _____

Signature/Title

Date

Original: Provider File
cc: Provider
 Quality Improvement Committee