

**MONTHLY MAT QA CHECK LIST REVIEW LOG**

DMH MAT Coordinator/Psychologist

DMH Service Planning Area/Office

Month and Year

Case Name (First Name, Last Initial)	DMH IS Number	MAT Refer Date	MAT Accept Date	SOF Comp. Date	SOF Eval. Date	MAT Agency	Sec. 1 Y/N	Sec. 2 Y/N	Sec. 3 Y/N	Sec. 4 Y/N	Sec. 5 Y/N	Sec. 6 Y/N	Sec. 7 Y/N	Sec. 8 Y/N	Comments
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1. In each row, enter case name, DMH IS Number, the MAT referral and acceptance dates, the dates the SOF Report was completed and evaluated, and the name of the MAT agency that completed the SOF Report you evaluated.
2. Under each column, Sections 1 through 8, indicate if you considered each section of the SOF Report to be adequate, as you indicated on the QA Check List, entering "Y" for Yes and "N" or No. Enter any comments at the end.
3. At the end of each month, photocopy the log. Retain the original and fax the photocopy to the DMH Quality Assurance Division designee within 5 working days following the end of the report month.