FOHFS	Fountain of Hope Family Services Inc.	**Policy and Procedures**
	Policy Type:- General Program Standards	Policy# **GSP-209**
	Subject:- Record of the Person Served	Adopted:-**05/06/2014**
	Section:- (2-G)	Effective:-**06/11/2015**
	Approval By:- Michael Oladipo	Revised:-**08/15/2020**

Policy

1. The individual record communicates information in a manner that is:
   a. Organized: Each record is contained in a file folder that is organized in such as way as to allow ease of access to all parts of the record.
   b. Clear: Each record is clearly identified with the person's served name and placed in alphabetical order.
   c. Complete: Each record contains information regarding all the services the person receives.
   d. Current: Each record is maintained and kept current by a system that allows for timely filing of all documents.
   e. Legible: Clinicians are encouraged to submit all forms completed in a type written format, but hand written documents are acceptable if two personnel are able to read the document without seeking the assistance of the Clinician who developed the document.
2. All documents generated by **FOHFS Agency** that requires signatures include original signatures.

3. **The individual record includes:**
   a. The date of admission is include on the screening and referral form.
   b. Information about the parent or guardian is included on page one of the **psycho-social**.
   c. Information about the person to contact in the event of an emergency is included on page one of the **psycho-social**.
   d. The Clinician coordinates services of the Client and signs the treatment plan's signature page indicating their position as primary provider for the Client.
   e. The **psycho-social** includes Behavioral/Psychiatric Health History/Status where prior treatment is documented. The Clinician may request records from those agencies by including consent for release of information from the Client. All records for **FOHFS Agency** are maintained in one file.

- **The release will have the following information**:

  - The name of the person about whom information is to be released
  - The content of information to be released
  - To whom the information is to be released
  - The purpose for which the information is to be released
  - The date the release is signed, along with the date, event or condition which the release expires.
  - Information on how and when the authorization can be revoked.
  - The signature of the person who is legally authorized to sign the release.

  f. A Health Care Coordination Form is used to communicate services being provided by **FOHFS Agency** to the person's served primary care physician. This form is included in the file and includes the person's served primary care physician's name, address, and telephone number.

  g. Healthcare reimbursement information is included in the Screening and Referral Form.

  h. The person's
  (1) Health history is included on page **3** of the psycho-social.
  (2) Current medications are included on page **3** of the psycho-social and are also included on each treatment plan.
  (3) Preadmission screening is documented on the Screening and Referral Form.
  (4) Documentation of orientation is documented on the form labeled Documentation of Orientation.
  (5) **FOHFS Agency** assessment is referred to as the psycho-social.
  (6) All treatment plans, extensions, modifications, and corrections will be documented in the person's served records.
  (7) Transition plans are included in the Transition/Discharge Summary form; this form is to be included in each person's served record.

  i. A Transition/Discharge Summary is included in each person's served record.

  j. Correspondence pertinent to the Client is maintained in that person's record.

  k. Authorization for release of information is maintained in the person's served record.

  l. Documentations of all referrals are maintained in the out of office referral log and are noted within in a progress note that is maintained in the person's served file.

4. Initial assessment is performed within 7 days of acceptance into the program. The **Comprehensive Treatment Plan** is developed **within 15** service days of starting services. Treatment plans are reviewed twice (2) yearly. Any deviation from these procedures is documented in the individual's case record.
   a. Documentation relating to the following forms should be filed within **5**

days of receipt by **FOHFS Agency** personnel: Assessments, Authorizations for Treatment, Releases, Referrals, Historical Information, and Individual Treatment Plans. Progress Notes are to be completed and filed in the charts within 5 days of billing for service. Any other information not included above must be filed within 5 days of receipt.

5. Duplicated information is not maintained at **FOHFS Agency**. Each person's served information is maintained in their file, exceptions to this are billing requirements such as treatment plans being maintained on the **FOHFS Agency** web site.

▸ Access to Files

Access to files is as follows: counselors, management team members and others designated by the management team. All persons having access to the files will be oriented to confidentiality.

