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Date Revised	01/97, 08/03	Subject	1001 Maintaining the Client File
Rule Referenced	5123:2-3-13		

1001 Maintaining the Client File

The client file is a collection of confidential documentation pertaining to bank statements habilitation training, personal money records, daily notes, photographs, inventories, and other items that document client services.

The Client File Index lists all documents required to be in the client file. It is essentially the Table of Contents for the main Client File.

The Client File Inventory describes where each document named in the Client File Index is found. Maintain the Client File Inventory form in a page protector inside the front cover of the main client file.

Maintain the main client file in a white binder and, if possible, in one volume. Index tabs divide the main file according to the Client File Index. All client file documentation may be kept in the main file if it fits and if it is convenient to do so.

Maintain the secondary file in a black binder. The secondary file contains those documents that need to be accessed at additional locations.

Label all client file binders with the client's name on the spine of the binder. Neatly print or type the client's first initial and last name in a size only large enough for reading at a close distance to maintain client confidentiality.

The Client File History is a chronological list of occasions when the client file was accessed, such as purging or copying information. This history documents who used the file, when the file was used, and any changes, such as the addition or relocation of records. The purpose of the Client File History is to safeguard confidentiality and record retention. Maintain the Client File History in a page protector inside the front cover of the main Client File.

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General Rule

As a general rule, the file should contain two years worth of documentation. The licensure standard states that documentation must span the time between the last two Annual Individual Plan Meetings plus all documentation since the most recent annual Individual Service Plan Meeting. As long as the file meets this requirement, purge documentation at the beginning of each calendar year or at the time of the client's next Annual Individual Plan meeting, which ever is more convenient. The Program Administrator maintains the originals purged from the main file in temporary, accessible storage (a cardboard file box near the Program Administrator's desk at the main office) until moving them into permanent storage (when the file box is filled with one client's records). Shred copies from the secondary file. Record the date of purging, the time span of the purged documentation, and the new location of the purged documentation on the Client File History.

Special Directions

To prevent the client file from becoming cumbersome due to the amount of documentation it contains:

- Use page protectors to protect unique documents and hold small, loose, or irregularly shaped items, such as warranty cards, insurance cards, and photographs.
- Do not tape items to a page. Tape deteriorates and damages the documentation.
- Avoid stapling unnecessarily.
- Do not file paperclips.

Some documentation, such as I.O. Waiver Re-Determinations and Annual Individual Plan Packets, are actually bundles of documents. Separate the documents and file each appropriately.

File the documents in one of the following ways:

- File each section chronologically,
  OR
- File each type of document chronologically within the section.

Always file the most recent document on top.

Occasionally there may be a need to maintain documentation beyond the purge date. If so, flag the document with a sticky note saying "Hold In File" and explain when to purge.

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Documentation serves the purposes of:

- Documenting the services the client has received.
- Preserving a comprehensive history for the client.
- Strengthens caregiver continuity in the client's life.
- Helps the client's Interdisciplinary Team plan for the future.

Copy file material only when:

- Current releases signed by the client or guardian are on file.
- There is a valid reason to create a copy.

Avoid copying unnecessarily.

Client File Specifics

The following information contains a description of each category in the Client File Index. Forms created by Choices In Community Living, Inc. have a file prompt at the bottom of the first page to facilitate filing. Some Choices In Community Living, Inc. programs are licensed by the state and are required to operate under licensure rules that, except for a few exceptions that are noted, apply to all Choices In Community Living, Inc. programs.

I. Identifying Information

The **Face Sheet** is a Choices In Community Living, Inc. form that is updated as needed or at least annually so that all the information is current. Update the Face Sheet when any of the information on the form changes such as when the client moves, family information changes, the Service and Support Manager changes, or a medical provider changes. Maintain Face Sheets in the main file, secondary files and in client record logs at residences. The Executive Director and each Program Director carries a log of client Face Sheets and receive updated Face Sheets as changes occur. Maintain old Face Sheets together in the main file to provide a backup against which new information can be checked. Maintain the current Face Sheet in a page protector and old Face Sheets together in separate page protector.

The **Birth Certificate** may be an original or a copy. Birth certificates that have an official seal are equal to originals and are more useful than a copy without a seal. Originals are used to get a state identification card. Maintain the birth certificate in the main file in a page protector due to the

importance of the document. A copy may be maintained in a secondary file.

