POLICY:
Piedmont Community Services is responsible for maintaining and providing clinical information in a timely and service-oriented manner for the purposes of client treatment, billing, and internal and external reviews. The clinical record is the central repository for information related to client care and is crucial to improving the overall quality and timeliness of care. All documentation that supports the service, planning, coordination and accountability of these services shall be recorded/stored in the client’s clinical record. This policy does not supersede the requirements set forth in the Rules and Regulations for the Licensure of Facilities and Providers of Mental Health, Mental Retardation and Substance Abuse Services. It is meant as a supplement to these regulations.

Therefore, it is necessary to establish the following procedures in order to insure immediate availability and accessibility of medical records.

CONFIDENTIALITY:
In order to protect the confidentiality of our consumers, the strictest confidentiality policies will be imposed. For issues relating to the confidentiality and release of information from the clinical record, please refer to Section “B” of this policy.

HIPAA:
In 1996 the Health Insurance Portability and Accountability Act (HIPAA) became law. It’s purpose is to improve the “portability and continuity” of health insurance coverage. It requires agencies to adopt standards for Code Sets and Transactions, assure privacy and security of confidential protected health care information (PHI), increase provider accountability, and increased consumer rights. It is the intent of PCS to comply with all the requirements set forth by HIPAA.

PROCEDURES:
The following procedures are outlined in this policy and are intended to be utilized throughout all departments and divisions of Piedmont Community Services.

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SECTION A. LOCATION, SECURITY AND ACCESS TO RECORDS

Record storage shall be safeguarded at all times. Consumer records are required to be secured against loss, tampering, destruction and use by unauthorized persons.

a) All records shall be stored under double locks at all times unless in use for clinical purposes or for supervisory review. Any person checking out a record from the file room will be responsible for its safety and confidentiality until it is returned or is transferred to another person.
b) Records should only be transported between PCS facilities. No record should be removed from PCS property without prior approval from the supervisor or for emergency treatment of consumers. If transportation of records is approved, they must be secured in a locked container during transport.
c) Any person checking out a record from the file room will be responsible for its safety until its return or is transferred to another person. It is the responsibility of the person checking out the chart to see that it is returned in a timely manner. No person shall remove a record from the file room without checking it out or documenting its removal.
d) No persons shall have access to any clinical record except in the provision of services.
e) When in use within Piedmont Community Services or any other location, consumer records shall be kept in secure areas at all times and not left unattended in areas accessible to unauthorized individuals.
f) Every effort should be made to return all medical records to the file room by the end of each business day. If after hours, charts should be placed in after-hours drawer.
g) Physical and data security controls shall exist for all electronic records.
h) Medical records are only to be checked in and out by authorized staff, unless otherwise approved by a supervisor.
SECTION B. CONFIDENTIALITY AND DISCLOSURE OF INFORMATION

i. Record Retention: All consumer medical records shall be kept for a minimum of 10 years after date of discharge. Records of consumers that are under the age of eighteen (18) and persons declared incompetent by a court, shall be retained for five (5) years after such persons reach the age of majority (18) or competency has been restored, or ten (10) years following date of discharge whichever is greater. Records of consumers who are deceased shall be retained at a minimum of five (5) years after the consumer’s death.

The following information must be kept permanently:
1. Client’s Legal Name
2. Social Security Number
3. Date of client’s birth
4. Dates of admission and discharge
5. Name and address of legal guardian, if any

ii. General Disclosure of Information: Consumer records contain vital and confidential information about individuals receiving services from the CSB. All information provided regarding consumers, including if past or present services were provided, is confidential information. Upon written consent of the consumer or legal representative, information may be disclosed. All requests for disclosure of information shall be reviewed to assure proper authorization. All requests for disclosure must also be reviewed by the primary therapist for approval prior to the release. The information disclosed shall only be within the terms of the authorization, and the requests for information shall be responded to within 15 calendar days of receipt.

A record of all external disclosures must be maintained and shall become part of the consumer record. Each record or disclosure shall include to whom the information is disclosed, the date, the purpose of the disclosure, and a description of the information disclosed.

All requests for information shall be processed through the medical records department.

Minimum Requirements For Acceptable Authorization:
1. Specifically identify the consumer by Social Security No. and/or Date of Birth.
2. Specifically identify the provider of services (organization, individuals, custodian of records) to make the disclosure.
3. Specify the individual or organization to which the information is to be disclosed.
4. Identify the extent or nature of the information to be disclosed.
5. State the purpose of the disclosure.
6. Indicate the date, event, or condition upon which the consent will expire.
7. Include a statement that the authorization may be revoked, but not retroactive to data already released in accordance with the prior consent.
8. Effective date of the consent.
9. Signature of consumer or legal representative.
If an authorization does not meet the minimum requirements, a letter will be sent to the person/agency requesting the records outlining the information must be supplied in order for PCS to release the requested records. Once a proper authorization is received, the records will be released.

**Minor Consumers (persons under the age of 18)**

In the case of minors, the consent of a parent or legal guardian must be obtained to disclose records except when the minor is emancipated, married, or has presented himself for psychological, psychiatric, or substance abuse services as an adult.

**Note** In the event a non-custodial parent desires access to their minor child’s records, he/she may receive them unless legal documentation exists specifically stating that the non-custodial parent is unable to have access to his/her minor child’s records.

**Deceased Consumers:** In the case of a deceased consumer, obtain consent to release in the following order or priority:

1. Executor / Administrator of Estate
2. Spouse
3. Adult Son or Daughter
4. Either Parent
5. Adult Brother or Sister
6. Other relative in descending order of blood relationship

**Revocation of Authority:** Authorization may be revoked, but not retroactive to information already released, in accordance with the consent. Revocation of authorization should be submitted in writing. If the consumer or legal representative is unable to provide revocation in writing, an oral revocation may be accepted and should be documented by the person accepting the revocation. A record of all revocations shall be maintained as part of the consumer record.

**iii. Direct Consumer Access:** Consumers ordinarily are granted access to their records. Only in rare occasions are they denied access.

- **Consumer Access:** Following the consumer’s written request and approval by their CSB Service Provider / Program Manager and assuring that no harm would come to the consumer having direct access, the consumer may have access to his/her records. The review of the record by the consumer shall be done in the presence of a professional staff member (preferably CSB Service Provider). The staff member shall explain and/or interpret the contents of the record. Documentation of the disclosure shall be noted in the record.

- **Consumer Access Denial / Limitation:** In rare instances, consumer access may be denied or limited. If the CSB Service Provider and/or Program Manager feels the disclosure will be harmful for the consumer to have direct access, the case shall be referred to a physician/clinical psychologist. If the physician/clinical psychologist concurs with the
staff member(s) he/she shall compose a written statement expressing that in his/her opinion direct access to his/her records will be detrimental to the physical and/or mental health of the consumer. In such case, upon written request of the consumer, any licensed mental health professional, physician, or attorney may review the records. If the CSB Service Provider and/or Program Manager feels that only limited access should be permitted, the case shall also be referred to a physician/clinical psychologist. If the physician/clinical psychologist concurs with the staff member, he/she shall sign a written statement designating which information is to be withheld from the consumer.

- Consumer Disputes Record Content: Consumers have the right to challenge, correct or explain any information about themselves documented in their record. If the consumer disputes information in the record, the record may be changed following an investigation if the staff member determines the change is warranted (usually factual information only). If the staff member agrees that the entry contains an error, the staff member should make the correcting entry in the record. The original entry must not be obliterated. The entry should be corrected by drawing a single line through it, documenting the correct data, and by signing and dating. If the staff member denies the request for change, the consumer is allowed to include a signed statement of not more than 200 words expressing his/her position. This statement becomes a permanent part of the record and must be supplied to any previous recipient of the information. This statement must be included with any further disclosures.

iv. Conditional Disclosure (without consent)

- Emergency Disclosure: Disclosure may be made to any person necessary when an emergency exists. An emergency exists when it is reasonable to believe that a delay in the disclosure of the information will result in serious bodily injury, death, or deterioration of the physical or mental condition of the consumer or other person threatened by the consumer.

- In responding to an emergency, the legitimacy of the request shall be verified. Only that information required to relieve the emergency shall be released. Documentation of the disclosure shall be recorded in the record. It should include what was disclosed, to whom the disclosure was made, the date of the disclosure, and the name of the individual releasing the information.

