

**FAMILY SERVICES CASE RECORD
POLICIES AND PROCEDURES**

Effective January 1, 2005

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I. INTRODUCTION

The Department of Human Resources maintains service case records on those individuals and families who are receiving services or have received services from the Department. These case records provide the Department with historical and current information on the individual and family that assists child welfare staff to make informed decisions on how to best serve the individual and family.

A. Purpose

The primary purpose of service case records is to maintain information and documentation that will justify services provided and actions taken by the Department. Service case records shall also be well organized and properly documented in order to assure that those who need to review the records can locate and find needed information. Service case records must:

- provide historical information;
- maintain on-going assessments of individual family members' strengths and needs;
- substantiate the provision of initial and on-going services through the individualized service planning process;
- identify and document an individual's or family's progress relative to safety, permanency, and well-being;
- provide the basis for disapproving, changing, or terminating services;
- document casework decisions to achieve desired outcomes;
- substantiate decisions to approve, deny, renew or revoke an approval or license of a resource (e.g., foster family home, day care home, group day care home);
- verify compliance with state and federal mandates, policy, and audits (e.g., financial); and
- provide information needed to evaluate child welfare practice and system performance.

B. Legal Base

Code of Alabama 1975 § 38-2-6 (8) provides that the Department of Human Resources (DHR) will establish and enforce reasonable rules and regulations governing the custody, use and preservation of the records, papers, files and communications of the state and county departments.

C. Confidentiality

The Alabama Open Records Act, Code of Alabama 1975 § 36-12-40 provides that any citizen has the right to inspect and request a copy of any public writing (e.g.,

Departmental policies) of the State unless restricted by another statute. The public may review DHR policies in county offices without a charge; however, DHR's Administrative Manual provides that "duplication of documents is available at a cost of 25 cents per page plus the actual cost of employee time involved in the duplication."

The following sections 1 through 4 provide general information about several state and federal statutes that restrict access to Departmental records and the confidentiality statutes covering these records. Individual policies (e.g., *CPS Policies And Procedures*) may also address confidentiality specific to that policy.

1. DHR Records

Code of Alabama 1975 § 38-2-6 (8) provides that "all case records for recipients of, and applicants for assistance, including, but not limited to, payments and services, are confidential and not public writings and are not subject to public use or inspection. Disclosure of confidential information concerning children and their families for any reason not covered under this statute shall be a misdemeanor and punishable accordingly."

In addition to State law ensuring confidentiality of all DHR case records, the Health Insurance Portability and Accountability Act (HIPPA) of 1996 provides for the confidentiality of all personal health information (PHI) on individuals. Specific authorization must be obtained from a client that stipulates how personal health information will be used before it can be released.

2. Child Abuse And Neglect (CA/N) Records

Reports and records of child abuse and neglect, and related information or testimony, shall be confidential, and can only be used or disclosed for the purposes stipulated in *Code of Alabama* 1975 § 26-14-8 (c).

CA/N information may be released under the following circumstances.

- *Code of Alabama* 1975 § 26-14-8 (c), paragraphs 1 through 4, 6 and 8, provides for the release of CA/N Central Registry information to an appropriate court, district attorney, and law enforcement agency; and
- *Code of Alabama* 1975 § 26-14-8(c)(9) provides for the release of CA/N and other related information to social service agencies of another state in order to carry out their responsibilities under law to protect children from abuse or neglect.

Refer to *Child Protective Services Policies And Procedures, Central Registry*, section E. Use And Disclosure Of CA/N Information for a discussion of purposes that child abuse and neglect records may be used or disclosed.

Note: CA/N information on non-indicated reports may be included in court reports only when that information is subpoenaed or its provision is expressly authorized by a court order. Refer to *Child Protective Services Policies And Procedures, Legal Proceedings*, section C. Predisposition Study And Report, for additional information.