Guardianship Papers are official court documents that specify who is the guardian of the client and the nature of the guardianship. These may be copies since the guardian usually retains the originals. Maintain guardianship papers in the main client file and secondary client file for each client who has a legal guardian.

Health Insurance includes Medicare, Medicaid, and private insurance through an employer or family member. Maintain the original Medicare card (available from the Social Security Administration) and the original or a copy of any private medical insurance card the main client file.

Make a copy of the Medicaid card before distributing it to the client or staff member. File the copy in the main client file as a backup to the original. The card is good for one month. Maintain the Medicaid card or copy for each month in which the client is Medicaid eligible because medical billing departments occasionally will request a back copy of the card for a particular month in which medical services were provided. Maintain all expired original Medicaid cards in the main client file under Medicaid Cards and Medicaid Documentation. Copies may be filed where needed.

Maintain the original **Social Security Card** in the main client file unless the client carries the card independently. If so, file a copy of the Social Security Card. If a client does not have the original card, he or she can get another one from the Social Security Administration. Copies of the card may be kept in secondary client files.

Life Insurance refers to actual life insurance policies payable upon the death of the client. Maintain the policies and any additional documentation pertaining to the policies such as statements of face value of the insurance, the name of the insurance agent, and payment receipts in the main client file. Information on life insurance is verified annually for Medicaid.

A **Burial Plan** may refer to a life insurance policy or a prepaid burial plan at a specific funeral home where the client has made final arrangements. Maintain a copy of the burial plan contract and a payment history in the main client file. Medicaid will request documentation to verify the status and value of the plan before determining Medicaid benefits for the client.

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Maintain a current **Photograph** in the main client file and each secondary client file to visually identify the client. The photograph should be a clear, full-length picture updated often enough to keep up with any changes in the client's appearance, such as significant changes in weight or age. Identify the photograph on the back with the name of the client and the date the picture was taken. Do not include other people in the photograph.

Maintain a copy of a **State of Ohio Identification Card** or a **State of Ohio Driver License** in the main client file and each secondary client file. The client maintains the original, either carrying it or keeping it ready for use at the residence.

Note: Purge Identifying Information cautiously. Never purge unique items, such as birth certificates, guardianship papers, burial plans, insurance policies, marriage licenses, divorce decrees, Medicare cards, and Social Security cards. Photographs, state identification cards and copies of a driver's license or state identification card can be purged according to the general rule.

II. Releases and Rights

Maintain the following original releases in the main client file and copies in the secondary client files:

The Release of Information	Allows an exchange of information in order to provide client services	Update annually
Student Release	Allows students receiving academic credit to work with clients	Update annually
Authorization for the Release of Information	Allows specific information to be released to an individual or agency on a one time basis	Completed as needed
Medication Consent Form	Provides the client's written acknowledgment that the medications he or she takes are psychotropic	Renewed annually or as medication changes occur

Copies of any releases that the client signs for another agency or individual	Copied as needed

Each client reviews, signs and dates the MR/DD Bill of Rights annually. Maintain the original MR/DD Bill of Rights in the main client file. Copies may be maintained in the secondary client files.

Note: Purge Releases and Rights documentation following the general rule. It is very important to have signed updates of all the documents in this section.

III. Medical

Medical Appointment Forms refer to all forms that document that clients received medical services. The forms may be from the primary care physician for an annual physical, illness, psychiatric visit, counseling sessions, podiatrist visit, or specialist for as OB/GYN, orthopedic, ENT or neurology visits, etc. Maintain all originals in the main client file and copies in the secondary client file as needed.

The **Weight Records** and **Seizure Records** are used for tracking purpose. Other related forms may include **Hospital Discharge Orders** and **Outpatient Tests**. Maintain the original forms in the main client file. Copies may be maintained in secondary client files as needed. If the client is financially responsible for the invoice for medical services, keep the invoice as a receipt and file under Personal Finances. If Medicaid or Medicare pays for the medical service, it is not necessary to file the receipt.

Note: Use caution when purging Medical documents. Be on the alert for medical information, such as test results, major surgery, and hospital discharge summaries that may be necessary to understand the client's medical history. Maintain Annual Physicals if there is a substantial amount of helpful information contained within. If the Annual Physical is routine, ensure immunization dates and other significant information are carried forward before purging.

