SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU
Community First Choice Policy Manual

Title: Home Health Policy 610
Section: ADMINISTRATIVE REQUIREMENTS
Subject: Clinical Records
Reference: ARM 37.40.702, 42 CFR 484.48

CLINICAL RECORDS

Every member receiving Home Health services must have a clinical record which contains past and current findings in accordance with accepted professional standards. These records should include:

1. Plan of care;
2. Appropriate identifying information;
3. Name of the physician;
4. Drug, dietary, treatment, and activity orders;
5. Signed and dated clinical and progress notes;
6. Copies of summary reports sent to the attending physician; and
7. Discharge summary.

NOTE: The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the member's medical and health status at discharge.

RETENTION OF RECORDS

Clinical records are retained for 6 years and 8 months after the month the cost report to which the records apply is filed with the State. Policies provide for retention even if the HHA discontinues operations. If a member is transferred to another health facility, a copy of the record or abstract is sent with the member.

PROTECTION OF RECORDS

Clinical record information is safe-guarded against loss or unauthorized use. Written procedures govern use and removal of records and the conditions for release of information. A member's

written consent is required for release of information not authorized by law.