3. CPS Prevention Records

Information contained in CPS Prevention referrals and assessments can be released to a non-law enforcement source only when a court order authorizes their release, and only according to the parameters established in the court order.

CPS Prevention referral and assessment information may be shared with district attorneys or law enforcement upon an Alabama subpoena or subpoena duces tecum (a subpoena to produce documents), when authorized by a court order or for use by a multidisciplinary team Code of Alabama 1975 , § 38-2-6 (8) and § 26-14-8.

CPS Prevention information may be included in court reports only when that information is subpoenaed or its provision is expressly authorized by a court order. Refer to *Child Protective Services Policies And Procedures, Legal Proceedings*, section C. Predisposition Study And Report for additional information.

4. Child Care Facility Records

Code of Alabama 1975 § 38-7-13 provides that child care facilities must maintain case records that pertain to all children's admission, progress, health and discharge. DHR has the authority to promulgate rules and regulations governing the custody, use and disclosure of information in child care facility records, and children's records shall be kept confidential by the facility and the Department. Refer to *Minimum Standards For Residential Child Care Facilities*, section IV, for additional information.

D. Client Access to Record

- The Department is allowed to establish and enforce reasonable rules and regulations that govern the custody, use, and preservation of the records, papers, files, and communications of the state and county departments. As a general rule, clients are not entitled to view, copy, or read their case records. Clients have limited rights to information in their record in cases in which DHR has taken adverse action and a hearing has been requested [Code of Alabama 1975 § 38-2-6 (8)].
- The Health Insurance Portability and Accountability Act (HIPPA) of 1996 provides clients with certain rights related to personal health information contained in Departmental records. Clients have a right to view or get a

copy of the personal health information in their record when they submit a written request. They also have a right to request restrictions on the disclosure of personal health information, and the Department determines if such restricted disclosure is in the client's best interest. Clients may submit a written request that the Department correct or amend personal health information in their record. The Department can deny the request if the information was not created by the Department, if the information is correct, or if the information is part of health information maintained by the Department.

- Generally, adoption records are confidential. However, when adult adoptees reach age nineteen (19) years, they may petition the court for disclosure of identifying information. In certain cases, the birth mother or the birth or alleged father may have given, in writing and under oath, consent to disclosure of identifying information per Code of Alabama 1975 § 26-10A-31 (h) which allows SDHR or a licensed child-placing agency to release identifying information as specified in Code of Alabama 1975 § 26-10-31 (d). If the birth parents are deceased, cannot be found, or do not consent to the release of the identifying information, the court shall weigh the interest and rights of all of the parties and determine if the identifying information should be released without the consent of the birth parents per Code of Alabama 1975 § 26-10A-31 (j).

II. ESTABLISHING AND MAINTAINING SERVICE CASE RECORDS

Within each county there must be a uniform method of establishing paper case records. Establishing and maintaining service case records is directly related to entering correct case name data into child welfare automated systems. Family Services System (FSS) identifies the first adult registered in a case as the "primary adult" (i.e., the adult to whom a case number is assigned when a new case is opened in the county). FACTS maintains individual children in foster care in a separate case with links to siblings and legal parents.

A. Establishing Service Case Records

Counties must create a paper case record for each individual or family for whom a service is initiated and for prospective foster family homes, prospective family day care homes and prospective adoptive parents. When services are initiated for individuals and families, the County Department shall use the case number previously assigned to the individual or family, or assign a number if one does not exist.

1. Physical Preparation of the Case Record Folder

A master index card shall be set up and maintained in a central card filing system for each case that is established. The individual's or family's name and case number on the folder or file tab shall be the same as that on the PSD-723, Basic Social Service Information (Face Sheet), and the master index card.