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IV. Medication Administration Record

Maintain the original **Medication Administration Records (MARS)** in the main Client File. Copies may be filed elsewhere.

File the **Home Visit Medication Administration Record** that accompanies the client on visits away from Choices In Community Living, Inc. chronologically with the Medication Administration Record in the main client file.

Medication that is not returned to the dispensing pharmacy is discarded and documented on the **Medication Discard Form.** File the Medication Discard Form in the main Client File chronologically with the Medication Administration Record, or grouped together with other Medication Discard Forms.

The **Medication History** is used for tracking medication by the date it is introduced and discontinued. It may be maintained in the main client file while in use or it may be maintained elsewhere while in use and then file in the main client file when the form is full.

Note: Purge Medication Administration Records, Home Visit Medication Administration Records, and Medication Discard Forms according to the general rule. Do not purge Medication History Forms.

V. Dental

Each client's dental exam schedule is noted in the client's Individual Service Plan. Each dental appointment is documented on the **Dental Appointment** form. File the original Dental Appointment forms for routine periodic exams and specific treatments, such as dentures, oral cancer screenings and follow visits, in the main Client File. Also file paperwork signed by the primary care physician approving anesthetizing for a dental procedure in the main client file in the Dental section. Copies of any Dental Appointment forms may be filed in a secondary client file as needed.

Note: Use caution when purging Dental documents. Purge according to the general rule.

VI. Vision

This section contains documentation for visits to eye specialists. The frequency of periodic vision exams, usually annually or biannually, is stated in the client's ISP. Use the **Vision Exam Report** to document periodic vision exams. Doctor visits for diseases of the eye such as glaucoma and cataracts, which require the attention of an eye specialist, are documented on the **Medical Appointment** form but filed under Vision. Follow-up appointments with an eye specialist may or may not include a vision test. If a vision test is given, ask that it be noted on the Medical Appointment Form. Place originals in the main client file and place copies in the secondary client file as needed. Illnesses such as sties or eye infections that do not require an eye specialist but are treated by a primary care physician are documented on the Medical Appointment form and filed under Medical.

Note: Use caution when purging Vision documents. Purge according to the general rule.

VII. Speech and Hearing

Each client's Individual Service Plan states how often a hearing exam is required. The **Hearing Exam Report** documents periodic hearing exams. Clients with histories of ear infections may see an Ear, Nose and Throat Specialist who may check for a hearing impairment after each infection has cleared. Hearing exams may be documented on the same Medical Appointment form that documents the medical treatment for the infection. If the hearing exam will be used to comply with the Individual Service Plan schedule for hearing tests, request a copy of the Hearing Exam Report from the doctor's office and maintain it in Speech and Hearing section of the main client file. File documentation for treatment of ear diseases in the Medical section of the main client file. File copies of the Hearing Exam Report as needed in the secondary client files.

Speech Therapy refers to speech evaluations, speech therapy sessions with a speech therapist, speech therapy progress reports, and speech therapy treatment plans. Choices In Community Living, Inc. does not have in-house speech therapy forms. This documentation is generated by outside providers. File original documentation in the main Client File and copies in secondary client files, as needed.

Augmentative Equipment Information refers to any adaptive equipment a client uses to compensate for speech or hearing deficits. Some examples of equipment are talking computers, hearing aids, adapted smoke detectors, alarm clocks, doorbells, and similar items. File all

warranties, contracts for repair service, and instructions for the care and operation of the equipment and any other information regarding the equipment in the Speech and Hearing section of the main client file. Copies of the documentation may be maintained in secondary client files as necessary.

Note: Purge Speech and Hearing documentation according to the general rule except for documentation that is needed to fully understand and track unique problems. Flag such documentation as "Hold In File". Purge warranties, service agreements, and product information as they expire and are replaced with updated information.

VIII. Personal Finances

Pay Stubs are used by the Social Security Administration, the Ohio Department of Jobs and Family Services, and the Montgomery County Board of MR/DD Cost to Live subsidies to verify client income, regardless of the nature of the client's employment. When Pay Stubs are not available, accounting printouts from the employer may be an acceptable substitute. Pay stubs have the advantage of showing what has been withheld, and show both gross and net income. Track Pay Stubs carefully because they are an excellent source of documentation. Direct deposit of pay appears on bank statements but do not contain the same information as the pay stub.

