

CASE RECORD:

PURPOSE OF CASE RECORD:

- A. Case Record Purpose:** The purpose of the case record is two fold:
1. **Single Location:** To keep information about the client in a single location; and
 2. **Client Information Retrieval:** To keep the information filed in an orderly fashion for retrieving all pertinent information on a client.
- B. Care Plan:** The case record is the basis for the following regarding care plans:
1. **Continuance/Adjustment:** Continuance or adjustment of the client's care plan; and
 2. **Quality Assurance:** The basis for reviewing the client's situation.
- C. Case Record Information:** When clients request service from an agency, they give the agency the right to receive information about their condition. This information enables the case manager to perform the following tasks:
1. **Service Planning/Provision:** Plan for and provide appropriate and timely services;
 2. **Update Client Information:** Update information for current and future delivery of services.

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CONTENT OF THE CASE RECORD:

The case record shall contain the following items:

- A. **Assessment Form:** Completed client assessment form(s):
 - 1. **DOEA Forms 701A, 701B and/or 701C**, as appropriate;
 - 2. **Updates**; and
 - 3. **Reassessments**.
- B. **Care Plan:** Completed care plan—DOEA Forms 203A and 203B—with updates and review dates indicated.
- C. **Client Authorization:** Signed client authorization for release of information form.
- D. **Case Narrative:**
 - 1. **All Case Narratives:** Each narrative entry shall be signed and dated by the case manager who performed the activity. Case narrative entries made by a case aide shall be signed and dated by the aide.
 - a. Case management or case aide services are documented with the actual units of services provided, as well as the time spent on the activity. For billing of case management or case aide services, the time spent in direct service with or on behalf of a client is accumulated on a daily basis. The cumulative amount of time per service is totaled for the day and minutes are rounded up to the nearest quarter of a unit.
 - b. Service logs documenting the delivery of other services provided may be kept in the client file or may be kept in separate files.
 - 2. The case narratives for **Adult Protective Services High-Risk Referrals** require the following additional documentation:
 - a. The specific services authorized and the specific service dates for services provided during the 72 hours following the referral must be recorded. This includes non-DOEA services.
 - b. If services were delayed or not provided, the reason why must be stated and all actions taken in an attempt to provide service must be recorded.

- E. **Release of Information:** List of agencies to whom client information has been released.
- F. **Co-pay Assessment Form:** Copy of the co-pay form for CCE and ADI clients.
- G. **Home Care for the Elderly (HCE) Financial Worksheet:** Copy of the HCE financial worksheet shall be included for HCE clients.
- H. **Physician's Assessment/Order:** Copies of the physician's assessment and order if the following services are provided:
 - 1. Home Health Aide;
 - 2. Skilled Nursing;
 - 3. Occupational Therapy;
 - 4. Physical Therapy; and
 - 5. Speech Therapy

The original physician's order shall be filed at the provider location with a notation of the physician's order in the case narrative.

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STANDARDS FOR SECURITY AND PRIVACY OF CASE RECORDS:

- A. Locked Files:** Client records shall be kept in a locked file within the agency.
- B. Client Informed Consent:** The case manager must inform clients of the following:
 - 1. **Purpose:** Purpose for which the information is collected; and
 - 2. **Manner of Usage:** Manner in which it will be utilized, maintained and disseminated.
- C. Information Obtained:** The case manager shall inform applicants/clients that information obtained about them is:
 - 1. **Required** to provide services.
 - 2. **Confidential** and protected from loss, defacement, and unauthorized access.
 - 3. **Available for review** by applicants/clients and/or their representative.
- D. Case Record Review:** The client and representative/guardian have the right to review the client's case record.
 - 1. **Case Manager Responsibility:** The case manager shall review and update the case record before releasing it for the client's review.
 - 2. **Case Manager Availability:** The case manager shall be available to discuss the contents of the case record with the client if requested.
 - 3. **Method of Case Record Review:** Active case records shall not be mailed to clients. The client may review the record in the case manager's office or, if homebound, request that an authorized staff person bring it to the client's residence for review.
 - 4. **Case Record Copy:** The case manager may provide one copy of the case record to the client.

RETENTION OF CASE RECORDS:

Client case records shall be retained for a period of six (6) years after case closure or longer if required by federal regulations.