2. Guidelines For Setting Up Paper Case Records

- When both parents have custody of and live in the same home with the children, the paper case record may be set up in one parent's (usually the mother) name or both parent's name.
- In situations where the children do not reside with both parents (e.g., parents living in separate homes; court-ordered custody changes; children residing with relatives or friends), the paper case record should be established in the parent's name with whom the children reside or the name of the primary adult caregiver involved in the ISP process.
- If the children are residing with a primary caregiver (see *Child Protective Services Policy And Procedures, Glossary*, for definition of primary caregiver) other than the parents, the parents are not involved in the children's lives or the ISP process, and the primary caregiver is also the primary adult involved in the ISP process, the case record may be set up in the primary caregiver's name and the master index card should be cross referenced to all other appropriate persons' cases to keep information current.
- When a sibling group is placed in the same resource home in Alabama through the Interstate Compact on the Placement of Children (ICPC), the case record is set up in the resource's name and the children are included in that case.
- In an ICPC case where there are several siblings placed in different homes, the parent lives out-of-state, and there is no current case on the parent in Alabama, set up a paper case record in the mother's name, document her status, put all the children in the mother's case number and cross reference the placement resources' case numbers. The children are linked on FACTS through the common case number and maintained as a sibling group which also allows for one family focused ISP.
- When abuse/neglect reports are received, separate CA/N records shall be established for each family. This record may be a case record folder unto itself or it may be a "red folder" when accordion files are used for family case records. The CA/N record shall be labeled with the family name, names of children identified in the CA/N report, and the family's case number. Refer to *Child Protective Services Policies And Procedures, General Policies And Procedures*, section A. *Establishing And Maintaining Child Abuse/Neglect Records, 1. Establishing CA/N Records* if additional information is needed.
- When CPS Prevention referrals are received, a separate CPS Prevention folder shall be established to maintain the referral and assessment for each family in order for the information to be

immediately accessible. This record may be a folder unto itself that is filed within the service case record or it may be an “orange” folder when accordion files are used for the case record. The CPS Prevention folder shall be labeled with the family name, names of children identified, and the family’s case number, and the referrals and assessments shall be maintained within the service case record.

- Resource (i.e., prospective foster, adoptive or family day care home) records are set up in the applicant’s name.

3. Arrangement of Service Case Record Materials

County Departments may choose to maintain service case records in either a single file folder system or an accordion file folder system. The system selected must be uniform within the county.

a. Single File Folder Records

(1) Left Inside

Attach the following documents to the left side of the folder in the order listed with the most current documents on top.

- Legal documents (e.g., petitions, court orders, court reports, judicial/administrative reviews)
- Applications, licenses and approvals for resource cases
- Foster care forms (e.g., DHR-FCS-731, Agreement for Foster Care)
- County Department/Agency Placement Agreement (PSD-BFC-750)
- Interagency Agreement (DHR-DFC-823)
- ICPC forms (e.g., ICPC-100A, Interstate Placement Request)

(2) Right Inside

The following case information is to be placed on the right side of the folder in the order listed.

- Basic Social Service Information (Face Sheet), PSD-723
- Current forms, as applicable, are filed inside the folded 723 (e.g. DHR-RMP-758, Funding Certification for Child Welfare Services; PSD-BPA-755, Eligibility For FCMP/ACFC Medicaid Referral; DHR-RMP-2107, Review for Eligibility)

- Comprehensive Family Assessment (CFA) maintained with the current ISP
- Current Individualized Service Plan (DHR-FCS-2117)
- HIPPA Privacy Authorization filed with the current ISP
- Current Case Planning Addendum For Children In Out-of-Home Care (DHR-FCS-2118), when applicable
- Case narrative, arranged chronologically and with pages numbered
- Correspondence, filed chronologically with the most recent on top, thereby allowing supervisors, new workers and others reviewing the record to immediately review current communications
- Other pertinent forms
- Obsolete forms, filed chronologically with most current on top

b. Accordion File Folder Records

An alternate method of maintaining paper case records is the accordion or expanding file folder. Information in the case record is grouped into categories and different colored folders contain specific information. Colored folders are then filed inside the accordion folder.