▸ Individual Case Records

⇥ Policy

FOHFS Agency adheres to the funding source requirements and applicable accreditation standards for maintaining case records.

Case records are set up uniformly in a central location for the entire corporation. There is one case record format developed for each Client.

⇥ Procedures

⇥ Format

Each section of the file is arranged in chronological order, most recent on top.

Intake/Cover Sheet
Consents
Releases
Authorizations
Financial/Legal
Grievance Procedures
Rights and Responsibilities
Criteria for Discharge
Orientation
Medical
Psychosocial Assessment
Treatment Plans
Progress Notes

Psychological/Psychiatric Evaluations
Other Evaluations
Copies of records from other sources
Correspondence

⇥ Filing

The designated staff within corporate headquarters completes filing.

⇥ Filing Time Lines

FOHFS Agency staff believes in the importance of maintaining current and up-to-date case records for the individuals served. In order to ensure the individual case records contain the most current information available, the **Clinician Director** has established some time lines for the filing of the documentation that has been received and/or completed for the individual and belongs as a part of the permanent case record.

Documentation relating to the following topics should be filed within 2 days of receipt.

⇥ Incident Reports

Documentation relating to the following topics should be filed within 5 days of receipt.

Assessments
Authorizations for Treatment
Releases
Referrals
Historical Information
Individual Treatment Plan
Progress Notes are to be completed and filed in the charts within 30 days of service.

Progress notes

Policy:

It is the policy of **FOHFS Agency** to regularly document the progress of Clients' treatment goals and objectives. Entries to the records of the persons served should be made within 7 days of the services provided.

Progress notes are entered in the Client's record and include:

a. Chronological documentation of the Client's Clinical course
b. Documentation of all Clinical treatment rendered to the Client
c. Documentation of the implementation of the treatment plan
d. Description of each change in each of the Client's conditions
e. Description of responses to and outcomes of treatment
f. Description of the response of the Client, Client's family and/or significant others to events

g. Documentation of no shows and attempts by the program personnel to Improve compliance, including adjusting schedules

Progress notes are dated and signed by the individual treatment team member who provided the service, makes the entry, and references the treatment objectives. Progress documentation will be entered daily if possible but at least weekly (minimum of once per month). Correct documentation will be monitored during weekly case reviews and staffing. The **FOHFS Clinical Director** or designee will conduct an annual Clinical review for the purpose of assessing services provided by staff to Clients. **FOHFS** uses measured results and findings for the purpose of keeping all Clinical policies and procedures current

 Discharge assessment mental health conditions consumers:

All **FOHFS Agency** staff shall assess each consumer for appropriate of discharge from our mental health treatment program. Each consumer shall be assessed using **DSM IV** that includes a list of symptoms for all the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination for appropriate placement to a specific level of care based on the consumer's severity of symptoms and current situations.

 Continuing Care Plan

FOHFS Agency staff shall assist the consumer to obtain services that are needed, but not available within the Agency, and/or in transitioning from one level of care to another, and/or discharging from **FOHFS Agency. FOHFS Agency** professional staff will compile a written plan of recommendations and specific referral for implementation of continuing care services, including medications, shall be prepared for each consumer who meets mental health dimensional continued services criteria, in each level of care. Continuing care plans shall be develop with the knowledge and cooperation of the consumer. The continuing care plan may be included in the discharge summary. The consumer's response to the continuing care plan shall be noted in the plan or a note shall be made that the consumer was not available and why. In the event of death of the consumer, a summary statement including this information shall be documented in the record.

 Discharge Summary

A complete discharge summary shall be entered in each consumer's record with fifteen (15) days of the consumer completing or discontinuing services.

 The discharge summary shall include, but not limited to, the following:

- Identified needs at intake;

- Initial condition and condition of consumer at discharge;
- Summary of current medications, when appropriate;
- Treatment and services provided, and summary of treatment outcomes and results;
- The signature of the staff member completing the summary and the date

Consultation reports

The consumer record shall contain copies of all consultation reports concerning the consumer.

Psychological or psychometric testing

When psychometric or psychological testing is done, the consumer record shall contain a copy of a written report describing the test results and implications or recommendations for treatment.