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CASE NARRATIVE GUIDELINES:

General Guidelines:

- A. Reflection of Activity:** Case narratives are completed to reflect activity that relates either directly or indirectly to the implementation of the care plan.
- B. Framework:** The reviewer should be able to determine the following as it relates to the care plan:
 - 1. Is the care plan valid?
 - 2. Are the services appropriate?
 - 3. Are the services responsive to the client's needs in both duration and intensity?

Case Narrative Sections:

Case narratives shall consist of the following three (3) sections:

- A. Section 1—Contact Summary:** The following information shall be included in the contact summary:
 - 1. **Date of Contact**
 - 2. **Type of Contact:**

<u>Contact:</u>	<u>Abbreviation:</u>
a. Office Visit	OV
b. Telephone Call	TC
c. Field Visit	FV
d. Home Visit	HV
 - 3. **Staff Name:** Name of staff making the contact and person contacted.
- B. Section 2—Narrative:** A summary of data shall include the following:
 - 1. **Client's Progress:** The client's progress towards goals.
 - 2. **Care Plan:** Pertinent data related to the care plan and/or the client's overall situation.

3. **Follow-Up Activity:** Documentation of contacts and other action performed for the client. This includes contacts with external entities and persons as well as agency staffing or other activities performed within the agency that relate directly to the client. Dates of follow-up activity must be documented.
4. **Service Barriers:** Problems encountered in service delivery.
5. **Special Circumstances:** Unique circumstances affecting the case.
6. **Semiannual Contacts:** Each active problem listed in the care plan addressed for each client semiannual contact.
7. **Initial Entries:** Initial entries should reflect the following elements:
 - a. **Available Resources:** Available resources are explored, including involvement of client's family and friends.
 - b. **Client Goals:** Provider is advised of the client's goals (for arranged or referred service only).
 - c. **Consistency:** Service provision is consistent with the care plan.
 - d. **Variances:** Variances from the care plan are addressed including reasons for the change.
 - e. **Other Data:** Any other appropriate data is included.
8. **Assessment Case Notes:** The following applies to case notes taken during the assessment process:
 - a. **Assessment Notes:** Notes taken on the assessment form at the annual assessment or reassessment shall generally serve as case notes for the assessment visit. Any specific information about the client, his/her needs, surroundings, the assessor's observations of the situation, or other information not captured on the assessment form, should be noted in the narrative for the visit, along with the date and the purpose of the visit.
 - b. **Case Note File Entry:** Notes written about the client's problems and needs on the assessment form do not have to be rewritten in the case narrative.

9. **Ongoing Narrative:** Ongoing narrative must reflect the following:
- a. **Appropriateness:** That services, as well as the duration and intensity, continue to be appropriate for meeting the client's ongoing needs.
 - b. **Service Consistency:** That services continue to be consistent with the care plan and are delivered in accordance with program policy.
 - c. **Adjustments Needed:** Any need for adjustments to be made to the plan based on new information received.
 - d. **Problem Status:** The status of each active problem listed on the care plan:
 - i. **Semiannual Standard:** The case manager shall address each problem in case notes at least semiannually following initial client contact.
 - ii. **Tracking:** For tracking ease, the problem number on the most recent care plan should correspond with the problem number entry that updates the case note.
 - iii. **Progress/Barriers:** Case notes should describe progress or addition problems encountered in achieving desired outcomes stated on the care plan.
 - e. **Other Data:** Include any other data appropriate to the client's situation.
 - f. **Client's Satisfaction:** Include how satisfied the client are caregiver are with the services being provided.
 - g. **Termination:** Circumstances for termination.

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GRIEVANCE PROCEEDINGS:

Please refer to Appendix D, “Minimum Guidelines for Recipient Grievance Procedures”, included in this handbook.

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Authorization for Release of Information

I, _____, hereby give my consent to release the following information to the _____ representative (name of agency):

1. Any and all information concerning my physical condition, treatment rendered, medical and hospital records, or any other material or information related to my medical history.
2. Any and all social information related to me.

I further authorize _____ to release information to other agencies or persons as they deem necessary in order to arrange services for me under the _____ program.

I understand that the above information is necessary and will only be used by the _____ or its authorized representatives as it pertains to this program.

I further understand that data gathered as a result of my participation in this program will be used in reporting and research; however, my name will not be used.

I also understand that:

1. My refusal to either sign the release of information form or submit needed information may make it difficult to arrange for services to assist me even though I may be considered for this program.
2. If I have had adverse action (termination, suspension, or reduction in service), I may file a grievance.
3. I have the right to inspect my own records and can contest their validity, add data, or request deletion of parts.

Signature

Witness

Date

Date