

Non-Assessment Contact Documentation

- ☐ Document **ALL** contacts and attempted contacts.
 - All contacts made on the **same** day can be included in one case note but with a clear separation between the contacts.
- ☐ Identify the type of contact made (phone, face-to-face, e-mail, etc.)
- ☐ When contacting a provider, note the provider agency's name, the provider's staff member's name, and the phone number used.
 - If the contact was made via e-mail, note the e-mail address used.

Assessment Documentation

- ☐ Where was the assessment completed?
- ☐ Who was present for the assessment? Who responded to the assessment questions?
- ☐ Is there a POA/DPOA, guardianship, or authorized medical representative?
- ☐ Living arrangements
 - Does the participant live alone or with other people?
 - If other people in the home are authorized for HCBS, document how services are to be coordinated to avoid duplication of tasks and ensure they are listed in the 'Manage Household' tab in the electronic case record.
 - If the participant lives with others, are they minors or have a disability that would prevent them from assisting with cleaning shared spaces or meal preparation?
 - Is the participant currently admitted to a hospital/facility/inpatient rehab? Note the reason for admission and expected discharge date.
- ☐ Participant's need for HCBS
 - Note the primary health condition(s) and how they create a need for HCBS
 - Document the physical/mental limitations causing the participant to need assistance with daily tasks; information should help justify tasks on the care plan
 - Clarify coding of Section G: What type of assistance does the participant need with ADLs/IADLs (e.g., assistance needed in/out of both)?
- ☐ Participant's Environment and Safety
 - Condition of the home:
 - Include a general statement about the physical condition of the home.
 - Additional clarity should be provided for issues coded in section Q.
 - Note if a referral was provided for resources/assistance.
 - If "F1g – Neglected, abused or mistreated" is coded as anything other than zero, clarify if referral was needed or if situation is resolved.
 - If a situation merits a referral to Adult Protective Services, the HCBS case record documentation should state "appropriate referral was made."

☐ Participant's Supports and Procedures

- Explain coding for vague InterRAI questions, such as:
 - **K2e** – Physician ordered therapeutic diet. Document the nutrient being restricted, weighed, or measured **and** the ordered calculation. (Example: 150g of protein)
 - **K3** – Mode of nutritional intake.
 - **N8** – Mental condition monitored monthly.
- Formal care (N3) – If participant is receiving services that would impact the authorization of HCBS (e.g. HDMs, hospice), document the type of assistance being provided, how often, and for what period of time; information will assist the care plan development.
- Informal caregivers (Section P) – Type of care being provided? Will the caregiver continue to assist?

☐ HCBS Forms

- If the participant is unable to sign and/or understand the forms, and there is no authorized representative, document why the participant cannot do so
- At initial assessment, document that the Physician Notification Form was sent to the participant's Primary Healthcare Provider (**DSDS Assessor only**).
- Provider Reassessors need to provide an agency associated email to all case notes

Care Planning Documentation

- ☐ Document any discrepancies between the coding of the assessment and the tasks on the care plan. Example: if a participant is coded as needing bathing assistance due to safety risks but refuses due to modesty concerns.
- ☐ If tasks are authorized about suggested time/frequency, or above what would be expected based on the coding of the InterRAI, provide an explanation for why additional time/frequency is needed.
- ☐ At reassessment, if units are reauthorized with no change, or increased despite recent underutilization, the reason for underutilization should be explained.
- ☐ Document all actions that adversely affect a participant's services.
 - Any decisions to reduce/remove services should be explained.
 - Document whether the participant/representative agreed with the change(s) to services.
- ☐ Provider Selection
 - Initial Assessment: Document the participant's preferred provider & if needed, an alternate provider (**DSDS Staff Only**).
 - Reassessment: Document the participant's satisfaction with the current provider or, if requesting a change, the name of the provider being requested.
 - If a participant does not have a preferred provider, document that they were given a list of available HCBS providers or will obtain one via the [Provider Search Database](#)

Private vs. Public Case Notes

- Private case notes should only be used by field assessors or PRR when documenting correspondence with APS regarding hotline situations.
- PCCP & Intake team members should refer to the PCCP & Intake Protocols regarding acceptable private case note entries.