- Disclosure to Courts: All properly executed subpoenas shall be responded to within the time frame specified on the document. CSB staff shall accept the subpoena and route it to the appropriate CSB Service Provider or Program Manager. If the Service Provider or Program Manager questions the merits of the subpoena, they shall immediately notify “CSB Legal Counsel”. In civil matters, privilege exists for licensed counselors, psychologist, social workers, and physicians with the following exceptions:

  - Where the physical or mental condition of the consumer is at issue in the action
  - In matters related to child abuse and neglect
When the court deems disclosure necessary to the proper administration of justice

Staff shall consult with CSB legal counsel and move to have the subpoena quashed in order that the Court may rule on the merits of the subpoena.

Subpoenas Regarding Consumers in Substance Abuse Programs: Substance Abuse records may only be released with a subpoena accompanied by a Subpart E Court Order. (Ref. 42 CFR, Part 2, Subpart E) If a routine subpoena is received, the CSB must move to have the subpoena quashed. If the consumer’s attorney issues the subpoena, request that his/her attorney provide an authorization signed by the consumer. An authorization would alleviate having to take steps toward quashing the subpoena.

Court Orders: Upon receipt of a properly executed court order, you should respond to the order as directed. All disclosures should follow normal documentation procedures in the consumer’s record.

Third Party Payers: When a consumer requests that a claim be submitted to a third party payer for payment, only the following information shall be released relating to the claim:

- The consumer’s name and the contract/policy number
- The date the consumer was admitted to the CSB
- The date of onset of the consumer’s illness
- The date the consumer was discharged from the CSB or the date services were terminated
- The diagnosis, with brief information substantiating the diagnosis
- A brief description of the services provided, including type of therapy, medications ordered and administered, and number of hours spent in individual, group, or family treatment, recreational therapy, or rehabilitative activities
- Status of the consumer, whether inpatient or outpatient
- The consumer’s relationship to the contract subscriber or policyholder

In the event the third party payer is unable to settle the claim based on the information provided above, a physician employed by the third party payer may request additional information stating the reasons for the request. The additional information may then be forwarded to the third party payer.

Disclosure to Accrediting and Licensing Agencies: CSB accreditation, federal and state licensure surveyors may have access to health information to the extent necessary to enable the surveyors to conduct reviews for the purpose of licensure or accreditation. Authorization of the consumer or his/her legal representative is not required in such cases, provided the survey reports do not identify any individual. A confidentiality statement shall be signed to attest to the above agreement.
• **Child Abuse and Neglect Reporting:** Any health professional who has reason to suspect that a child is abused or neglected shall report the matter immediately to the local department of Social Services. The person making the report is required, upon request, to make available to the child protective services coordinator and the local department of social services any records or reports which document the basis for the report of suspected child abuse.

• **Adult Abuse Reporting:** Any mental health professional who has reason to suspect that an adult is abused, neglected, or exploited shall report the matter immediately to the local department of social services. The reporting requirement is intended to protect the elderly and those who are under mental or physical disability. The person making the report is required to disclose any records or reports that document the basis for the report of suspected abuse, neglect, or exploitation.

• **Medical Examiner:** The medical examiner’s office is expressly authorized to investigate the cause and manner of the death of any person from trauma, injury, violence, poisoning, accident or homicide, or suddenly when in good apparent health, or when unattended by a physician, or in jail, prison, other correctional institution or police custody, or suddenly as an apparent result of fire, or in any suspicious, unusual or unnatural manner. The medical examiner making an investigation into the cause and manner of death is authorized to inspect and copy the pertinent medical records of the deceased whose death he is investigating.

v. **Record Redisclosure**

Any information received from another service provider used in the consumer’s diagnosis and/or service planning shall be maintained permanently in the consumer’s record. Prior authorization shall be obtained from the consumer or legal representative when access to another services provider’s information is requested. CSB’s may only redisclose consumer information from another facility without CSB’s authorization in case of a medical emergency.

When information from a consumer record is provided to authorized third parties, this information shall be accompanied by a statement: “The use of this information for other than stated purpose is prohibited”. The recipient is also prohibited from further disclosure of this information to any party without the consumer or legal representative’s written authorization, unless such information is needed in an emergency or otherwise required by law.

vi. **Faxing Information:**

Faxing of information shall occur only when the original paper record or mail delivered copies cannot meet the needs of immediate emergency care.

The fax machine opens avenues for breaching confidential consumer information. The fax machine shall be located in a secure area with limited access. Accompany each
disclosure with a cover letter including the date and time of transmission, sending facility’s name, address, telephone number, fax number, and sender’s name, receiving facility’s name, address, telephone number, fax number and authorized receiver’s name, number of pages including the cover letter, statement regarding redisclosure, statement of destruction and instructions for authorized receiver to verify receipt of information.

Internal Use:
If possible, use the original record for exchanging information within the CSB. If information must be faxed, once the information has been used, destroy the fax copy or return copies to the Medical Records Department.

External Use:
The fax machine should not be used for routine release of information to insurance companies, attorneys or other non health care providers. The CSB should have a separate policy for these types of releases. The fax machine may be used in an emergency. Program Managers shall determine what constitutes an emergency.

Misdirected Fax:
If a fax does not reach the recipient, fax a request to the incorrect fax number. Explain the misdirected fax and ask for destruction of all documents received from this CSB. Complete an incident report and forward to Division Director.

vii. Copying Fees:

A reasonable charge, not to exceed fifty cents per page for up to fifty pages and twenty-five cents a page for the remainder, and a fee for searching, handling and mailing not to exceed ten dollars, may be made for such copies. These charges may be waived if the agency deems the case exceptional.
REFERENCES

FEDERAL STATUTES
1974 Federal Privacy Act, 5 USCA 552(a)
Federal Freedom of Information Act, 5 USCA 552
Alcohol and Drug Abuse Act, 42 USCA 290-3(42 CFR 2.5 – 2.67)
Mental Health Bill of Rights, 42 USCA 9501

STATUTES OF VIRGINIA
Virginia Freedom of Information Act, Code of VA, Section §2.1-342
Privacy Protection Act of 1976, 2.1-277 et.seq., VA Code, 1950 amended
Virginia Code § 2.1-378, Record Access and Storage
Virginia Code § 2.1-382, Record Access and Storage
Virginia Code § 8.01-399, Disclosure to Courts
Virginia Code § 37.1-226-227, Third Party Payer Disclosure
Virginia Code § 37.1-84.1 (4), Rules & Regulations to Assure the Rights of Residents of
Facilities operated by the Department of MH/MR/SAS)
Virginia Code § 37.1-236
Virginia Code § 32.1-127.1:02, Deny/Limit Patient Access to Records
Virginia Code § 8.01-413, Reasonable Charges for Records
Virginia Code § 42.1-79.1, Record Retention
Virginia Code, Rule 4:9, Disclosure to Courts
Virginia Code § 8.01-400:2, Disclosure to Courts
Virginia Code § 19.2-76, Court Orders
Virginia Code § 32.1-40, Accreditation and Licensing Agency Disclosure
Virginia Code § 9-6.14:3, Accreditation and Licensing Agency Disclosure
Virginia Code § 63.1-248.3, Child Abuse and Neglect Reporting
Virginia Code § 63.1-55.3, Adult Abuse Reporting
Virginia Code § 32.1-286B, Medical Examiner Disclosure
VR 470-02-13, Rules and Regulations for the Licensing of Facilities and Providers of
MH/MR/SAS 1/13/1995, Section 3.24

OTHER
Medical Records Management, Eighth Edition, Edna Huffman
Maintenance, Disclosure and Re-disclosure of Health Information, Mary D. Brandt
Position Statements of the American Health Information Management Association
Minimum Policy Standards for Confidentiality and Release of Information for Medical
Records Department, by the Virginia Department of MH/MR/SAS
SECTION C. STRUCTURE AND CONTENT

This section outlines the approved structure and content of the primary clinical record. This structure shall be used for all clinical records. The following describes each section of the clinical record and details the content of each section. All forms, reports, and notes shall be filed in a chronological order (unless otherwise noted). Items **BOLD & UNDERLINE** indicates tabs within sections.

