Client Records Policy

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I. Purpose

To ensure complete and legal documentation of all client records falling under UCP's Mental Health License, compliance with certification standards for Adult Case Management, and to comply with federal, state and local laws and regulations regarding the retention of the client record.

II. Maintenance of Client Record

Client records are maintained in accordance with accepted professional standards (including MaineCare rules, mental health licensing standards, certification standards (ACM), and best practice). All documents and entries in the client paper record shall be legible, dated and signed by the person making the entry, written in ink or typed and properly corrected if necessary (if error occurs, cross out entry with one line, write void, initial and date of correction).

Client records contain (as applicable per program):

- Referral Information
- Emergency Crisis Plan (for programs that it is a requirement)
- Release of Information
- Service Agreement
- Safety Care Treatment Consent
- Case Management or BHH Choice Letter
- Child Health Questionnaire (for BHH)
- Program Specific Enrollment Information
- Service Assessment
- Plan of Care
- Discharge Summary
- Collateral documentation (physician records, school records, other provider assessments and legal documentation).

A client record is maintained for each client at UCP, either in paper or in the Electronic Medical Record (EMR) as UCP works toward agency wide implementation of the EMR.

Client records are monitored for compliance with accepted professional/legal standards and are filed (electronically or in a paper record) in the Quality Assurance (QA) Department at UCP.

Back-dating entries in the client record is prohibited. If an entry in a client chart is late, it must be identified as a late entry using appropriate phrasing and documentation.

Client records are reviewed to ensure that established policies and procedures are followed in providing services and to determine the adequacy of the plans of care and the appropriateness of continuing care.

III. Filing, EMR, and Access to Client Records by Staff

The QA department files paper client records alphabetically. Client records in the EMR are accessed through the remote desktop connection. Any documents that need to be scanned into the EMR are to be emailed to the QA email address so QA staff can file them in the EMR.

Staff accessing a client's records in the EMR are granted access through a Remote Desktop Connection, with a username and password required to log in. If staff are accessing client files that are not assigned to them, our EMR has auditing capability to see who accessed the client files. The EMR maintains a separate server that is backed up nightly.

Client paper records will be locked and located in four different locations, the Quality Assurance Department at the Woods, medication room at ELC, Brewer Bridges, and in the Waiver homes. The Quality Assurance Department will be open Monday – Friday, 8 a.m. – 4:30 p.m. daily with the exception of agency-recognized holidays.

UCP of Maine service providing staff may review records and access client files for service coordination and treatment purposes during hours of operation. File reviews should take place in the file room unless there is a service need for the file to be reviewed elsewhere. If staff needs to review a file outside of the file room they must sign the file out by documenting their name – relation to client – date – time – and purpose of the review. All files must be returned the same day before the department closes to ensure the confidentiality of records overnight.

Staff working in the Quality Assurance Department are the only staff allowed access to the file room outside of normal business hours and this access is limited to work-purposes only.

The file room staff will not be available after hours or on the weekends. If after hours or weekend work is anticipated, please request the documents you may need during normal business hours.

When a staff member needs a paper client record they may find the record in the file cabinets, and sign their name on an insert as a placeholder for the file they remove.

When paper records are removed from the file room, the record shall be returned by the end of each working day. Copies of client's records may be carried by individuals providing direct services if they are safeguarded for confidentiality.

When accessing UCP's EHR or the state-wide EHR HealthInfoNet, staff are strictly prohibited from accessing records for any individual for which the staff member is not providing care. Staff must **never** access their own record or family member records in HealthInfoNet or the UCP EHR while logged in as a UCP employee, as this is a violation and terminable offense.

IV. Record Retention and Destruction
Client records are maintained in a locked file room at UCP.

Client records are retained and protected for confidentiality as outlined by the Document Retention and Destruction Policy.

In the event UCP discontinues operations, the client records are retained as indicated as directed by the UCP Board of Directors and/or attorney.

V. Protection of Client Record
The staff of UCP shall, as far as possible, guarantee confidentiality and privacy in regard to treatment, records and discussion of or about any people we serve. The fact that an individual is served by the agency must be kept confidential. Only authorized staff may make entries in the client's record.

Provisions for the protection of the client's right to privacy shall be maintained at all times within the agency. All staff shall follow the following procedures:

Internally:

- Client records are not available to unauthorized persons with the appropriate Release in place.
- No paper records or lists containing first and last names of clients will be maintained where they may be seen or read by other people we serve, volunteers, or members of the community.
- All staff will have access to records on a need-to-know basis.
- All staff will continually be made aware of the need to maintain confidentiality.

Externally:

- Information in a client's record obtained from sources outside the agency will only be released by the agency if the proper documentation is completed.
- The decision to release information from a client's record will be made only by an authorized person within the agency.
- In the event of a court order, subpoena, or a state statute for the release of records, an authorized person within the agency shall approve the release of such information.

VI. Requests for Client Record

The agency shall make the client records available to the client and/or parents/guardians upon their request within thirty (30) days of the date of the request. The requests shall be made to the QA Department. The QA department will arrange to meet with the parent/guardian to assist in the record review. In the event that the parent requests copies of records, copies will be provided within thirty (30) days from the date of the request. There will be a $15 fee for requests that require more than fifty (50) pages of records, a $30 for 500 or more pages of records, and a $50 fee for records requests of 1,000 or more pages.

All requests for client records must be on a formal release of information document and at a minimum include:

- Specific information needed, including dates
- Client's name and DOB
- Client or legal guardian's signature, dated within one year of the request
- Date of request

A notation will be made in the client record

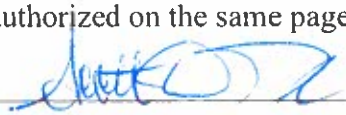
- Date the request was sent out
- Documentation that was sent
- Who requested the information

An original of the request with notations will be kept in the correspondence section of the client record.

This procedure will apply to all requests including those from physicians, payers and attorneys. Subpoenas will be handled according to the law.

- All requests for client records will be processed by the designated staff person.
- No record may be taken from the UCP premises except by subpoena.
- All copies of records will be handled confidentially.
- Faxed physician signatures are accepted and do not require an original hard copy, unless requested by a payer.

Initials of direct client staff persons may be used in the client record, but must be authorized on the same page or on the back of the page.



12/12/24

Scott Tash, CEO

Date