Bank Statements verify client assets. Bank statements may be for checking or savings accounts and may be published monthly or quarterly. The signature of two Choices In Community Living, Inc. employees, one of whom does not have routine access to the funds, appear on each bank statement to verify its accuracy. Verify all bank statements and turn in copies to the Fiscal Director within two weeks of receipt. If there are only a few cancelled checks, staple them to the bank statements and maintain in the main client file. If there are too many checks to make this practical, maintain the checks, with or without the accompanying statements, in a cancelled check storage box.

Supported Living clients, or those clients who do not live in state licensed programs, use **cost to live documentation** to record monthly expenses. The monthly expenses are summarized quarterly and a cost to live budget is completed annually based on these records. Maintain receipts with the monthly accounting sheet to support the expenses. Treat invoices for medical services like an expense if the client is financially responsible. **Do not** file the invoice if Medicaid or Medicare covers the expense. Hold the invoice separately until financial responsibility is

resolved. The annual cost to live budget is submitted to the Montgomery County Board of MR/DD and qualifies the client for a cost to live subsidy. Increases or decreases in subsidies are made whenever the client's needs significantly change.

Many clients have **personal expenditure accounts**. Clients who live in licensed homes and do not handle their money without considerable assistance maintain an account book in the home which shows the date and the amount of cash funds made available to them, and the date, amount and receipt for each expenditure. Other non-licensed programs may use the same or similar system. Each client's Individual Service Plan describes the accounting of personal expenditures and how much money the client can be personally responsible for. The documentation of the personal funds should match the description in the Individual Service Plan and the Choices In Community Living, Inc. fiscal policy.

Keep the individual copy of the client's **W2 Form** after the tax forms are filed. Clients often do not have enough earned income to require the filing of a tax return. If no tax return is filed, retain the W2 as is. If any significant amount of federal tax has been withheld, request a refund. Remember that any earned income qualifies the client for an earned income credit that is computed along with the tax refund. Maintain copies of the actual tax form and any IRS correspondence.

The State of Ohio administers **Energy Assistance** programs to help low income individuals pay winter heating costs. DP&L and Vectren supply applications and information on eligibility. Maintain copies of applications and notices of eligibility for future reference about past assistance.

Client **Trust Fund Agreements** and records of trust fund transactions are filed in the main client file in the Personal Finances section.

Keeping a complete, accessible set of personal financial records for each client is very important. Social Security may request many years worth of paycheck stubs and other income verification. For reasons of space and convenience the main Client File is not always the best place to maintain all the personal financial information. Personal Finance documentation can be filed in several formats, such as a ledger for Supported Living cost to live receipts or a special box for cancelled checks. State licensure requires that clients have access to their money and that an accounting ledger with receipts be available on site financial records can be awkward to store and access. A simple system that is centrally located and easy to use helps to keep documentation

organized. Avoid unnecessary duplication. It is especially important to describe the location of the Personal Finance documents on each client's client file Inventory.

Note: When purging, follow the general rule with the exception of unique documents, such as trust fund agreements and related documentation. Flag unique documents that are never purged as "Do Not Purge". When purging other more routine material, specify in the Client File History where the documentation will be stored. Do not place in permanent storage until it is reasonably certain that the documentation will no longer need to be referenced.

IX. Medicaid Cards and Medicaid Documentation

Clients who are Medicaid eligible receive a **Medicaid Card** each month. Copy the Medicaid Card immediately and maintain the copy in the main client file. Maintain each month's original Medicaid card where it can be easily accessed for medical appointments and prescriptions. If the client takes personal responsibility for the original Medicaid Card, rely on the file copy for future reference. If both the main Client File and a secondary Client File are used, file the original card in the main client file and a copy of the card in the secondary client file.