Clip 1
Top of Authorizations:
1. Intake Questionnaire / Consumer Intake Printout Form # 101(always on top)
2. Financial Printout
3. Diagnosis Addendum Form # 102
4. SMI/SED/At Risk Administrative Checklist Form # 107

**Authorizations:**
1. Consent for release of Information Form # 110
2. Voter Registration Agency Certification Form # 106
3. Acknowledgment of Rights Notification Form # 114
4. TB referral form
5. Agreements to participate in special projects
6. PCS Contract for Services
7. Consumer / Family Participation Agreements
8. Court Subpoenas & Court Orders
9. DMAS 412 Pre-Authorization Form
10. Physician Referral Acknowledgment Form Form # 124
11. Medicaid Appeal Form
12. Provider Choice Form Form # 125
13. PCS Emergency Fund Form / Acute Needs Fund Form

**Housing Information**
1. Referrals for Rich Acres and Church Street Square

Clip 2
Table of Contents

**Program Enrollment / Release Forms Form #103**

**Correspondence:**
1. General correspondence, letters, reports, etc.
2. Insurance and related forms completed by staff, M.D.
3. F.A.P.T. Team Notes

**Residential:**
1. Any correspondence, progress notes Form # 105, etc. generated in residential programs.
Miscellaneous:
1. Priority Population Checklist Form # 123
2. Classification Forms
3. Referral form for Horizons

Clip 3
1. Individual Service Plan Form # 108.
2. Quarterly/Status Updates Form # 109 (filed under the ISP).
3. Social Assessment Update Form # 104.b
4. Service Assessments / Social History Form # 109
5. Discharge Summary Form # 112
6. Interview Regarding Service.

Psychological/Other evaluations:
1. Any psychological evaluations and related tests.
2. Evaluation Instruments (ex. CAFAS, PECAFAS, ASI, WIA application, misc. evals)
3. Any correspondence, progress notes Form # 105, etc. from the Crossroads, Roots and Wings, Second Chance, New Beginnings, STARR, Clean Start, and VASAP Programs should be filed under this section

Clip 4
1. Progress Notes Form # 127
2. Initial Needs Assessment
3. Service Referrals
4. Emergency service notes
5. Emergency Assessment Form / Addendum
6. Pre-Discharge Planning Notes

Clip 5
PAP
1. Documentation related to Patient Assistance Program

Medication
1. Medication Sheet Form # 129
2. Patient Assistance for medication forms
3. Drug Use Profile / Medical Evaluation Form

Nursing Notes
1. Nurses Notes Form # 105.b
2. Medication Evaluation Note
3. Vital Signs Sheet Form # 128

M. D. Orders
1. Physician’s Orders Form # 130
2. Medication Informed Consent Form # 115

M.D. Notes
1. Psychiatric Evaluation
2. Psychiatric Notes  
3. Permission for school to administer medication  
4. Psychiatric Progress Note

Clip 6

Lab Work
1. In-house Drug Testing Log  
2. Lab reports from hospitals or MD’s offices  
3. Results from lab work

Other/Outside MD Records
1. Physician Referral Acknowledgement Form  
2. Primary Care Physician Assessment Form  
3. Any medical progress notes

Hospital
1. Admission / Discharge Information from any hospital  
2. Notes / Information from any hospital

Creating New Volumes Procedure:

When creating new volumes, the following items should be taken out of the active chart and stored in an archive chart.

1. Medications over 2 years old.  
2. Lab notes over one year old or last available.  
3. M.D. notes over 5 years old.  
4. M.D. notes from outside the agency over 1 year old; leave in last available.  
5. Hospital/discharge info over 2 years old; leave in the last 2 admissions.  
6. Clinical treatment notes and progress notes over 2 years old.  
7. Nurses’ notes over 1 year old.  
8. ITP’s and status updates/quarterlies over 1 year old.  
9. Discharge/transfer summaries over 2 years old; leave last admission.  
10. Crisis intervention notes and preadmission screenings over 1 year.  
11. Any authorizations not for the current enrollment.  
12. Any Medicaid/Medicare appeals not for the current enrollment.  
13. Any face sheets/intake questionnaires not for the current enrollment.  
14. Any rights not pertaining to the current enrollment.  
15. Any TB referrals not pertaining to the current enrollment.  
16. Any contract for service forms not relating to the current enrollment.  
17. Any referral forms not related to the current enrollment.  
18. Insurance and related forms over 1 year; Insurance authorization forms 1 year after expiration.  
19. Any enrollment not current (closed enrollments).  
20. Pre-discharge planning notes over 2 years old.  
21. Hospital admission notifications over 2 years old.
22. Correspondence over 1 year old (except notes referred to in item #4 above).

SECTION D.  RETENTION AND DESTRUCTION

Piedmont Community Services will follow the provision of the Virginia Public Records Act, Sections 42.1-76 et. seq. Code of Virginia, for the retention and disposition of records (General Schedule No. 18). The following outlines the retention timeframes for clinical / treatment records.

A. **Claim on Clients’ Insurance Files (Bills):** Retain 5 years after payment and audit, then destroy.

B. **Client Case Files (Financial Records):** Retain 5 years after last entry or completion of audit, whichever is longer; then destroy.

C. **Referral Records:** In instances where consumers call requesting services or information about services and no follow-up or admission is made, referral records must be retained for a minimum of 6 months.

D. **Client Case Files (Medical Records):**

   a) **Adults:** Retain 10 years after the last date of treatment or contact, and then destroy. (*Code Section 42.1-79.1*)

   b) **Juveniles:** Retain 10 years after the last date of treatment or contact, or for 5 years after the patient reaches the age of majority, whichever is longer, and then destroy. (*Code Section 42.1-79.1*)

   c) **Persons under a disability:** Retain 10 years after the last date of treatment or contact, or for 5 years after the removal of the disability, whichever is longer then destroy. (*Code Section 42.1-79.1*)

   d) **Court-Ordered Psychological or Forensic Evaluation Files (not part of client case file):** Retain 1 year after testing, then destroy.

   e) **Logs (Admission, Closing, Crisis, Emergency Treatment, Requests for Service):** Retain 5 years after completion of the log, and then destroy.

   f) **Medicare/Medicaid Billings and Supporting Documentation:** Retain 5 years after initial billing, and then destroy.

   g) **Prescreening Reports:**

      1) **Client accepted for treatment:** Transfer to Case File

      2) **Client referred to other agency or not accepted:** Retain 10 years, and then destroy.

Prior to destruction, the following information must be removed and kept permanently:

1) Client’s Legal Name
2) Social Security Number
3) Date of client’s birth
4) Date of Admission and Discharge
5) Name and address of legal guardian, if any
SECTION E.  OPENING, CLOSING, AND REVIEW PROCESS

Opening a Case:

All intake paperwork should be completed on the first (intake) visit (unless otherwise noted). The following procedure should be followed when opening cases.

1. All forms in the intake packet should be completed.
   - Intake Questionnaire *
   - Diagnosis Addendum *
   - Program Enrollment *
   - Social History **
   - Progress Notes
   - SMI Checklist *
   - Authorization for Information Exchange
   - Individual Treatment Plan **
   - Voter Registration *
   - TB Referral Form (SA Consumers Only)
   - Your Rights & Responsibilities
   - Provider Choice Form
   - Appeal Form (as necessary)
   - Physician Referral Form
   - Contract For Services (as necessary)

* Required to open case.
** Completed within first 3 visits or 30 days whichever happens first.

2. As the forms are completed, route them to the appropriate data entry staff or file room staff for processing. The forms marked above with an asterisk (*) are required to open a case. One Program Enrollment form must be completed for each program you are enrolling the client to.

3. Once processed, the chart will be created and filed in the appropriate file room.

Program Release:

When releasing clients from individual programs, a program release should be completed. If the client is only open to one program, skip to the Case Closing Section.

1. Remove the enrollment form from the chart and complete the release information on the back of the form.
2. Submit the release form to data entry for processing. It is not necessary to submit the entire chart.
3. Once processed, the form will be filed back in the chart.
Case Closing:

This procedure is used when closing the “last” enrollment in the chart.

1. Fill out the bottom of the release form. Place the release form on top of the Intake Questionnaire.
2. Complete a Discharge Summary. Place the Discharge Summary form on top of the ITP. When reopening a case, place the old Discharge Summaries under the progress notes section.
3. Have the chart transferred to your supervisor for review.
4. Once the review is completed, the supervisor should route the chart to data entry for processing and filing.

Case Review Process:

A case review process shall exist for each unit of Piedmont Community Services. At a minimum, each department shall develop a case review checklist that address issues such as completeness, accuracy, timeliness of entries and quality assurance. At a minimum case reviews shall be completed on all open records every ninety days. Programs may choose to have case reviews completed in shorter time periods (such as programs that are time limited).
SECTION F. AGENCY FORM INSTRUCTIONS

Note: Only “Black Ink” may be used in charts.

