Case Note: Outline & Examples

MISSOURI DEPARTMENT OF HEALTH & SENIOR SERVICES
Division of Senior & Disability Services

The following items should be documented in case notes. However, not all items are relevant to every HCBS participant. To save time and effort, limit documentation to only the information that is important and relevant to the specific participant's circumstances, avoiding any excessive documentation that is already stated in the assessment.

- ☐ Face to Face assessment completed in (home/RCF/etc)
- ☐ DPOA or Guardian notified (if applicable)
- ☐ Who was present and answered questions?
- ☐ Living Arrangements (Who lives in home? Which areas are shared?)
- ☐ Condition of home or facility (How concerns were addressed?)
- ☐ Explanation of Safety/Abuse/Neglect/Exploitation concerns and action taken
- ☐ Ability to self-direct if requesting or receiving CDS
- ☐ Primary diagnoses which creates the need for services
- ☐ Description of how diagnosis limits ADL and IADLS completion.
- ☐ Informal/formal supports
- ☐ Further elaboration of:
  - ☐ Respiratory Therapy
  - ☐ Treatments
  - ☐ Non-Routine Preventative Treatments
  - ☐ Transfer Device
  - ☐ Clean Equipment
  - ☐ Physician ordered diet
  - ☐ Dietary Modifications
  - ☐ Monthly monitored diagnosis
  - ☐ RCF med passes
  - ☐ ITP provider (contact info if needed)
- ☐ Explanation of tasks that exceed suggested time/frequency
- ☐ Explanation of task not authorized, but need is reflected in assessment
- ☐ Explanation of the care plan changes - what changed, why, and if participant is in agreement.
- ☐ Provider selection/satisfaction
- ☐ Explanation of Underutilization