Medicaid eligibility is determined as often as 90-day intervals for some Montgomery County MR/DD Supported Living recipients and at yearly intervals for Medicaid Waiver recipients. For reference maintain the notices from the Montgomery County Department of Job and Family Service specifying food stamp amounts and letters denying food stamp assistance. The MCDJFS sends out many notices and letters, most of which do not need to be maintained. Papers describing appeal procedures and letters notifying clients of upcoming appointments may be discarded. The paperwork for client re-determination appointments consists mostly of client financial records and various forms required and provided by MCDJFS. The client financial records needed to prove Medicaid eligibility are found in section VIII. Personal Finances and section X. Medicare, Social Security, and Federal Entitlements, of the main Client File. Aside from the notices mentioned above, discard the MCDJFS forms once the client's Medicaid eligibility is confirmed for the current time period. New forms will be sent before the next appointment.

Note: Purge following the general rule.

X. Medicare, Social Security, and Federal Entitlements

Maintain the following documentation in the main client file and as needed in a secondary client file.

As the representative payee for clients, Choices In Community Living, Inc. receives a variety of **correspondence from the Social Security Administration**. Eligibility and award letters, payee reports, over payment and back payment notices, and letters requesting specific information about a client's income and ability to work are examples of Social Security correspondence. Letters stating the monthly Social Security check amount can be used in place of a copy of the Social Security check to verify income for Food Stamp assistance Immediately **copy each check** and maintain in the main client file Deposit the check in the client's account within three days of receipt if the client does not have direct deposit.

Clients eligible for Medicare receive **Medicare Summary Notices** each time they receive medical care. File the Medicare Summary Notices in this section due to the fact Medicare is administered through the Social Security Administration.

Other **entitlement programs** are Social Security Insurance, Veterans Benefits, and Black Lung Benefits. Copy all entitlement checks and file the copies in the main client file. Each entitlement program has its own paperwork. File all documentation concerning entitlement amounts and eligibility.

Note: Purge following the general rule except for over-payments or back-payments from Social Security that require extra correspondence and documentation. Flag this correspondence and retain it until the matter is resolved, then purge according to the general rule.

XI. Service Funding

This section is for the paperwork that verifies that the client is receiving funding for services and specifies the type of funding received. Funding notices are sent to both the client and to Choices In Community Living, Inc. Maintain originals in the main client file and copies in a secondary client file, if needed. The documentation that is mailed to the client is the client's property and should not be maintained the client's files.

Payment Authorization for Waiver Services (PAWS) forms are financial statements that show the name of the client, the amount of funding and length of time the funding covers. The PAWS form is an important document maintained readily available for all inspections by the state or the county. State licensure requires a copy of the current PAWS form is maintained on site.

The Ohio Department of MR/DD notifies clients about the status of their funding. The original notices are mailed to the client and belong to the client. Copies of these notices are mailed to Choices In Community Living, Inc. and are maintained in the main client file.

The Montgomery County Board of MR/DD sends out notices for **Supported Living** funding. The original notices are mailed to the client and belong to the client. Copies of these notices are mailed to Choices In Community Living, Inc. and are maintained in the main client file.

Waiver notices are notifications of eligibility and are labeled either “initial” or “re-determination”. The client receives the original and copies are sent to Choices In Community Living, Inc. Maintain a copy in the main client file and the secondary client file, if needed.

Note: Funding notices are usually accompanied by a cover letter. If the letter does not contain actual funding information, it may be discarded. Funding sources are re-determined annually and new documentation is sent to the client. Follow the general rule for purging.

XII. Social Histories

The **Long CICL form** refers to the complete social history that Choices In Community Living, Inc. requires completed for each client every other year. The **Short CICL form** is used to update the Social History in alternate years. **Social Histories** from other agencies often accompany the client when services begin. Social histories preserve much information about aspects of a client’s life that would be lost if not recorded. For clients that are elderly and without family, the social history may be a major source of information about that client. All social histories, regardless of origin, are maintained in the main client file. Copies may be maintained in a secondary client file, if necessary.

Note: Complete social histories are never purged. If the information on the Short CICL form is transferred to a more recent and complete Long CICL form, purge the short form.

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XIII. Family Information

This section will vary greatly from client to client, depending on individual circumstances. **Contact documentation** is a record of when and with whom the client has spoken or visited. Usually contacts with family are documented in each person's Client Record. Contact documentation is additional documentation that may be necessary for programmatic reasons. Maintain **Maps** or directions to the homes of relatives The **Family Medical History** is a CICL form that contains information on the health of various family members and helps the client anticipate possible health problems. Personal correspondence between the client and his or her family is the property of the client and is not filed in the client's file. Assist the client in the safe keeping of personal correspondence elsewhere.