Even though the folders within the accordion file are color coded, it is important to label each folder's tab. The folders shall be labeled by subject, as follows, with information pertinent to the subject label filed within the appropriate folder.

RED	CA/N reports and assessments
ORANGE	CPS Prevention referrals and assessments
GREEN	Financial/eligibility forms and materials (e. g., DHR-RMP-758, PSD-BPA-755, disbursement requests, Medicaid Rehab, TCM)
WHITE	Case face sheet (PSD-723); case narrative arranged chronologically; comprehensive family assessment (CFA); current ISP; Case Planning Addendum (DHR-FCS-2118), when applicable; HIPPA forms

YELLOW	Legal documents (e.g., petitions, court orders, court reports, judicial/administrative reviews) filed in descending order with most current on top
BLUE	Family members' health information (e.g., medical examination reports, professional evaluations EPSDT reports)
PURPLE	Correspondence, filed chronologically with most recent on top
PINK	Obsolete materials

NOTE: Counties already using a different color file folder system at the time of this policy's release are not required to change their existing system. The case record system should meet the county's needs and be uniform within the county.

B. Restricted Case Records

“Restricted” is a status that, when applied to a specific case, means access to the case material (written or automated data) is limited to designated individuals. Access to restricted cases is determined according to security levels assigned by County DHR Directors and SDHR supervisors. Refer to *Child Protective Services Policies And Procedures, Special CA/N Procedures*, section A. for more detailed information.

Paper case records on restricted cases shall be stored in a secure location (e.g., locked drawer, locked file cabinet). County Departments shall develop local storage procedures that ensure the case material is accessed only by designated individuals.

1. Determining Restricted Status

Cases involving the following individuals shall be “restricted.”

- Current DHR employees (active, on leave, contract) and their immediate family members
- Children in DHR permanent custody (including non-finalized adoptive placements).

Cases involving close working associates of DHR **may** be restricted. County Directors are responsible for identifying specific individuals (doctors, teachers, Multi-Disciplinary Team members, QA committee members, etc.) in their county whose working relationship with the County Department may be adversely affected by case information being made available through county or statewide search. The restriction may also cover that person's spouse or children.

2. Assigning Restricted Status On The Family Services Automated Systems

County Departments shall restrict appropriate cases when registering information on FACTS. Questions regarding data entry on restricted cases should be directed to the FACTS help desk.

Use the following instructions when restricting cases on FACTS:

- Highlight the actual referral or case that needs to be restricted.
- Click on the restrict button at the bottom of the workload list screen.

You will receive the following pop up “Restricting Investigation, continue?” The system refreshed and place 3 asterisks in the Restricted column in the line that contains the referral or the case. The 3 asterisks indicate the information is restricted. Only the primary worker, primary worker’s supervisor and County Director can view restricted cases. Helpdesk is to be contacted to restrict closed referrals.

3. Removing Restricted Status

The restricted status shall be removed on cases involving current employees (and their immediate family members) after six (6) months of non-DHR employment. Other individuals’ restriction status may be removed at the County Director’s discretion by contacting the FACTS Help Desk. When the restricted status is removed, an individual’s record (written and automated data) becomes available for county and statewide inquiry.

C. Maintaining Service Case Records

Information shall be appropriately filed in the service case record as it becomes available. If the county is using the single file folder system and case material cannot be maintained in one folder, set up a second folder, labeled “Volume II,” for correspondence and obsolete materials. Volume I is always used for current materials.

D. Transferring Case Records Within A County Department

It is important that there be minimal disruption in the provision of on-going services to families. Transfer of cases within a county department is guided by each county’s organization and caseload standards. Each county should develop a protocol for transferring cases between workers and units. The following guidelines are recommended for transferring cases when counties have specialized caseloads.

- The case should have no known uncontrolled safety threats at the time of transfer.
- The sending unit should coordinate the case transfer with the receiving unit.
- The family should be prepared for the transfer, including introduction of the new worker, whenever possible.

