State of Connecticut
Department of Developmental Services
Guidelines for Provider Documentation
September 12, 2011

These guidelines were developed to assist Providers in maintaining the proper documentation to support the delivery of services to participants funded through the Department of Developmental Services (DDS) as defined in the Action Plan (IP.5) of the Individual Plan (IP.) Provider Documentation must be in accordance with the Participant/Individual's Plan (IP,) the Vendor Service Authorization (VSA) or the Contract Service Authorization (CSA,) as well as, in accordance to the State of Connecticut Medicaid Home and Community-Based Waiver requirements, Connecticut State Statute 17a-218(g); and DDS Policies and Procedures.

Providers are required to establish system-wide procedures to accurately account for the provision of supports to each DDS funded participant. Documentation must include information on attendance, the identified supports provided to the Individual and the Individual's progress in achieving his/her person-centered goals. The following three documents are the required sources for Provider Documentation. Agencies can create their own forms for Attendance and Service Documentation. Providers must include the information below to fulfill Federal Regulations, State Statutes and DDS Policies and Procedures.

1. **Attendance Documentation for billing:** *Must include the following...*

    - Provider Name/Location
    - the Individual's Name who is being served
    - listed Service Type as defined in the scope of the service as listed in the HCBS Waiver Manual
    - Date of Service
    - Start Time and End Time of Service Billing Unit for Hourly/ 15 minute or unit increments

    Unit increments for each waiver service can be found on the Waiver Services: Code Units and Rates forms which can be found on the DDS Website under "Providers", "Fee for Services Rates",

    http://www.ct.gov/dds/cwp/view.asp?a=3166&q=391042&ddsNav=|

    Provider representatives signs off for the time period of service delivery for those receiving service through a Vendor Service Authorization.
    Provider representative signs off in WebResDay for the time period of service delivery for those receiving service through a Contract Service Authorization.

2. **Service Documentation:**
    Residential, Vocational, or non-vocational goal(s) *(as identified on the Individual's Annual Plan (IP) and specifically written on the Action Plan (IP.5)* should drive the service documentation. The following forms are examples of documentation that have been accepted as sufficient data. These forms matched the language of the Goal/Desired Outcome, addressing issues/needs/wants.

    (examples of forms matching IP.5 language; included but not limited to and all forms do not have to be present for every person. The minimum requirement is that Provider must have at least one of these for each individual for each date of service).

    - Daily Individual or group activity logs
    - Daily communication logs
    - Daily Production data
    - Daily Progress Notes
    - Employment data, hours of paid work
    - Health/Clinical Data

3. **Individual Progress Review (IPR:) (DDS INDIVIDUAL PROGRESS REVIEW FORM MUST BE USED)**

- IPR's must occur at least every 3 months for individuals in CTH's; IPR's must occur for all other individuals, every six months.
- IPR's must be submitted in writing or electronically submitted to the DDS Case Manager.
- IPR's need to be made available for staff review, the Individual's Support Team, DDS Case Managers, Quality Reviewers, Auditors and DDS Administrators upon request.
- The IPR must be maintained in the individual's file at the designated program location.
- Progress on Desired Outcomes and the Action Plan/goals and objectives needs to be reflected within the body of the IPR Form.
- The Provider should recommend in the IPR why this Desired Outcome/Action Plan/goal and/or objective should continue or change.
- If changes or a new need/desire has been identified on the IPR, action steps need to be incorporated into the body of the Action Plan and those steps need to be implemented within 30 days from the date of the IPR.
- Assessments, Screenings, Evaluations and Reports need to be attached to the IPR.

