Policy: Case Chronological Documentation for Client Services

ChildNet Number: CN 003.005
Original Approved Date: May 16, 2003
Policy Revised Date(s): January, 2010; March, 2010, June 22, 2010
Policy Sunset Date:
COA Standard(s): RPM 7.01,7.02,7.03,7.04, 7.05, 7.06

Statement of Policy
It is ChildNet's policy to ensure specific, factual, legible and relevant documentation of the delivery of case management-related services in the client services' case file in a timely and concise manner, consistent with state and federal law.

Board Chair's Signature: _____ **Date:** 10/29/10

Procedure: Case Chronological Documentation for Client Services

ChildNet Number: CN 003.005
Original Approved Date: May 16, 2003
Procedure Revised Date(s): January, 2010, March, 2010, June 22, 2010, May 14, 2014, February 21, 2018, August 10, 2022, May 8, 2024
Procedure Sunset Date:
COA Standard(s): RPM 7.01, 7.02, 7.03, 7.04, 7.05, 7.06

Definitions (If any):

Client Services Case File: For the purpose of this policy and procedure, all information for a case contained in the Florida Department of Children and Families' Comprehensive Child Welfare Information System (CCWIS), as well as the supporting paper documentation gathered during provision of services to that family, is consistent with law. A case file is maintained for each child under the mother's name or following the Department of Children and Families naming protocol.

Statement of Procedure:
This procedure establishes basic requirements for case chronological documentation of ChildNet client case records. At a minimum, client case records contain sufficient, accurate information to identify the client/consumer; support decisions about interventions or services; and document the delivery of services.

1. **Case Chronological Documentation.**
   a) Case file entries are made by authorized personnel only. All case activities, including contacts and attempted contacts with a child, the child's parent or caregiver and collaterals must be entered in the Child Welfare Information System no later than 48 hours after the actual contact or other event.These cactivites include::
      i. Contacts and attempted contacts, including but not limited to telephone contacts, emails, home visits, office visits and school visits, case staffing;
      ii. demographic and contact information;
      iii. the reason for requesting or being referred for services;
      iv. up-to-date assessments;
      v. the service plan, including mutually developed goals and objectives;
      vi. copies of all signed consent forms;
      vii. a description of services provided directly or by referral;

viii. routine documentation of ongoing services;

ix. documentation of routine supervisory review;

x. discharge or aftercare plan;

xi. recommendations for ongoing and/or fracture service needs and assignment of aftercare or follow-up responsibility, if needed; and

xii. a closing summary entered within 30 days of termination of service.

b) Documentation is to be factual, maintained current, relevant, legible, signed and dated by the person who provided the service and signed and dated by the supervisor, when appropriate.

c) Activities for which documentation is placed in the case file includes but is not limited to the following:

i. Progress towards completion of case plan tasks within the required timeframes.

ii. Effectiveness of current services and identification of additional services if needed.

iii. Indication of child's development, physical condition, side effects of prescribed medication and interaction with the parent or caregiver and household members.

iv. Description of progress towards case plan tasks and services aimed at ensuring the child's well-being, including educational, emotional, developmental, physical, or mental health needs.

v. The child's last physical and dental exam as well as the next scheduled date child health checkup according to the periodicity schedule.

vi. Prescribed medications, benefit of medication, side effects and/or risk of taking medication, discussion of need to adhere to medication and any medication change.

vii. Home environment, adjustment, and interaction with the caregivers and current placement. Interviews with the child should be documented as outside the presence of the caretaker. Compliance with the Visitation Plan and contact with parents, siblings, and others identified on the plan.

viii. All interviews should focus on safety, well-being, permanency, and evidence supported in chronological notes.

ix. Safety and risk assessment made/documented at each contact.

x. Compliance with Safety Plan, if applicable.

xi. Recommendations for ongoing and/or future service needs and assignment of aftercare or follow-up responsibility.

d) Case chronological documentation in the clients' services case file must reflect all contacts and attempted contacts and shall be entered into CCWIS within two days of the contact or attempted contact and are kept up to date from intake through case closing.
e) Documentation required at case closure shall include

f) Service recipients may add a statement to their case records, and any response by personnel is added with the service recipient's knowledge; and the service recipient is given the opportunity to review and comment on such additions.

2. Falsification of Records
See CN-009.049 Corrective Action Policy

President's Signature: Larry N. Rein **Date:** 6/3/2024