- All paperwork (e.g., ISP, narrative recording) should be up-to-date and completed based on the county's protocol for transferring cases.

Note: Refer to *Transfer of Cases* for policy and procedures when families move to another county or state while CA/N initial assessments are being conducted or on-going services are being provided and for exceptions to transferring case responsibility.

E. Closing Case Records

Prior to case closure, the ISP shall confirm that the parent or primary caregiver has sufficient protective capacities to control safety threats and manage risks and the following tasks shall be completed.

- Close any existing safety plans
- Update the ISP (per *ISP* policy section **II. C. 7. D. Safe Case Closure**)
- Update narrative recording
- File all correspondence chronologically
- Obtain and file final court orders (e. g., order relieving DHR of custody)
- Complete required data entry procedures (e.g., close the case on all appropriate automated systems) and file turn around documents

Child welfare supervisors shall review the case record to determine that it is complete and all information is accurately filed before the case record is returned to the county's central files.

F. Case Record Retention

Case records involving the following situations shall be maintained for seventy-five (75) years.

- CA/Ns
- Foster Care
All children placed in foster care pursuant to a temporary custody order, permanent custody order, or Agreement For Foster Care (including those in adoptive placements), and their birth families
- Adoption
Children in permanent custody (including those in adoptive placements) and their birth families (refer to *Adoption Policies And Procedures, DHR Placements*, section **VI.** section I. for more information on retention of adoption records)
- ICPC foster and adoptive placements
- Foster family resource records with children placed in the foster family home

Case records involving the following situations shall be maintained for twenty-five (25) years.

- All on-going CPS
- All CPS Prevention referrals and assessments
- Adoption inquiries; adoption studies not approved; and adoption studies approved, but the adoption was never finalized

Other than noted above, all other case records are maintained for five (5) years.

- Service case records other than child protective services, foster care and adoptions
- Approved foster family homes with no children ever placed
- ICPC foster care and adoption cases with no children ever placed
- Information & referrals
- Constituent contacts

If a county has concerns about purging a case record, contact the specific program area within SDHR's Family Services for assistance.

III. DOCUMENTATION AND NARRATIVE RECORDING

Documentation and narrative recording are used for several purposes which include, but are not limited to, the following:

- **Record of Contacts**
Contacts with children, family members, and any other individuals pertinent to the case shall be documented in the case narrative. A record of contacts is used to document efforts made by the individual or family and the Department to meet the needs of the family.
- **Assessments**
Detailed family information is needed to complete a comprehensive family assessment (CFA) and to develop a family's ISP. Refer to *ISP* policy, section **II.**, F. for more detailed information on assessments and ISPs.
- **On-going Services**
Accurate and complete documentation facilitates appropriate service delivery and decision-making, and helps clarify understanding of the progress being made by an individual and/or family. When there is a change in child welfare staff working with a family, case documentation supports decisions made by child welfare staff to provide services to a family with minimal interruption in the continuity of services.

- Correspondence

Copies of all correspondence, both sent and received, shall be maintained in the case record. Correspondence may be used to confirm the substance of interviews or telephone calls, to confirm appointments, to document efforts made by the Department or to confirm progress made by families.

Correspondence includes return receipt requested registry cards (stapled to a copy of the letter mailed). These cards are used when trying to locate or obtain a response from the person to whom a letter was addressed and may provide documentation of the person's lack of response.

- Court Reports and Testimony

Court reports must be complete, factual, and concise. A well-documented case record with accurate information is invaluable to child welfare staff when preparing court reports and/or testifying in court.

- Narrative Recording

Narrative entries must be made as soon as possible following contacts, but no later than forty-five (45) calendar days following a contact. Upon this policy's release, counties with a local policy of a shorter timeframe (e.g., 30 days) will not be required to change and are encouraged to maintain their local policy.