When developing forms for documentation keep in mind:
On the Action Plan of an Individual's Plan (IP.5,) the Issue/Need/the Desired Outcome/Action Plan should be clearly written on documents that will be used to support billing. The IP.6 must match the waivered services and units as defined in a VSA or CSA. Documentation needs to include:

Method of writing measurable goals	Attendance documentation for billing found on the IP.6 and on the VSA or CSA	Service documentation on the IP.5: Action Plan in the IP
Type of Service	Group Supported Employment (GSE)	Mary will be supported by a job coach at work to earn more money (Desired Goal)
Scope of Service	Providing job coaching to Mary who will be hanging clothes on racks in preparation for sales at a store	Mary will tear off the plastic wrap from the bulk clothing and hang each piece of clothing on the rack in the receiving room of the store with verbal reminders from her job coach (Action Plan)
Amount of Service	Over the course of the summer	For the next three months (amount of time)
Frequency of the Service	5 days a week	5 days a week (frequency)
Duration of the service	5.5 hours a day	And remain on-task at least one hour of a 5.5 hour work day (duration)

Staff Training Documentation:
As referenced in the Provider Qualifications and Training Form (IP.7.) Providers and Supporting Staff need to be able to produce documentation that the staff, working with the Individual, has received all required trainings and is aware of the Individual's Needs and Action Plan. Staff must review the Individual's Plan (IP,) the LON and all programs and guidelines related to the person. This information must be made available to the Individual's Support Team, DDS Case Managers, Quality Reviewers, Auditors and DDS Administrators upon request.

Timeframes of Record Keeping:
The State of CT Library advises and DDS Contract Service Authorizations (CSA's) state that documents related to state business need to be accessible for 10 years. Documents related to waiver recipients should be accessible for ten years. Vendor Service Authorizations (VSA's) should be accessible for ten years.

Audits/Reviews of Master Records:
Federal Auditors, State Auditors and/or DDS Central Office Staff/ Administrators can audit files to review Billing and/or Service Documentation. When a DDS Audit occurs, Providers need to provide documentation/records for reviews. This is typically demonstrated through daily notes, the Individual Progress Review and the Individual's Plan.

Please note that Provider Staff may be interviewed to demonstrate knowledge of the Individual's Issues/Needs/Desired Outcome/Goals and Action Plan for achievement.

Resolving Issues:
The Individual Plan is developed and approved by the Team. Should questions or issues arise around the development or implementation of the Individual's Action Plan or LON, the Provider should contact the DDS Case Manager, utilizing the Team process to resolve it. Providers should contact the DDS Case Manager for questions regarding Provider/Vendor Service Authorizations. Should further intervention be necessary, the Provider can contact the Supervisor of Case Management to assist in resolving the issue/concern.

Providers should contact DDS Regional Resource Managers for questions regarding Contract Service Authorizations.

Attachment A

Individual/Family Agreement with Vendor

Name and Address of Individual/Sponsoring Person:

(First Name) (Last Name) (Phone)

(Street) (City) (State) (Zip Code)

Name of person services will be provided to:

(First Name) (Last Name)

Name of Case Manager:

(First name) (last Name) (Phone Number)

Effective date of Agreement:

Name and Address of Agency:

(Name) (Address) (City) (State)

Contact Person:

(Name) (Phone Number)

Fiscal Intermediary:

Check appropriate box:

☐ **Negotiated Rate** ☐ **Agency with Choice**

Type of support:

Hourly Rate of Pay: $

Days/Hours of Work:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Hours							

Billing Method: ☐ Invoices sent directly to FI ☐ Invoices sent directly to family

Terms for Discontinuation of Service (can be negotiated up to a maximum of 30 days):

Agency With Choice

Role of the Individual in Selecting & Dismissing staff:

I agree to provide the services and supports identified in this agreement and to ensure staff, prior to working alone with individual, are provided standard training and specific training identified in the individual plan.

