

CENTRAL CARE POLICY CONSUMER FILES

SUBJECT:	CONSUMER FILES
ANNUAL REVIEW MONTH:	June
RESPONSIBLE FOR REVIEW:	Director of Central Care
LAST REVISION DATE:	August 2010

POLICY:

Each consumer will have a file maintained by the on-site manager in the home. Personal information shall be treated as confidential and shall not be disclosed except to the consumer and his or her representative or legal surrogate, if any, an authorized agent of the Department, and others to whom written authorization is given by the consumer or his representative or legal surrogate, if any.

REFERENCE: Chapter 290-5-35-.17, Consumer Files; Policies and Procedures for Community Habilitation and Support Services Waiver Program Chapter 1100, Documentation Process.

PROCEDURES:

Exterior Front of the Record

Flagged with the Consumer's Allergies Precautions

- A. The file shall be divided into nine sections to include:
 1. **Consumer Identification/Emergency Contact Section**
 - a. Consumer Photo
 - b. Identifying Information
 - c. Family Contacts
 - d. Emergency Contacts
 - e. Phone Numbers for Physician, Dentists, Service Monitors, etc.
 2. **Financial Section**
 - a. Waiver Application
 - b. Agency Service Agreement
 - c. DMA 6s
 - d. DMA 80s
 - e. Medicaid Waiver Service Report
 - f. Medicaid/Medicare Cards
 - g. Social Security Documents & Correspondence
 - h. Insurance and Other Benefit Information

- i. MAO Communication (if application)
- j. Inventory of Consumer Belongings

3. Rights/Consents/Legal Section

- a. Consumer Rights(signed by the consumer)
- b. Grievance/Complaint Process
- c. Release of Information Consents
- d. Freedom of Choice Form
- e. Involuntary Commitment Papers(if applicable)
- f. Living Wills/Advance Directives
- g. Other Legal Documentation

4. Medical Section

- a. Physician Orders
- b. Physician's Progress Notes
- c. History and Physical
- d. RN/LPN Nursing Notes
- e. Nursing Assessment
- f. Physical Health Referrals
- g. Other Health Professional Notes
- h. Tracking Sheets for Doctor's Visits
- i. Informed Consent for Psychotropic Medicaid
- j. Abnormal Involuntary Movement Scales (AIMS) (if applicable)
- k. Vital Signs
- l. Seizure Records (if applicable)
- m. Intake and Output
- n. Medication Administration Record
- o. Laboratory/Xray reports

5. Assessment Section

- a. Agency Initial Assessment(s) completed by Central Intake & Evaluation
- b. Consumer/Family Perceptions of Strengths & Needs
- c. External Assessments: Psychosocial, Vocational, etc.

6. Individual Service Plan (approved by Regional Board)

- a. Plan of Care Cover Page
- b. Individual Service Plan (with appropriate signatures)
- c. Individual Service Plan Addendum(s)/Reviews
- d. Individual Service Plan Staffing Notes
- e. Behavior Plan
- f. Discharge Plan

7. **Progress Notes for All Services:**

(each in their own section)

- a. Residential, Day Habilitation, Day Services, Supported Employment, Service Monitor Progress Notes (as applicable)
- b. Staffing Notes (if held separately from ISP staffing-filed in the appropriate Progress Note section)
- c. Progress toward Goals Tracking Sheets (as appropriate)
- d. Daily Activity Schedule

8. **Records of Previous/Current Providers**

- a. Hospital Discharge Summaries
- b. School Records (if applicable)

9. **Correspondence**

- a. General Correspondence

- B. Records shall be kept up to date.
- C. The consumer file shall be available for inspection and/or copy to the consumer or the consumer's representative or legal surrogate, if any, upon request.
- D. Consumer files shall be maintained for three years after a consumer's discharge.
- E. Sample forms are attached.

APPROVED:

_____ **TITLE:** Director of Central Care **DATE:** _____
George Harris, LCSW

Attachments: Sample forms