A. **Intake Questionnaire:** (101) This form is used when admitting new clients for services. This form collects pertinent client identifying information needed for several purposes. The form consists of five sections.

- **Personal Information:** Includes legal name, address, phone numbers, social security and birth date, guardian information, etc.
- **Emergency Contacts:** List the client’s nearest relative, physician, and other contacts he/she may wish to include.
- **Statistics:** This section collects statistical information needed for reporting purposes, insurance billing, etc.
- **Medical History:** List here the client’s medical history as well as drugs and substance usage.
- **Financial Information:** All financial information should be collected using this section.

Once this form is completed, it should be routed to the MIS Department for entry into the computer system. Once entered, the information will be printed out and placed in the client’s permanent clinical record.

B. **Diagnosis Addendum:** (102) This form is used to collect the client’s Diagnosis Information. Once completed, route to MIS for data entry.

C. **Program Enrollment / Release:** (103) This form is used to enroll and release clients to individual programs. Each time a client is enrolled to a program, the Program Enrollment should be completed. Once the client completes treatment from the program, remove the same form from the record and complete the reverse side to release the client from the program. If the program you are releasing the client from is the last program he/she is enrolled in, then this will completely close the case. In addition to the release being completed, a Discharge Summary must also be completed.

D. **Assessment/Social History:** (104) This form is used to collect significant current and historical information including Presenting Problem and History, Developmental, Family Origin, Marital History, and Children, Employment History, Consumer’s Goals, Strengths and Coping Skills, Treatment History, and Legal History. Also included are symptoms related to Mental Status, Drug and Alcohol Use History, Judgment, Insight, and Prognosis.

This form must be completed by the end of the third interview or thirty days, whichever occurs first. Completion is required before the Individual Treatment Plan (ITP) is completed, as the information in it leads to the treatment plan.
For consumers re-admitted to services after one year from discharge, a complete Assessment/Social History Form must be completed.

**Progress Notes:**

**Standard Progress Note** (form #105) is used to document telephone calls, meetings pertaining to the consumer, court attendance, subpoenas, court orders, failed appointments/no-shows, cancellations, follow-up attempts, requests for information release, distribution of medications, psychiatric contacts, receipt or sending of correspondence, and other client related types of activities.

**Progress Note** (form #120) is used to document and summarize the results of individual consumer sessions. Each time the consumer is seen, progress notes are written.

The note will need to identify the recipient of services (account name), account number, and social security number.

The first section of the form addresses session information. The provider will enter the date the service was provided and check MH, MR or SA to indicate the program area the note refers to. Next, check the appropriate service provided, the length of the session, and the type of contact that was made. Enter a description of the setting in which the contact was made and list the person(s) that were involved in the contact. Finally in this section, check whether or not a Face-To-Face contact was made.

In the Observations Section, the provider will indicate if the consumer has issues relating to Grooming, Concentration, Affect, Mood, Stressors, Eye Contact, Judgment, Speech, Coping Ability, or Risk Factors. Anything that is not within normal limits must be addressed in the General Status section with plans to address the issues indicated. For MR Case Management, please use the section labeled “MR Case Management Observations”. For MH & SA Case Management, please use the section labeled “MH & SA Observations”.

In the body of the progress note, space is provided for providers to address the consumers General Status, staff contact and how it relates to the plan of care, progress toward goals and objectives in the plan of care.

Each section of the progress note must be addressed.

The signature and the credentials of the clinician must follow every note, along with the actual date that the consumer was seen.

Entries written by non-licensed staff that provides clinic option services will need to be signed and dated by the immediate supervisor or designee. The supervisor or designee’s signature indicates agreement with the contents of the clinical note.

When errors in writing are made, the counselor will need to mark through the error with a slanted line and initial it (ex. Walks err SJD). White out is not allowed in the chart, and only black ink may be used.
Progress notes must be written in a timely manner and in the chart no later than three business days after the event. These notes must be written legibly.

An electronic version of the progress note is available through CDMS. Note that any electronically entered should be printed out and filed in the consumer chart.

E. **Voter Registration Agency Certificate:** (106) Completion of this form at the time of intake is required by the State of Virginia. The following is quoted from the “Agency-Based Voter Registration Manual”, Revised 11/98:

1. All new applicants or anyone recertifying or changing their name or address for your services must be offered an opportunity to register to vote or change the information on their voting file.
2. You must inform all applicants that they should read and understand the statements found on the certification form as follows:

   - If you are not registered to vote where you live now, would you like to apply to register to vote here today?
   - If you do not check any box, you will be considered to have decided not to register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.
   - If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will remain confidential and may be used only for voter registration purposes.
   - If you would like help in filling out the voter registration application form, we may help you. The decision whether to seek or accept help is yours. You may fill out the application form in private, if you desire.
   - If you believe that someone has interfered with your right to register or decline to register to vote, your right to privacy in declining whether to register or in applying to vote, you may file a complaint with:

     Secretary of the Virginia State Board of Elections
     Ninth Street Office Building
     200 North Ninth Street, Room 101
     Richmond, VA 23219-3497
     Telephone: (804) 786-6551

3. Once the applicant has checked one of the three boxes at the top of the form, review the following:

   - Has the applicant printed his/her name in the **Applicant Name Space**?
   - Has the applicant signed the form in the **Signature space**?
- Has the applicant dated the form with today’s date in the Date space?

4. If any information is missing or not legible, return the form to the applicant for completion or clarification.

5. If the person does not fill out the form or refuses to sign the form, print the individual’s name on the form and place your initials beside the name. **This will be considered a declination to register to vote.**

**Completion of the form by agency:**
After the certification form has been filled in correctly, you may accept it and complete the agency portion of the form.

**First or Third block checked:**
1. Mark the “No” box next to the “Voter Registration Form Completed” statement.
2. Sign your name and date the form at the bottom of the page.
3. Place the form in a specified location to be filed at your agency at a later date. Do not mail certifications to the State Board of Elections.

**Second Block Checked:**
1. If the individual wants to register to vote, give them a copy of the *Virginia Voter Registration Application* form, providing whatever assistance the individual indicates is needed to complete it. Once completed, mark the “Yes” box next to the “Voter registration form completed” statement.
2. If the individual requests to take the form to be filled out later, mark the box next to the “Voter registration form given to the applicant for mailing” statement.
3. Sign your name and date the form at the bottom of the page.
4. Place the certification form in a specified location to be filed at your agency at a later date.
5. Place the completed voter registration application form in a specified location to be mailed to the State Board of Elections.

**Filing the Certification Form:**
The certification form should be kept in the client’s file so other agency personnel will know that the individual has been offered an opportunity to register. This form should be retained until superseded or until the client becomes inactive with our agency.

If additional blank forms are needed, you may photocopy these forms.

F. **SMI/SED/At-Risk Checklist:** (107) This form is to be completed on every client. The top portion is to be completed by writing the information or by using one of the self-sticking client labels. Each form is to be dated and should include the signature of the person completing the form.
The section for SMI is completed on all clients 18 years old or older. The requirements for determining if the person is SMI are at the bottom of the form.

The section for SED is completed on all clients age 17 and younger. The requirements for determining if the person is SED are at the bottom of the form.

The section for At Risk is completed on all clients age seven and younger. The requirements for determining if the person is At Risk are at the bottom of the page.

G. **Individual Treatment Plan:** (108) The top of the form is to be completed by the clinician. The *Account Information* can be completed by use of the pre printed self-sticking identification label.

List Consumer’s Strengths as well as Clinical Issues in the appropriate section. Both the consumer as well as the clinician can contribute to those sections and should be a matter of discussion.

A provisional treatment plan, good for up to 30 days or three visits, is completed at the time of the first appointment. The final/permanent Individual Treatment Plan (ITP) must be completed no later than the third visit or 30 days after admission, whichever occurs first. The development of the ITP grows out of the Social History, and the date that form was completed must be entered. The initial level of functioning should be completed.

Ideally, there is a flow from the assessment to the diagnosis to the goal(s), to the objective(s) and to the appropriate interventions. The goals, objectives and interventions are the heart of the ITP.

Each ITP must have one or more Individual Goals. A target date must be set for completion of the goal. The maximum length for a target date is 365 days. Obviously the length of time will depend on the chronicity of the issue being addressed. When a goal is met, the date of that event is recorded in the “Date Met Box”. It is assumed that the goal is completed at that time. The consumer and clinician may be working on several different goals simultaneously, some of which may have different target dates. Goals are numbered consecutively, regardless of interruptions in sequences of treatment. Goals should be stated in positive terms. For example: Alleviate depressed mood and return to previous level of effective functioning.