Agency Representative Signature:_____ Date:_____

Sponsoring Person Signature _____ Date:_____

Attachment B

Connecticut Department of Mental Retardation
HCBS Waiver
Vendor Service Authorization

Consumer Name:_____ DMR #:_____ Fiscal Intermediary:_____

Case Manager/Broker:_____ Phone # _____ Region: _____

_____ is authorized to provide the following
Agency/Vendor name

services to:_____
Consumer Name

Service:	Unit	Rate / Unit	Units / Month	Monthly Cost	Annualized Cost

The Agency/Vendor shall invoice the applicable Fiscal Intermediary monthly for services provided.
Check the assigned Fiscal Intermediary below:

F. I. Addresses:

☐ Allied Community Resources, Inc
PO Box 1086
Enfield, CT 06082-1086

☐ Public Partnerships, LLC
6 Admirals Way
Chelsea, MA 02150

☐ SUNSET SHORES
720 Barnum Ave. Cut Off
Stratford, CT 06614

Effective Start Date: _____

Authorized by: _____ Title:_____
Print Name

_____ Date:_____
Signature

Attachment C

Sample Bi –Weekly Service Delivery Data for Group Day and Respite Programs

CONSUMER NAME												DMR #			
	Mon Date	Tue Date	Wed Date	Thr Date	Fri Date	Sat Date	Sun Date	Mon Date	Tue Date	Wed Date	Thr Date	Fri Date	Sat Date	Sun Date	Procedures SHE T2022 DSO T2021 GSE T2019 Staff Modifier
Procedure Code															
Time In															
Time Out															
Time In															
Time Out															
Procedure Code															
Time In															
Time Out															
Time In															
Time Out															
Staff Modifier															
Time In															
Time Out															
Time In															
Time Out															
Time In															
Time Out															

Signature of Person Submitting Form _____ **Date** _____

Attachment D

Sample CT DMR Waiver Bi-Weekly Service Delivery Data for Individual Services

Participant Name	DMR #

Service Type	IS Habilitation	Supported Living	Personal Support	Adult Companion	Individualized Day Support	Individual SE	
Procedure Code	97535	T 2003	T 1019	S 5135	T 2019	T 2019	
Service Type	Respite Per Hour	Respite Per Diem	Interpreter	FICS	Behavior Support	Counseling	Nutrition
Procedure Code	S 5150	S 5151	T 1013	T 2040	H 2019	S 9484	S 9470

The signature of the individual/family is an optional requirement and is at the sole discretion of the individual or family.

Procedure Code	Date	Time In	AM PM	Time Out	AM PM	Individual/Family Signature	Staff Signature

Signature of Staff Submitting Service Delivery Data _____ Date _____

Attachment E

THE SAMPLE CORPORATION

QUARTERLY PROGRESS NOTES:

Client:_____ Date:_____

Program Type:_____ Period Covered: _____ to_____

Program Location:_____

1.) PROGRAM GOALS:

2.) OVERALL PARTICIPATION:

3.) COMMUNITY PRESENCE:

4.) INCIDENT REPORTS:

5.) ADDITIONAL INFORMATION:

GUIDELINES

- ☐ Service Needs Assessment
- ☐ Safety Assessment
- ☐ Level of Support
- ☐ Health and Safety Screening
- ☐ Level of Support Ambulation
- ☐ Mealtime Guidelines
- ☐ Loading and Unloading Van

Signature of Person Completing Report _____ Date_____

Attachment E

HCBS WAIVER - INDIVIDUALIZED SERVICES

Sample Agency Name
Sample Agency Address
Town, State Zipcode

Sample Agency Phone Number

Date:_____

Consumer Name:_____

Service Type:_____

Procedure Code:_____

Start Time:_____ End Time:_____

IP Goal Area

Tasks Performed

Comments:
(For example, progress, service changes, vacation notices, or staffing changes, etc.)