Narrative recording may be completed in either **chronological** or **summary** form (see *Appendix* for examples). County Departments may use the method of their choice as long as it is used consistently within the county. The amount of detail included in narrative entries is dependent upon an entry's nature, purpose, relevance to the case, and whether the information is located elsewhere in the case record. Reference may be made to the type and location of the other pertinent information.

The recording of concise and pertinent information in the case narrative provides a clear picture of the nature, level and frequency of contacts by child welfare staff as well as sufficient details which support on-going casework with the family. Narrative entries shall include a record of all contacts (e. g., home and office visits; telephone calls; correspondence; reports of any type connected to the family members). Dates and events must be recorded accurately.

It is not necessary to repeat basic family history in the narrative once it has been recorded unless it comprises a component of an assessment, social summary or other relevant information or documentation. Any changes in family composition and/or circumstances must be duly noted.

APPENDIX

DOCUMENTATION/NARRATIVE RECORDING EXAMPLES

Case Example

Mary Green, age 17, was sexually abused by her step-father and has lived in a foster family home for the last year. Mary is withdrawn and seldom socializes with her peers. She spends most of her leisure time in her room doing pen and ink drawings. A strength identified for Mary is she is talented in art, and an identified goal is to improve her self-esteem.

a. Chronological Recording

This method of narrative recording refers to dictation entered in order by time occurrence with one marginal date for each entry. The following uses chronological narrative recording for the above-referenced case example.

- 5/01/98 One of the goals identified in the ISP is for Mary to improve her self-esteem. Today I picked Mary up from her foster home and we went to the vocational school and enrolled her in art classes. Mary and I then went to Wal-Mart and purchased the art supplies she'll need for the twelve (12) week course.*
- 5/15/98 Letters mailed to ISP team members notifying them of the June 2nd ISP meeting.*
- 5/24/98 Ms. Sally Jones, Mary's art teacher, called to request permission for Mary to attend the regional art show for vocational students. She'll bring the information and permission slip to next week's ISP so it can be reviewed and completed prior to the deadline. Ms. Jones reports Mary is quite talented and may qualify for an art scholarship to the local junior college. She and Mary are looking into this and will let me know when they obtain additional information. Ms. Jones also mentioned that Mary has become friends with one of the other students and they are working together on illustrations for the art show brochure. She indicated Mary seems to be more out-going than she was when she first joined the class.*
- 6/2/98 ISP meeting held today for the Green family. While Mrs. Green had to be encouraged to attend, she seemed proud of Mary's accomplishments noted during the meeting. The last ISP identified several steps designed to maintain Mary's physical health and these steps have been completed. New steps were added to continue this goal. See ISP for revisions.*

b. Summary Recording

This method references the contact dates and provides complete documentation of the purpose of the contacts, casework action and information. The following is an example of summary narrative recording based on the same case situation.

Summary Recording	5/1/98, 5/15/98, 5/24/98
Goal	<i>One of the goals in the ISP is for Mary to improve her self-esteem.</i>
Steps	<i>Mary was enrolled in art classes at the vocational center and her supplies were purchased at Wal-Mart. Mary will be attending a regional art show. She and a fellow student have become friends while working on illustrations for the art show brochure. Her teacher, Ms. Jones, feels Mary is talented and she is assisting Mary in checking into an art scholarship at the junior college.</i>
Assessment of Progress	<i>Mary's self-esteem appears to be improving. She is proud of her success in art and has also begun to make new friends.</i>
Goal	<i>Another ISP goal is for Mary to maintain her physical health.</i>
Steps	<i>As noted on the current ISP, steps have been completed and new steps added to maintain Mary's health.</i>
Assessment of Progress	<i>Mary's health remains good. Health needs will be monitored and reviewed at each ISP meeting with needs being addressed as they become known.</i>
6/2/98 ISP Meeting	<i>An ISP meeting was held this date for the Green family. While Mrs. Green had to be encouraged to attend, she seemed proud of Mary's accomplishments noted during the meeting. There has been progress toward each of the goals. Refer to ISP form for changes and additions.</i>