Together the client and clinician develop one or more objectives and include a statement of frequency of that event when appropriate. The objectives should be measurable. This section will address what the consumer will do to successfully fulfill the goal. For example: Take prescribed medications responsibly at times ordered by physician; or, Identify cognitive self-talk that is engaged in to support decisions.
The Strategies section of the ITP will identify what the clinician will do to help the consumer meet the stated goal. The questions of whom, how and how often will be defined in this section. Example: Counselor will monitor and evaluate medication compliance and the effectiveness of the medications on level of functioning; or, Counselor will assess and monitor suicide potential. Obviously, these same strategies should be mentioned in the progress notes.

The level of functioning (GAF) should be entered and rated as of the date of the setting of the (new) goal.

The supervisor should sign all Medicaid cases and other third-party payment situations as appropriate.

The client is to sign the ITP and date it. There should be a discussion with the client about his/her agreement with the treatment plan. The therapist must always sign and date the ITP. The psychiatrist must review and sign the ITP in all Medicaid cases and in those other third party payer situations that require his/her signature.

ITP’s must be reviewed every 6 sessions or quarterly, whichever comes first; beginning with the date the case was actually opened. This is done by use of the Quarterly/Status Update form.

H. Quarterly/Status Update: (109) Name and Account Number go at the top. Indicate the program in which this update is for. Updates are to be completed at least quarterly. For Medicaid, every six visits or quarterly which ever comes first.

Therapist is to complete sections 1, 2, and 3 and review these with the client. The client and the therapist sign and date the form in the appropriate spaces for that quarter. As indicated by case specifics, the guardian or parent would sign for the client. A teenager 14 years of age or older who seeks treatment on his/her own and the parents’ insurance is not being billed is an exception. In that case, it would be appropriate to discuss the review with the underage client and have them sign it, indicating his/her understanding and agreement.

In all Medicaid cases, the Quarterly/Status Update Form is to be reviewed and signed by the physician and the supervisor or designee.

I. Consent for Release of Information: (110) The Consent for Release of Information is an important part of the client’s record. When obtaining the client’s permission to release information to any party, the client must provide written consent; except in medical or psychiatric emergencies.

Each section of the Consent for Release Form should be filled out completely and accurately.
All information in the identifying information section should be filled out completely. The client’s full name should include middle name, maiden and any last names the client has had through marriage.

**Person/Facility to Receive/Provide Information**
Check the box that best applies to the release situation. Please provide full name and address of the person or agency from which the information is being requested or released.

**Purpose of the Release**
Check the box that best applies. When checking “other” please specify the purpose.

**Dates of Information to be released**
Fill in dates completely.

**Information to be released**
Check all that apply. When “other” is checked, please specify information to be released.

**Communicating Released Information**
Check each box that applies. **REMINDER:** Faxing of client information is for emergencies only.

**Effective Date of Consent**
Note the date that the consent becomes effective.

**Signatures**
Always obtain the signature of the client on the release. The person obtaining the client’s signature on the release should witness the release. Obtain a parent or guardian signature as applicable.

**J. Data Change Form (111)**

The Data Change Form is used to change certain client information. The person completing the form should enter his/her name in the Completed by: box at the top of the form. The date of the change and the assigned office code should also be completed. You should always complete the client name and number in the “Account Information” section of the form. Once the form is completed, it should be submitted to data processing. The information will be updated in the client’s record, and a new printout will be placed in the record.

**Account Information:**
Use this section to change/update any account information such as social security number, address, phone number, etc.

**Emergency Contacts:**
Use this section to update the emergency contacts for the client. Please note that a doctor is required for all clients.
Provider Change:
This form may also be used to transfer a client from one provider to another. Simply complete this section entering the current provider’s number and listing the provider you wish to transfer the client. If the transfer is for a specific core service, list the core service to which the transfer applies. If you are changing all core services, check the “all services” box. The client will be transferred to the new provider for all core services that the current provider has enrolled the client.

Hospital Section:
If the client becomes hospitalized during the course of treatment, complete a Data Change Form and indicate to which type of facility the client was admitted.

Diagnosis Information:
If the client’s Axis 1-5 Diagnosis or Diagnoses changes, you should complete a new Diagnosis Addendum.

Other Changes:
Use this section to list other data changes that need to be made to the client’s record.

K. Transfer/Discharge Summary: (112) This form is used to document a client’s progress toward treatment goals at program release or discharge. A Transfer/Discharge Summary form should be completed each time a client is closed from a service. The summary should reflect the services and progress for that specific service. By completing a summary form at each release, this alleviates the need to address all services received at the time the case is closed. The form has been redesigned to give the counselor the ability to use check boxes to indicate responses rather than a lengthy narrative.

L. Your Rights: (113) This form outlines the rights of clients receiving services from Piedmont Community Services. Each client must be furnished with this form upon enrollment to services.

M. Acknowledgment of Rights Notification: (114) This form is required by the State of Virginia to be completed at the time of intake and annually thereafter as long as the case is open. The accompanying document entitled: “YOUR RIGHTS” is to be reviewed with the client. If the client is unable to read, it must be read to him/her. The client is to be given a copy of “YOUR RIGHTS” with the name of the staff member responsible for receiving complaints written in the blank near the bottom of the document. In most situations that person would be the Director of that division.

Once the above has been accomplished, the top portion of the Acknowledgment of Rights Notification form is to be signed by the client. If the client is unable or unwilling to sign, then the lower portion of the form is completed and witnessed by another person. Spaces are provided at the bottom of the form to indicate that the Rights Notification has taken place. If all spaces have been completed, a new form should be used.
N. **Medication Informed Consent:** (115) This form is used to make clients aware of the medications they are prescribed; its purpose and possible side effects. The form is to be completed for each client at the time of psychiatric intake, if medication is prescribed. The nursing/medical staff is responsible for completion of this form.

O. **Interview Regarding Services:** (116) This form is used by the acute/intake staff to assess consumers as they call and request services. If a follow-up appointment is made, please indicate the date and time at the bottom of the form along with the name of the referring counselor.

P. **Service/Group Logs** (121/122) These logs are used to collect service data that are not collected on service tickets or other logs developed by individual service areas.

Q. **In-House Drug Testing Log:** (119) This form is designed to provide a location to record all in house urine drug testing. Staff within Piedmont Community Services should utilize this form instead of copying the urine test device on a copy machine.

Enter the Name and Account Number on each log. Record the date of the test. Under each column, indicate “pos” for positive or “neg” for negative on each test done. Any column not tested, mark with a slash. The clinician performing the test signs his/her signature in the Signature column. The “Client Initials” column is optional. If you choose not to have the client initial this column, simply line through it. Check whether the urine specimen was witnessed or not by staff.

This form should be located directly under the “Lab” divider tab in the third section of the clinical record. All labs performed by outside labs (out of house labs) will be filed under the “In House Drug Testing Log” with the most recent test directly under the log.

R. **Priority Population Checklist:** (123) This form is used to identify which Priority Population a consumer is a member of. Staff will complete this form and forward it to MIS for data entry. For definitions of each category, see the priority population worksheets that are provided by the Department.

S. **Physician Referral Acknowledgement Form:** (124) More than just a Medicaid and performance contract compliance issue, there is a great deal of literature available today detailing the interrelationships between mental health care and primary health care (including mutual exacerbation of problems). PCS is committed to the improved health of the entire person, not just their brains; therefore, PCS will pursue the following protocol:

a. For all consumers receiving Medicaid Clinical Option or SPO MH Case Management services;

   I. Each consumer will be asked if he/she has a family/primary care physician;
II. For those consumers answering negatively (The Emergency Room is not accepted as a primary care physician, and such a response should be treated the same as a negative answer), the provider will have available (via PCS) a listing of possible physicians for the consumer to access for a physical examination;

i. A copy of this list will be made available to the consumer, or an appointment may be arranged with a physician of the consumer’s choice at that time;

ii. If an appointment is made or is agreeable to the consumer, this should be documented on the Physician Referral Form. On the back of the Physician Referral Form is a specialized Release of Information Form. This should also be completed at that time, and a copy of that form given to the consumer for delivery to the physician.

iii. It is possible that the consumer may refuse to see a physician. If this is the case, it should be so documented on the Physician Referral Form and in the progress notes of the consumer’s chart.