Service Recipient Approval **Staff Signature**

Attachment E

THE SAMPLE CORPORATION
WEEKLY CALENDAR AND NOTES

DATE

Consumer Name:_____ Week:____/____/____ Program Type:_____

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

DATE	STAFF	COMMENTS

Attachment F

PUBLIC PARTNERSHIPS, FISCAL INTERMEDIARY SERVICES FOR THE CONNECTICUT DEPARTMENT OF MENTAL RETARDATION AGENCY INVOICE FORM

FI Name: Public Partnerships

Invoice Service Period Start Date: 3/1/2006 End Date: 3/31/2006

Agency Name: Vinfen Corporation of CT

Agency Address: 100 Main St. New Haven CT 11111

Hfac_ID: VINF002

Prepared On (mmm/yy): Mar06

DMR ID	CLIENT NAME (LAST)	CLIENT NAME (FIRST)	START DATE	END DATE	Service/Commodity Type	Procedure Code	UNIT	TOTAL UNITS	NR	UNIT RATE	TOTAL
44444	Smith	John	03/03/06	03/31/06	Group Day – Sheltered Work	T2019	15 min	19.00		10.37	197.03
44444	Smith	John	03/07/06	03/31/06	Assisted Living (Per Diem) Level 2	DSS Code	per diem	21.00		49.43	1038.03
44444	Smith	John	03/10/06	03/31/06	Assisted Living (Per Diem) Level 2	DSS Code	per diem	16.00		33.15	530.40
44444	Smith	John	03/14/06	03/31/06	Personal Support	S5150	15 min	22.00		23.72	521.84
44444	Smith	John	03/17/06	03/31/06	Is Habilitation	S5150	15 min	69.00		8.98	619.62
44444	Smith	John	03/21/06	03/31/06	Individualized Day	T1019	15 min	36.00		25.53	919.08
44444	Smith	John	03/24/06	03/31/06	Group Day – Sheltered Work	T2019	15 min	18.00		10.37	186.66
44444	Smith	John	03/28/06	03/31/06	Assisted Living (Per Diem) Level 4	DSS Code	per diem	2.00		68.95	137.90
44444	Smith	John	03/31/06	03/31/06	Respite – Group Out of Home (Day)	S5151	per diem	2.00		310.46	620.92
55555	Jackson	Susan	03/07/06	03/31/06	Personal Support	S5150	15 min	2.00		23.72	47.44
55555	Jackson	Susan	03/14/06	03/31/06	Personal Support	S5150	15 min	2.00		23.72	47.44
55555	Jackson	Susan	03/21/06	03/31/06	Respite – Group Out of Home (Day)	S5151	per diem	10.00		310.46	3104.60
55555	Jackson	Susan	03/28/06	03/31/06	Respite – Individual In Home (Hour)	S2015	mile	5.00		0.41	2.05
55555	Jackson	Susan	03/30/06	03/31/06	Behavior Management	DSS Code	per diem	6.00		4.24	25.44
55555	Jackson	Susan	03/30/06	03/31/06	Respite – Individual In Home (Hour)	TBD		4.00		30.65	122.60
55555	Jackson	Susan	03/01/06	03/31/06	IS Habilitation	S5150	15 min	1.00		8.98	8.98
											0.00
								237.00		TOTAL:	8150.77

I certify that the information contained in this invoice(s) is true and correct and has been prepared in accordance DMR contract terms

PREPARER'S SIGNATURE & DATE

PREPARER'S NAME & TELEPHONE NUMBER

PROVIDER'S SIGNATURE & DATE

PROVIDER'S NAME & TELEPHONE NUMBER

Attachment G

Connecticut Department of Mental Retardation
HCBS Waivers (IFS and Comprehensive)
Vendor Billing Invoice Form

Consumer Name:	Vendor Name/Address:
DMR #	
F.I.	
	Vendor EIN#
Billing Month	T-XIX Provider #

Date	Service/Commodity Type	Procedure Code	Unit	#Units	Unit Rate	Total
					Sub Total	
					Grand Total	

Certification : I certify that the services listed above are true , accurate and complete. I further certify that the services are proper charges against the State of Connecticut and that payment has not been received from other sources. I certify that the services were provided in accordance with applicable Medicaid requirements and with other rules and guidelines as defined by the Connecticut Department of Mental Retardation.

Signature Date

Print Name