The following information must be included in written documentation

1. **Overall Condition of Participant** – Document the overall appearance of the participant (i.e., demeanor, physical appearance, etc.)
2. **Community Involvement** – Document activities in which the participant is involved. List upcoming activities and note if participant was unable to take part in activities of his or her choosing.
3. **Desired Accomplishments** – Document how provider is supporting participant in meeting his or her desired accomplishments (i.e., skills development, progress on objectives).
4. **Medical Issues & Health** – Document medical concerns or medication issues.
5. **Provider Satisfaction and Concerns** – Document identified concerns with provider/provider staff. Note overall participant satisfaction with services being received.
6. **Friendships/Social Interactions** – Document important relationships in the participant’s life, and how time with friends and family has been facilitated. Note assistance that is needed in maintaining important relationships.
7. **School (if applicable)** – Document attendance, IEP information that should be discussed, and objectives. Note goals the family is addressing at home. **If the participant is in school, this topic must be addressed.**
8. **Self-Determination** – Document how the participant makes his or her own choices. If the participant is self-directing services, note his or her satisfaction with these services.
9. **Employment (if applicable)** – Document participant satisfaction with employment. Note absences, and if he or she is interested in seeking different employment. If participant has expressed interest in work, but is not employed, note how the provider is assisting him or her with employment. **If participant is of working age, this topic must be addressed.**
10. **Environment** – Document overall condition of participant’s bedroom and home. Provide information on how he or she is involved in household activities. Include what he or she was doing upon your arrival.

**Case manager must document ONE of the following discussions**

1. **Discussion with participant and parent** – Provide details on overall health, and satisfaction with services and other activities.
2. **Discussion with Staff/Provider** – Provide details of how services are going, and note concerns regarding participant behavior, health, etc.

**Case manager monitoring/follow up (includes review of provider documentation)**

1. Follow-up to incident reports (if applicable) – *Includes restraint and PBSP documentation*
2. Follow-up to previously identified concerns – *Employment, PBSP, objective completion, providers.*
3. Follow-up to health/medical concerns identified during previous month’s review.
Review of Provider and Other Required Documentation

1. Review billing and service documentation for each provider, including those providing self-directed services. Review documentation and note discrepancies between the documentation of services and the services that were submitted for payment.

2. Review monthly progress on objectives.

3. Review medication assistance records (MARs) and other medical appointments (if applicable). The review of medications, including PRN medications, is required if the participant receives assistance with medication.

Case managers must complete and submit a Provider Documentation Non-Compliance form if a provider does not submit the required documentation in the time specified.

Case Management Activities

Service Observation (Every 6 months for non-habilitation services, every 3 months for habilitation services. Self-directed services are included.)

Service observations include discussion with the participant and provider, and observation of work on participant goals. Documentation must include what was observed and any concerns identified.

Plan Development

Plan development includes ongoing changes that occur within the plan of care. Changes may include modifications, or updates to the PBSP, rights restrictions, supervision levels, and medications. Must be completed at least annually, or when changes in the plan are necessary.

Monitoring and Follow Up

Monitoring and follow up include a monthly review of provider documentation, and follow up for concerns expressed by the participant and/or legally authorized representative, waiver provider, or case manager. Follow up should be documented until a resolution is reached, even if the concern spans several months.

Team Meetings

Team meetings include team meetings held to discuss changes to the plan of care or service delivery. Document a short summary of decisions made.
Participant Specific Training
Document the name of the provider/provider staff trained, the time and date of the training, and a synopsis of the training provided.

Face to Face Meeting with Participant, Guardian, Family
Document the names of attendees, the purpose, and the outcome of the meeting.

Advocacy and Referral
Advocacy and referral includes linking a participant to waiver or non-waiver services. Document any follow up that may be necessary.

Crisis Intervention
Crisis intervention includes the coordination of supports for crisis situations; this does not refer to the actual physical intervention during a crisis situation. Document follow up as necessary.

Coordination of Natural Supports
Coordination of natural supports includes assistance in developing naturally occurring (unpaid) supports within the community.

Other
Please include items that may not fit into other sections, but require documentation.