III. For consumers who already have primary care (family) physicians, medical records shall be requested for the latest physical examination conducted by that physician, provided it has been conducted within the past 12 months. If the consumer has not underwent a physical examination during that time frame, a new physical should be scheduled;

IV. The appropriate documentation should be made on the Physician Referral Form, and the necessary Release of Information shall be signed on the back of the Physician Referral form;

V. Refusal to undergo another physical examination and/or sign the Release of Information form shall be documented on the Physician Referral Form and in the consumer’s chart.

VI. If the consumer has had a psychiatric hospitalization during the past 12 months, and the hospital’s evaluation includes physical health, then that hospital evaluation will suffice for compliance with the Medicaid regulation.

b. For all Non-Medicaid Consumers:

All consumers should be referred to primary care physicians, regardless of circumstance. The list of physician options should also be made available, and the Physician Referral Form and Release of Information utilized. However, it should be left to the provider’s discretion as to how vigorously to pursue this recommendation on a case-by-case basis. Records from psychiatric hospitalizations should be handled in the same manner as for the Medicaid populations.
S. **Provider Choice Form:** (125) When consumers are enrolled in services, this form will be used to assure freedom of choice. This form is to be completed at intake for all consumers and must be filed in the consumers clinical record. If the consumer chooses not to receive any services, s(he) will indicate this by checking the box directly below the choices and signing the form.

T. **Release of Information Invoice:** (126) This form is used by reimbursement to bill consumers and agencies for copying and releasing of information.

U. **Case Management Progress Note:** (Completed by all service providers who provide case management to consumers) Progress note form #127 is used to summarize any case management contacts that are billable – both face to face and collateral contacts. Notes are to be completed each time a case management activity occurs.

The first section is entitled “Client Information”. Every entry must include the client’s full name (complete first name, middle name (NMN if there is no middle name and last name, the account number and the social security number).

The second section is entitled “Session Info”. The case manager needs to address the type of intervention that occurred (phone call, home visit, office visit, school visit, meeting, etc). The setting in which the intervention occurred must also be listed (home, PCS, court, school – include the actual name of the facility). The people involved in the intervention must also be noted in this section. The length of the session must also be marked next to the box including the amount of time the session lasted.

The third section is entitled “Client’s Current Status”. In this section, the case manager addresses the client’s current level of functioning and how he/she is doing in home, school, work, community, etc.

The fourth section is entitled “Staff interventions and how it is related to plan of care”. In this section, the case manager addresses the actions that they have taken as a case manager and how this relates back to the plan of care (ISP/ITP).

The fifth section is entitled “Client’s progress toward goals and objectives in plan of care”. This section addresses the client’s progress or lack of progress towards the case management goals and objectives.

All case management entries must have the signature of the provider, his/her credentials, and the date of the case management activity (no initials are allowed). (Examples: Susan Q. Jones, BSW; S. Q. Jones, BSW)

When errors in writing are made, the worker will need to mark through the error and initial it. (Example: threw SQJ). White out is never allowed in the clinical record. All notes must be written in black ink in legible handwriting. If additional space is needed, the case manager can use the back of the form.
Case Management Progress notes must be completed in a timely manner and must be in the chart/file no later than three (3) business days after the event.

Progress Note form #105 will be used to document “non-billable” contacts with the client and other activities. Examples of the need to use this form would be, subpoenas, court orders, failed appointments/no-shows, cancellations, follow-up attempts, requests for information, distribution of medications, psychiatric contacts, receipt or sending of correspondence and other client related non-billable services.

V. Vital Signs Flow Sheet: (128) This form will be placed in each chart of the Children’s unit. It will be used to record vital signs on an ongoing basis. Medical personnel will complete the form.

W. Assessment / Social History Update Form (104.b) This form is used to update the Original Social History. Social histories should be updated when the following conditions occur: Yearly, Re-Admission (for consumers re-admitted within one year of discharge), Admission to a new service, Interim Update or when New Information is needed. The consumers Identifying Information should be entered, check the reason for the update, indicate the section of the original social history that is being updated, and write a detailed note about the information being updated. The provider and the supervisor (if Medicaid) should sign and date the form. Finally, indicate whether or not an update to the ITP is required. If so, indicate the goal number(s) to be updated.

X. Medication Sheet: (129) This form must have proper client identification with complete name and client number. This form is used to record medications ordered from the Aftercare Pharmacy. A nurse will transcribe orders from the Physicians Order Sheet to the Medication Sheet. The date of the original order goes in the date column. The columns under the Date Given Out section are for the designation of number of refills available. (Schedule 6 medications can only be filled a total of 12 times and Schedule 5-3 for only 6 times). When a medication is delivered to a client, the individual delivering the medication to the client will record the date, # of pills in the bottle, and their initials. If it is an injectable medication, the nurse should record the date, amount given, and their initials. If a medication order is changed, the order will be lined though with the initial of DC and the nurse taking off the order, initial and date the order change on the sheet. The new medication order will then be written on a new line.

Y. Nurses Notes: (105b) This form must have proper client identification with complete name and client number. The Nurses Note is used to document all client-related activities by the Nursing Staff. This will include telephone calls, face to face contacts, meetings pertaining to the client, failed appointments/no-shows, cancellations, follow-up attempts, distribution of medications, psychiatric contacts, or receipt or sending of correspondence.

Z. Physician’s Orders: (130) This form must have proper client identification with complete name and client number. The Physician’s Orders Sheet is used to record all Medication Orders. Each medication is be legibly written with dosage, route, directions, and whether the provider is writing an actual prescription (Rx.), dispensing samples, ordering from
aftercare pharmacy or from patient assistance programs. Aftercare pharmacy medications will follow Hiram Davis Pharmacy Protocol for refills. Orders are to be signed by the provider at each visit.

Verbal and Telephone Orders are to be written on the Physician’s Order sheet by the nurse receiving the order. The order is to be signed by the provider on that date or at the next available clinic date. This sheet is also to record any lab work ordered.

A nurse will review the record after the provider has seen the client to order medication or change orders as required by policy in place for ordering. After the nurse has reviewed the orders, made necessary changes, the orders are to be initialed and dated.
## SECTION G. APPROVED FORMS:
The following pages are the forms approved for agency use.

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* Indicates forms necessary for intake / admission to services.
# Indicates forms to be included in intake packets.
Medical Records Policy and Procedures
Revision: 8/14/06

Note: The Medical records Committee must approve all changes to agency approved forms. To request changes, submit in writing along with a sample to the chairman of the committee. The committee will review the request, and if changes are approved, these will become part of this policy. These will be distributed to all affected parties. When changes are made to this policy, an update will be distributed through the regular meeting of the PCS Management Team. It will be the responsibility of the respective managers to assure that their staffs are made aware of the changes to the policy, and new forms are distributed accordingly.
SECTION H.  CASE TRANSFER PROTOCOL

Assignment of Responsibility for Medical records Maintenance
11/21/01

INTENT OF PROTOCOL

This protocol is designed to clearly define the assignment of responsibility for maintenance of the medical records of Piedmont Community Services’ consumers.

DEFINITIONS

“Assignment” means the alignment of responsibility (as defined below) with a single Piedmont Community Services’ service provider.

“Clinical Record” means the record (also known by some as “chart” or “file”) established to document the care received by consumer(s) at Piedmont Community Services.

“Core Service” means a grouping of similar services (i.e., Outpatient, Emergency, Case Management, Day Treatment, etc.) as defined in the Core Services Taxonomy, written by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRASAS).

“Maintenance” means the ongoing practice of exercising one’s “responsibility” (as defined below).

“Primary Provider” means the individual Piedmont Community Services service provider responsible for coordinating the care of the consumer

“Responsibility” means the responsibility for assuring that the record(s) meets the standards established by either Piedmont Community Services, DMHMRASAS Licensure regulations, and/or third-party payers, including Medicaid, Medicare, Trigon, etc.

PROTOCOL – ROUTINE CASE ASSIGNMENTS

1. At the time an individual case is assigned, either an outpatient therapist or case manager (and possibly both) should be involved as providers in the case. The primary provider will generally be assigned according to the POMS computer-based ranking/hierarchy.

2. In the event that both outpatient and case management staff are simultaneously involved in the consumer’s care, the supervisor(s) of the respective involved staff members will assign the responsibility of primary provider.

3. In the event that multiple providers within the same service (i.e., outpatient, case management, etc.) are involved in the consumer’s care, the responsibility of being
primary provider will be assigned by the program supervisor. That provider shall be listed as primary on the Program Enrollment screen of the Client Data Management System (CDMS).

