6001-F CASE RECORDS

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REFERENCES: 42 CFR 483.410(c)(1)(6)

Central Case Records

The Division of Developmental Disabilities (Division) maintains a central case record for each member to whom services are provided. This record contains all pertinent information concerning services provided to a member and is kept in a location designated by the local Confidentiality Officer/designee, but it is usually in the Support Coordinator/Qualified Intellectual Disabilities Professional's (QIDP's) office.

The Support Coordinator makes sure that all information generated regarding services to the member is documented in the central case record.

A. Central case records must contain the following:

1. Birth Certificate
2. Guardianship records, if applicable
3. Adoption records, if applicable
4. Divorce Decree, and/or Custody Orders, if applicable
5. Court Orders [including Orders of Protection], if applicable
6. Arizona Confidentiality Program (ACP) records, if applicable
7. A copy of the member's Planning Documents/Individualized Education Program (IEP)
8. Program data and progress notes
9. The member's identifying information and a brief social history
10. Pertinent health/medical information
11. Current evaluative data/assessments
12. Authorization for emergency care, if appropriate
13. Visitation records, if appropriate
14. Record of financial disbursements, if appropriate
15. Active treatment schedule (ICF/IID)
16. Resident fact sheet, if appropriate
17. Periodic dental records, if appropriate
18. ICAP, if appropriate

19. Documentation regarding the protection of member rights, including records authorizing the release of educational and protected health information.
20. An accepted diagnosis/diagnostic scheme
21. Documentation of an evaluation that identifies the member's specific needs
22. Reviews/modifications to the Planning Documents and IEP
23. Communication among persons involved with the member and his/her program, including emails
24. Documentation of protection of the legal rights of each person served including records of all actions that may significantly affect these rights
25. Documentation to furnish a basis of review, study and evaluation of overall programs provided by the Division
26. Member primary data from FOCUS
27. For members residing in a Nursing Facility (NF) placed on termination status:
    a. A Primary Care Physician (PCP) statement that the NF does or does not continue to meet the member's needs
    b. Documentation of the member's choice of placement
    c. The reason for non-placement in a NF placed on termination status for a new placement.

B. Case records, where applicable, must contain the following additional documentation:

1. Arizona Long Term Care System (ALTCS) eligibility
2. Utilization review report
3. Current photograph of the member, if needed
4. Physician statements of medical necessity
5. Pre-Admission Screening
6. Psychological evaluations/social history
7. Medication history
8. Immunization record
9. Incident, injury, illness, and treatment reports including hospital stays
10. Seizure reports
11. Records of contacts/referrals
12. An accounting ledger

13. Authorization for emergency care

14. Behavioral health records as described in this Policy Manual

15. Other pertinent information.

Program/Service Records

Occasionally, the delivery of services or a centralized recordkeeping system requires maintenance of separate program/service records; this includes overflow files. The Confidentiality Officer, Support Coordinator, or QIDP assures:

- Files are available at each site where the member receives services, as appropriate
- The Support Coordinator/QIDP has access to such files
- A summary of information contained in such records is entered into the member's Central record.

These files must contain:

A. The name, address and phone number of the physician or health facility providing medical care

B. Reports of accidents, illness, and treatments

C. Reports of significant behavioral incidents, if applicable

D. Current medication treatment plan, if applicable

E. A description of the member's specialized needs

F. A copy of the Planning Documents/IEP

G. Program data/progress notes

H. Identifying information/social summary

I. Pertinent health/medical information

J. Current evaluative data/assessments

K. Authorization for emergency care

L. Visitation records

M. Records of financial disbursements

N. Active treatment schedule (ICF/IID)

O. Resident fact sheet; and where applicable

P. Periodic dental reports.