2501: CHART DOCUMENTATION

Chart documentation includes any and all forms of documentation (written or in EdPlan) by SoonerStart staff recorded in a professional capacity in relation to the provision of early intervention services. Documentation demonstrates accountability and provides relevant information regarding the child and family and the services provided by SoonerStart staff. Chart documentation includes staff progress notes, EdPlan contact log as well as early intervention forms and reports.

Progress Notes:

SoonerStart chart documentation for services and activities with infants and toddlers and their families is completed in the Contact Log of EdPlan or on the **Service Provider Progress Note (Appendix N)**. Chart documentation must be legible and contain no erased, whited out or blacked out entries. Errors should be lined through and initialed.

All SoonerStart services or activities must be documented. Services or activities that are scheduled and do not occur should also be documented. Progress notes should be factual, non-judgmental and contain information reflective of professional observations and assessments.

Resource Coordinators: Resource Coordinators will use the EdPlan logging wizard for all chart documentation (progress notes) of case management services and non-billable activities completed with children and families. Documentation must be completed ≤ 5 working days after completion of an early intervention service or activity. Medicaid billable activities documented in the logging wizard are electronically submitted for reimbursement by PCG. The RC does not print, sign or submit a progress note for entry in the PHOCIS system.

Service Providers: Progress notes are designed to be completed immediately following the early intervention visit. If using the NCR progress note, a copy should be left with the family. Completed progress notes must be routed to designated personnel for data entry and filing in a timely manner (see above).

Forms/Reports:

All SoonerStart forms and testing materials are considered chart documentation and should be maintained in the SoonerStart record (see SoonerStart Client Record section) or in EdPlan as appropriate.

If it is necessary to complete the **Suspected Child Abuse/Neglect Report Form (ODH 333-F) (Appendix CC)** it should be maintained in the child's OSDH health department record in the Administrative Section. If no OSDH health department record exists, one should be opened. For the Oklahoma County and Tulsa County sites, a Health Department administrative file should be created and maintained per Health Department policies for confidential records. The child abuse report is not education related; therefore, it will not be retained in the child's SoonerStart Early Intervention record. The SoonerStart staff member completing the ODH

333-F form must document their activities either in the EdPlan contact log or on the Service Provider progress note. The documentation should state only that "ODH Form 333-F was completed".

The **Client Information Worksheet (CIW) (Appendix DD)** must be completed when the family presents for the initial evaluation and at each Periodic and Annual IFSP meeting. The information on the form must be entered into the Demographic, Financial and Insurance modules of PHOCIS and filed in the child's early intervention record (see SoonerStart Client Record section).