4. Medical staff (i.e., physicians, nurse practitioners, physician assistants and nurses) should never be assigned primary provider responsibilities when any other provider is involved in an individual consumer’s care.

5. The Division Director (or his/her designee) will resolve cases of disputed assignment of primary provider responsibility.

PROTOCOL – ROUTINE TRANSFER OF CASE

1. There are two (2) standard methods of case provider transfer in routine cases:
   a. Transfer of provider within a single core service; or
   b. Transfer between core services (i.e., outpatient to case management, etc.).

2. When a transfer of provider occurs within a single core service (either by agreement of the two providers or as assigned by the appropriate supervisor), the provider making the referral will:
   a. Assure that the transferred consumer’s clinical record complies PCS, DMHMRSAAS licensure and third-party standards. Cases may be returned to the referring provider for correction when these standards are not met; and
   b. Complete the “Provider Change” portion and case identifying information on the PIEDMONT COMMUNITY SERVICES Data Change Form (Form #111). Upon completion of that form, the provider receiving the referral assumes responsibility for the case. The change will be reflected on the Program Enrollment Screen within the CDMS.

3. When a case is transferred from one core service to a second core service, the provider making the referral completes the PIEDMONT COMMUNITY SERVICES Program Release (back of Form #103) as it relates to the referring core service. The provider receiving the referral will complete a new PIEDMONT COMMUNITY SERVICES Program Enrollment (Form #103) form. When the receiving provider completes this form, he/she assumes a minimum of core service-related responsibility (which, depending on the nature of the core service, may or may not create a new primary provider) for the case.

The timing of the completion of these forms should be coordinated between providers to assure that consumers are not left for periods of time with unnecessary ambiguity regarding the providers responsible for his/her case.

PROTOCOL – TRANSFER OF CASES INVOLVING PROVIDERS CHANGING POSITIONS WITHIN PIEDMONT COMMUNITY SERVICES
1. As stated in the Piedmont Community Services’ personnel policies, direct service providers are expected to give at least 30 days notice of their intention to vacate a position. That expectation applies to job changes within PCS as well to employees leaving to gain non-PCS employment.

2. Employees giving notice of an internal job change must ensure, within their 30-day notice, that all medical records of cases assigned to them are current and in compliance with all PCS, DMHMRSAS licensure and third party payer standards.

3. The supervisor of the unit/program being vacated by the provider will meet with the provider prior to the conclusion of the 30-day notice period to verify that all medical records meet the standards described above. If deficiencies in medical records are found, the provider must complete all possible corrections before the end of that same 30-day period.

4. If the identified deficiencies are not corrected within the 30-day notice period, the respective program supervisors involved shall consider alternative solutions, including delay of position transfer, disciplinary action, etc. The appropriate Division Director (or his/her designee) and the Director of Human Resources shall be involved in this discussion, designed to develop a mutually agreeable solution to all supervisory personnel involved. If no such solution is possible, the Division Director (or his/her designee) and Director of Human Resources shall choose an appropriate course of action.

5. If the supervisor of the unit/program being vacated fails to hold a meeting(s) with the provider to verify his/her medical records’ compliance, and should discover clinical record deficiencies after the provider has already changed positions, that supervisor (or his/her designee) is responsible for making the desired corrections, and will have no claim on the time of the provider. This standard also applies in situations where such a meeting was held with deficiencies identified, but with no follow-up on the part of the supervisor regarding the completion of the needed corrections.

PROTOCOL – TRANSFER OF CASES INVOLVING PROVIDERS LEAVING THE EMPLOYMENT OF PIEDMONT COMMUNITY SERVICES

1. Employees leaving the employment of Piedmont Community Services, during their required 30-day notice, will meet with their supervisor to ensure and verify that all medical records assigned to the provider meet the standards described above. The employee is responsible for assuring the compliance of his/her assigned records.

2. Should deficiencies be found in those records after the provider has left employment with Piedmont Community Services, the new provider responsible for the consumer’s case will be assigned responsibility of making any possible corrections to the record.
SECTION I – RIGHT TO ACCESS PROTECTED HEALTH INFORMATION

POLICY STATEMENT:

It is the policy of Piedmont Community Services (PCS) that each individual served has a right to inspect and/or obtain a copy of their protected health information (PHI) maintained in his/her own service record. An individual’s legally authorized representative has the same right as the consumer.

BACKGROUND:

It is the policy of PCS to supply protected health information to individuals served upon request EXCEPT FOR:

1. Any information compiled in reasonable anticipation of, or use in a civil, criminal, or administrative action or proceeding.

2. The individual served is an inmate of a correctional facility and if the information could jeopardize the health, safety, security, custody or rehabilitation of the individual served or other inmates, or the safety of any officer, employee or other person at the facility or responsible for the transportation of the inmate.

3. The individual served is involved in research that includes treatment and he/she has consented to not have access to his/her health information while the research is in progress. Access to the protected health information will resume upon completion of the research.

4. The individual’s attending psychiatrist or psychologist has determined that the information could be injurious to the individual’s physical or mental health, well being, or the life and safety of another person. (Reference: Code of Virginia 2.2-3705; 8.01-413; 32.1-127.1:03)

PROCEDURE (S):

1. The individual served may request to inspect and/or obtain a copy of his/her protected health information; the request for access must be made in writing to the consumer’s primary service coordinator.

2. The individual served may request to inspect and/or obtain a copy of his/her protected health information for as long as it is maintained in a designated record set.

3. If an individual served requests to inspect and/or obtain a copy of his/her protected health information the PCS shall:

   a. Determine if there are any grounds for the request to be denied.
b. The attending psychiatrist or psychologist determines that the individual’s life or physical safety might be in jeopardy if he/she has access to his/her protected health information, and, the attending psychiatrist or psychologist has made a part of the individual’s medical record a written statement that, in his/her opinion, the furnishing to or review by the individual served of his/her protected health information would be injurious to the individual’s health or well-being.

c. Another person’s life or physical safety might be in jeopardy if the individual served has access to his/her protected health information.

d. The information contains reference to another person and the information could cause harm to that person.

e. The individual’s legally authorized representative makes the request and the attending psychiatrist or psychologist has determined that access by the individual’s legally authorized representative could result in harm to the individual served or another person.

4. If PCS denies the individual served access to the requested information, PCS shall:

a. Provide the individual served with a written explanation of why access was denied within 15 days of the request (Reference Code of Virginia 8.01-413). This explanation is to include the reason for the denial and information on how to file an appeal/complaint with PCS. (Include the name, title, telephone number and address of the contact person(s) or office).

b. Honor the right of the individual served to request that a denial for access be reviewed by another psychiatrist, psychologist or attorney (designated by the individual served) who did not participate in the original decision to deny access.

c. Give the individual served access to any other health information requested that is not covered by the denial.

5. If accepted, provide the individual served with the requested health information within 15 days of the request.

6. If the information is in duplicate or at more than one location, PCS only has to provide one copy of the information to the individual served.

7. PCS will provide the individual served with the requested healthcare information in the format requested by the individual served -- either hard copy or electronic.

8. PCS may provide the individual served with a summary of the requested healthcare information instead of the actual information providing the individual served agrees in advance.
9. PCS will arrange with the individual served a convenient time and place to review the requested health information in the presence of the Program Manager or to mail a copy of the information at the individual’s request.

10. PCS may charge the individual served a fee for providing the information. The fee includes the costs of copying the material, labor, supplies, postage, and preparing a summary (if the individual served desires a summary). The Code of Virginia 8.01-413 provides that copying charges shall not exceed $0.50 per page for each page up to 50 pages and $0.25 a page thereafter. The charge for copies from microfilm may be up to $1.00 per page. All postage and shipping costs may be charged. Pre-payment of copying charges is preferred.

11. If PCS does not possess the information the individual served requests, but knows where it is maintained, PCS shall inform the individual served where to direct his/her request for access.
SECTION J – REQUEST FOR AMENDMENT OF THE MEDICAL RECORD

POLICY STATEMENT:

It is the policy of Piedmont Community Services (PCS) to respond to the request of an individual served to amend the medical record of that individual if the individual believes information in his/her service record is incomplete or incorrect.

DEFINITIONS:

“Agency” --- Used throughout these policies to mean Piedmont Community Services.

