Guidelines for Supportive Service Case Records

Service providers are usually required to maintain case records or charts that contain important documentation like the information listed below. Please note that this is not an exhaustive list. Case records are useful for maintaining, recording and transmitting information, and for documenting progress toward goals. Case records are required when billing a third party such as Medicaid. It is important to follow the guidelines of any funding source being billed for service. Case records need to be maintained in locked file cabinets, preferably in an isolated area or office.

Requirements vary regarding the amount and type of information that must be documented and how frequently progress notes and service plans should be recorded. Most important, however, is that case records remain current. Organizations also may choose or be required to track prescribed medications, physicals, hospitalizations, and collateral contacts with other community services. Computerized record-keeping systems lessen the burden of updating and storing paper records, and they can provide the service organization with comprehensive information about service utilization.

Maintaining updated and comprehensive case records and thorough documentation is important for many reasons:

- A well-organized record-keeping system provides quick access to important information.
- Records help with planning and monitoring progress toward goals.
- Progress notes provide proof and evidence of interventions done with clients.
- Service plans help staff and clients think more clearly about the work that is being done and provide goals.
- Records assist with continuity of service when there is a change in staff.
- Supervisors can use records as a tool to monitor and support the work of staff members.
- Records can document accomplishments and areas that need improvement.
- Records can reveal patterns of effective and ineffective interventions and support.
- Records can serve to document that regulatory requirements and agency policies are being met.

Releasing or receiving tenant information requires the tenant's permission and signed consent. Programs are expected to operate in accordance with federal, state, and local guidelines and statutes for sharing confidential information. Failure to adequately protect the privacy of medical, psychiatric, and substance use treatment and other confidential information is a breach of professional ethics and can be subject to legal action.

While the extensiveness of case records varies widely with the composition of the tenancy and funder requirements, the following is a sample format with recommendations for the frequency of recording.

Eligibility/Intake Forms

- Fact sheet with demographic and identifying information
- Emergency contact form (updated yearly or as circumstances change)
- Documentation showing proper eligibility for service participation and/or tenancy
- Income/employment information
- Homeless Management Information System collection form (if applicable)

Consent forms/release of information

- Consent forms (updated every six months or as stated on the document with the specific agency and information to be released or discussed)

Assessments

- Housing and employment assessment
- Psychosocial / diagnostic assessment (within first month)
- Mental health assessment
- Substance use assessment
    - NOTE: Not all assessments need to be completed separately if the information is integrated into one document. Diagnostic assessments are usually only required when billing Medicaid or when nationally accredited.

Service plan

- Comprehensive individual service plan completed jointly with the client (within first month).
- Service plans usually contain the following: broad goals with more specific measureable objectives to reach those goals, timelines, frequency of appointments, strengths and barriers of client related to the goal, and a place to record progress.
- Service plans also include any community people/agencies that are involved in providing service to the client.
- Service plan review (updated every six months), which includes progress and continued barriers on stated goals, as well as new goals that have emerged.

Progress notes (usually weekly to monthly)

- Notes usually reflect a summary of the intervention completed, progress toward service plan goals and objectives, client response, and any action plan/follow-up needed.
- Notes should include persons present, location of service, in person or by phone, date and length of time of intervention, activity, purpose, dated signature, and title of worker.
- Progress notes also should be written when communicating in person or on the phone with any collaborating organizations.

Documentation of service participation

- Identifies types of activities used (updated monthly)
- Summarizes participation in activities and contacts with service staff (updated monthly)
- Documents community-based services used with contact name, address and phone number

**Medical, mental health and substance use*

- General health assessment, including notes on changes in health status
- Medical documents and exams (updated annually)
- Medication regimen forms (updated as medications change)
- Monthly medication log (when medications are monitored)
- Mental health and substance-abuse treatment records

**Employment/Educational*

- Employment assessment
- Career plans
- Employment and educational history
- Military records

**Many times the lead service provider for the supportive housing project does not provide these services. It may be important for proper releases to be signed so copies of these forms can be obtained.*

Income

- Current income verification (updated annually or with changes in income)
- Entitlements and other benefits received

Miscellaneous

- Leases, incident reports, critical events (such as arrests), discharge summaries, important correspondence and rent arrears notices