Note: Family information is unique and difficult to replace, therefore, do not purge this section.

XIV. Assessments

Assessments cover a range of documentation about the client's emotional, physical, social, psychological, or mental state, or any other aspect of the client's life and abilities. Some assessments are done by CICL, while professionals in MR/DD or related fields complete other assessments. Assessments are completed periodically to track changes or to match resources to client needs. Assessments contribute to an understanding of the client's background, stressors, strengths and deficits. Assessments can ensure that needs are recognized and addressed.

The usual assessments found in this section are listed below. However, any assessment may be added to this section.

- Psychological evaluations
- CICL Safety Assessment
- Living and Working Independently Assessment
- Levels of Care (for funding eligibility)
- Vocational assessments (for training and employment)
- Functional assessments (that determine care levels)
- Quality Assurance Reviews (that examine every aspect of the client's life and help the client's team determine if supports are appropriate)
- Medication Administration Assessment

Note: A lifetime of assessments can provide a broad and valuable portrait of an individual. For this reason do not purge assessments from the main client file. If the Assessment section becomes too crowded, selectively purge the routine assessments, such as the CICL Safety Assessment, to make the file more manageable.

XV. Vocational and School

Employment Services and **Adult Services** develop job opportunities and habilitation programs for clients of the Montgomery County MR/DD Board. Adult Services runs the Kuntz, Jergens, and Calumet workshop sites. The **Bureau of Vocational Rehabilitation (BVR)** and **Goodwill Industries** provide job coaching and training.

United Rehabilitation Services (URS), provides work opportunities, therapy, skill-development, and socialization. **Special Education** classes throughout local school districts provide academic and vocational education for developmentally disabled persons up to the age of twenty-two. **Senior citizen agencies**, such as the Senior Resource Connection, address the needs of the aging population. Most clients will be involved with one or more of these supports at different points in their lives. Paperwork includes application packets, meeting documentation originating from that agency, client resumes, employment histories, and reports on progress and status. Do not file notifications for meetings, activity announcements, calendars, or any similar items that do not have serious, long-term relevance.

File original documentation in the main client file and maintain copies in a secondary client file, if needed.

Note: Follow the general rule when purging documents. Compare Vocational and School information to the current Social History section to ensure the information has been transferred before purging this section.

XVI. CICL Programs and Services

CICL requires clients' Interdisciplinary Teams to meet four times a year, although a meeting may be requested at any time if there is a need. A Choices In Community Living, Inc. Individual Service Plan (ISP) packet is completed for each meeting. The **Individual Service Plan** meetings

allow the team and the client to evaluate the quality and effectiveness of the services Choices In Community Living, Inc. provides as described in the Individual Service Plan. The minutes for the meeting contain what various team members report and conclusions and decisions the team reaches. State licensure requires that each client have four meetings a year, that each meeting is documented, and that the last two Annual Individual Service Plan packets plus all meeting packets since the most recent Individual Service Plan meeting are in the client file. Choices In Community Living, Inc. extends this requirement to all its programs. The packet for the Annual Individual Service Plan meeting includes more than just the packet documenting the meeting. It includes an assessment, a social history, releases, rights, and other updated items that are sent to team members each year. When filing the Annual Individual Service Plan packet, separate the items in the meeting packet and file each item under the category in which it belongs. Maintain original documents of all Individual Service Plan meeting packets in the main client files and copies in secondary client files, as needed.

The **Habilitation Plan** form is used to document skill development training or, in some cases, services that need more complete documentation than what is provided by the Individual Service Plan billing forms, such as fire safety and severe weather drills. These forms may be bundled together within this section or stored in a separate binder. Maintain two years' worth of documentation.

Maintain the **Behavior Plan** and all revisions in the main client file. Maintain documentation of behavioral team meetings and any relevant documentation that is used for implementation of the plan, as well.

Special Meetings are meetings that address unusual problems. Such meetings may or may not be full team meetings. There is no special form for such meetings. Documentation usually consists of the minutes of the meeting and possibly a signature page. Maintain documentation in the main client file.