PROCEDURES:

1. After reviewing his/her health information, the individual served may request an amendment to the information in the record.
   a. The individual served requests in writing an amendment to his/her primary service coordinator, including the reasons why he/she wants an amendment to the information.
   b. The agency has 60 days to act on the request to amend the information. If the agency cannot act on the request within 60 days, the agency may extend the time period once for an additional 30 days. The agency will write a letter to the individual served explaining the need and reasons for an additional 30 days and the expected date the decision about the request will be made.

2. In response to a request to amend health information, the agency:
   a. May deny the request if the information was not created by the agency;
   b. May deny the request if the individual who created the information that the individual served wants amended is no longer an employee of the agency;
   c. May deny the request if the information in the record is currently accurate and complete.

3. If the agency denies the request to amend the information, the agency shall:
   a. Write the individual served a letter explaining the reason(s) for the denial.
   b. Explain in the denial letter steps the individual served may take to appeal the agency’s decision.
c. Explain in the denial letter that if the individual served does not appeal the agency’s decision, he/she may request the agency to include the request for amendment by the individual served and the denial with any future releases of the disputed health information.

d. Explain how the individual served may file an appeal to the agency by giving the individual the name, address, and telephone number of the Privacy Officer.

e. Review a written appeal statement from the individual served disagreeing with the denial of all or part of the requested amendment.

f. Prepare a written response to the statement of disagreement of the individual served and provide a copy to the client.

   (1) Identify the information that the individual served wanted amended and attach the client’s request for amendment, the agency’s denial of the request, the client’s statement of disagreement and the agency’s written rebuttal.

   (2) Include the request for amendment by the individual served and the denial to make the amendment with any future releases of the information if the client has not submitted a written statement of disagreement.

4. If at any point the agency honors the request for amendment:

   a. The agency shall make the amendment. The minimum amendment accepted is identifying the information to be amended then providing a link to the amended information.

   b. Inform the individual served that the amendment(s) is accepted.

   c. Obtain from the individual served the names and addresses of individuals who need to have the amended information.

   d. Attempt to reach those individuals who need to have the amended information.

   e. Attempt to contact other persons or business associates regarding the amended information if the information was detrimental to the client.

5. Document in the progress notes of the individual served medical record the names and titles of the employees responsible for receiving and processing the request for amendment.
SECTION K - MINIMUM NECESSARY POLICY & PROCEDURES

BACKGROUND
The Privacy Rule under the Health Insurance Portability and Accountability Act (HIPAA) requires covered entities to take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Piedmont Community Service Board will adhere to the standards set by HIPAA and the ethical principles of the agency to insure that only information that is required to fulfill the stated purpose of the services, and that required by law, will be disclosed.

EXCEPTIONS TO THE MINIMUM NECESSARY STANDARD
The minimum necessary standard does not apply in the following circumstances:
• Disclosures to or requests by healthcare providers for treatment purposes
• Disclosures to the individual who is the subject of the information
• Uses or disclosures made pursuant to an authorization requested by the individual
• Uses or disclosures required for compliance with the standardized HIPAA transactions
• Disclosures to the Department of Health and Human Services (HHS) when disclosure of information is required under the rule for enforcement purposes
• Uses or disclosures that are required by other law

USE AND DISCLOSURE OF PHI INTERNAL TO THE AGENCY
Piedmont Community Service Board will insure the Minimum Necessary Standard is met by:
• Identifying the persons or classes of persons in the workforce who need access to PHI.
• Identifying the category(ies) of PHI to which access is needed.
• Developing and implementing procedures to insure that disclosure of PHI is limited to the amount reasonably necessary to achieve the purpose of the disclosure
• Maintaining standards of good practice to assure reasonable precautions are taken to prevent inadvertent and unnecessary disclosure, such as limiting discussion in public areas
• Developing and implementing procedures for review of requests for access

1. Persons or Class of Persons Who Need Access to PHI and Category(ies) of PHI to Which Access is Needed
In order to appropriately comply with Minimum Necessary Standards and effectively maintain healthcare operations, access will be determined by a role-based assessment and context-based assessment:
• Complete access to a client's PHI will be available to the direct service provider, his/her immediate supervisor, and other providers on the same service unit/team
• Emergency Services/ Crisis Intervention staff will have access to all clients' PHI
• Medical Records staff will have complete access to all clients’ PHI
• Reimbursement staff will have access to all clients’ PHI, as needed, to handle transactions
• Information Technology staff will have complete access to all clients' PHI
• Data Entry staff will have access to all client's PHI, as needed, to complete data entry
As our “Client Data Management System” develops the capability of electronically restricting access, implementation of access controls will be handled through the Information Technology department. Until such time, agency staff will be trained on the amount of access that their job requires, be required to sign acknowledgement of understanding of the agency’s policies regarding limiting access, and the agency will provide monitoring to assure compliance.

1. Procedures to Insure Disclosure of PHI is Limited to the Amount Reasonably Necessary to Achieve the Purpose of the Disclosure

Internal to the agency, there are numerous and varied ways in which PHI is used and disclosed for treatment and healthcare operations. To insure adherence to the standards, the following questions will be considered to determine appropriate safeguards are in place:

a. What PHI is necessary to complete the task?
b. What PHI can be omitted and healthcare operations continue unimpeded”
c. Who will have access to the information disclosed in the healthcare operation under review?

Procedures are also to be in place to ensure that the minimum necessary is disclosed:

a. Staff will be trained in HIPAA standards.
b. Supervisors will be available for consultation.
c. The agency’s Privacy Officer will be available for consultation and will be responsible for handling any complaints.
d. Periodic audits by Medical Records staff.

2. Precautions to Prevent Inadvertent and Unnecessary Disclosure

Staff will be trained about the need to take reasonable precautions to prevent inadvertent and unnecessary disclosure, such as disclosure that can occur if discussions were held in areas with public access.

3. Procedures for Review of Request for Access

Medical Records Staff will periodically audit procedures to assure compliance with all confidentiality and Minimum Necessary standards. Corrective action will be taken as needed and appropriate.

USE AND DISCLOSURE OF PHI EXTERNAL TO THE AGENCY

1. Authorization to Release Information

The Authorization form indicates the specific information to be disclosed or requested. Only the minimum necessary information needed to accomplish the intended purpose will be disclosed or requested. The form contains an explanation of confidentiality and Privacy Rule standards for the client's information. Client's must give informed, voluntary consent to any disclosure of PHI, and may revoke the authorization at any time.

2. Routine and Non-routine Requests and Disclosures

For routine and recurring requests and disclosure, individual review of each request is not necessary. Agency staff will limit information that is disclosed or requested to the minimum necessary to achieve the purpose of the disclosure. If a covered entity is requesting information,
staff may rely on the judgment of the party requesting the disclosure as to the minimum necessary amount of information that is needed. However, if the agency staff member has concerns that more than the minimum necessary is requested to be disclosed, the staff member may, in consultation with his/her supervisor, make his/her own minimum necessary determination for disclosure.

For non-routine requests or disclosure, agency staff, with the guidance of their direct supervisor, shall determine the minimum necessary that is needed to achieve the purpose of the disclosure. Some guidelines are:

- The medical record in its entirety will not **routinely** be copied
- Portions of the medical record will not **routinely** be copied
- If a request or disclosure is for treatment information, a summary of client contact may be prepared which includes:
  - the client's name,
  - date of birth,
  - service dates,
  - purpose for seeking services,
  - diagnosis and assessment information,
  - type and duration of services received,
  - outcomes of services received, and
  - discharge summary information and referral, if appropriate.
- Substance abuse information will only be shared if the Authorization for Release of Information specifically states that information is to be disclosed or in accordance with 42 CFR.
- Medical information such as diagnosis of TB, AIDS, HIV or other infectious disease will only be shared if the Authorization for Release of Information specifically states that information is to be disclosed.
- Agency staff will not routinely list all options on the Authorization for Release of Information, for information to be disclosed or requested. Agency staff must be very specific as to what is being requested or disclosed, applying the minimum necessary standard.
- Third party information is to be considered part of the Designated Record Set, and may be disclosed in accordance with this policy and applicable law.

3. **Monitoring**

*Piedmont Community Service Board* will monitor adherence to the Minimum Necessary Standards on a regular basis. Some examples of monitoring procedures are:

- **supervisors review requests and disclosure with supervisees during probationary employment period**
- **periodic supervisory review throughout employment**
- **regular, ongoing supervisory review if performance issues are present**

*Medical Records* staff will periodically conduct audits to limit use, disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose.
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