The **Individual Service Plan (ISP)** lists and describes the services the client receives. Each plan is marked "initial", "re-determination" or "revision". The Individual Service Plan is coordinated by the client's Service Coordinator and re-determined annually, when funding eligibility is re-determined. The client and his or her team must agree upon what services are written in the Individual Service Plan. Each Individual Service Plan revision or re-determination has new service documentation sheets attached. The service documentation is also called the "billing

sheet." The effective date of the Individual Service Plan is the same effective date for both the billing sheet and the habilitation documentation. The Service Coordinator usually retains the original Individual Service Plan signature sheet and forwards copies to the client and the team members. Maintain copies of the Individual Service Plan in the main client file and maintain a copy of each client's current Individual Service Plan at the client's residence. Copies sent to the client belong to the client and should not be maintained in Choices In Community Living, Inc. files. State licensure requires Choices In Community Living, Inc. to maintain copies of the last three months of billing sheets at the client's residence. If the program is not licensed, the billing sheets are given to and maintained by the Choices In Community Living, Inc. Billing Specialist.

The **Client Record** is the daily reporting of significant information about the client in the residential setting. Each client has a specific form for this. The forms are kept in a log, usually at the residence, and are completed by the residential specialist or the program administrator. These daily notes are an important part of the documentation of services Purge the logbook as necessary, maintaining two year's worth of purged pages easily accessible, either in the main client file or in a separate holding file. After two years the pages can be moved into a permanent storage file. Describe each step of the purging and storage of the Client Record on the Client File History.

Note: In general, all documentation in this section is among the most valuable documentation the agency produces. Take care to ensure that the documentation is complete, pages are not missing, and content is accurate. Ensure entries are dated. Purge the CICL Programs and Services section according to the general rule, except where otherwise noted.

XVII. Incident Reports and Plans of Correction

Incident reports document incidents that impact the client, the staff, or the agency in the course of providing services. The Ohio Department of MR/DD and the Montgomery County Board of MR/DD require that each incident be specified as a Major Unusual Incident (MUI) or an Unusual Incident (UI). The difference between the two is based on the seriousness of the event and the degree to which the event impacts the client. CICL also tracks each incident in a master file that tracks trends, patterns, and follow-up.

For some incidents Choices In Community Living, Inc. must submit a **plan of correction** that documents what steps were and will be taken to correct the reason for the incident. The Program

Administrator and Program Director write the plans of correction. Additional documentation may be needed to verify that the plan of correction was implemented as stated.

Original Incident Reports and Plans of Correction are retained in a master file maintained by each Program Director. A copy of each incident report, plan of correction, and follow-up documentation is routed to the Executive Director and forwarded to the Fiscal Director for tracking. The Program Administrator maintains copies in the main client file and may choose to file additional copies in a secondary client file.

Note: Do not purge Incident Reports and Plans of Corrections.

XVIII. Residence Information

Leases are contracts with various conditions that must be met for the lease to remain valid. Rental paperwork may include property inspections and the renter's responsibilities. Maintain the most current paperwork in the main client file and as long as it is relevant.

The state requires an annual **fire inspection**, including the fire suppression system, in licensed homes. The local fire department will conduct fire inspections for any residence upon request. **Safety inspections** of electrical wiring, furnaces, and water quality are performed as needed.

Maintain **Warranties** for household equipment in a page protector for safekeeping. **Document major household purchases** by maintaining receipts (or copies of receipts) and manufacturer's information in a page protector also. Receipts document the date of purchase, establish ownership and validate warranties. Receipts may be helpful in resolving who owns items in a shared household. Receipts are often used for more than one purpose and may be copied as needed.

Each client has an **inventory of personal property** that is updated as needed. Since the inventory is continuous, it is not purged. The inventory is maintained on CICL inventory index cards in a portable file box. Though the cards are not kept in the client file, note the location of the file box on the Client File History.

Date Adopted	09/85	Section	1000 Documentation
Date Revised	01/97, 08/03	Subject	1001 Maintaining the Client File
Rule Referenced	5123:2-3-13		

Note: Documentation in this section relates to the client's responsibilities as opposed to Choices In Community Living, Inc.'s responsibilities. Discard expired warranties, leases, and receipts. Update rather than purge inventories. Maintain two year's worth of inspections.