



Workforce and Talent Management Training Curriculum Series



Medicaid Service Coordination (MSC) Monthly Note Training

Participant's Manual



Andrew M. Cuomo
Governor

Courtney Burke
Commissioner



 **Putting People First**

Medicaid Service Coordination (MSC)

Monthly Note Training

 **Putting People First**

**MSC Monthly Note Training
Agenda**

- Introduction to the MSC Monthly Note: "The Basics"
(Why write a Monthly Note, Quality/Fiscal Standards)
- Purpose and Outcome
- Payment Standard
(List A.....List B; Qualified Contact)
- The MSC Monthly Note
- Examples
- Key Quality Considerations
- Frequently Asked Questions
- Additional Resources

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Why write a Monthly Note?

Because it's.....

A: Good clinical practice

- Provides pertinent historical and clinical information about the person and offers greater continuity of care and services

B: Required to support billing

- Our documentation has to prove to Medicaid that we are meeting the minimum standards

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Quality and Fiscal Standards

- Quality Standards – OPWDD’s Division of Quality Improvement (DQI) audits the services provided to ensure they meet quality standards set by OPWDD
- Fiscal Requirements –the State Office of Medicaid Inspector General (OMIG) is responsible for fiscal audits

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Quality and Fiscal Standards

- Have to meet both
- We are here to provide quality services not to merely meet minimum standards in order to bill
- Start with quality in mind while making sure you meet the minimum standards in order to bill
- In most cases, meeting the quality standard will mean meeting the minimum fiscal standard

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The Basics

The monthly note must contain the following REQUIRED elements.....

- The individual’s name
- Identification of the service provided
- Identification of the vendor providing MSC
- The month and year that the MSC service was provided
- The full name, title and signature of the MSC service coordinator delivering the service. Initials are permitted if a “key” is provided, which identifies the title, signature and full name associated with the staff initials
- The date the note was written (i.e., the signature date) which must include the day, the month, and the year

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The Basics

REQUIRED monthly note elements continued....

- A description of the activity(s) provided by the service coordinator, which serves to develop, monitor, or implement the valued outcomes in the person's ISP
 - If the activity is a face-to-face service meeting with the individual then the purpose and outcome of the contact must be included, as well as the location of the service meeting
 - If the activity is contact with a qualified contact then the purpose and outcome of the contact must be included. The identity of the qualified contact and the relationship to the person should also be included
- A monthly summary that includes the person's satisfaction with services along with any follow-up taken, changes in the person's life, and any issues or concerns, including health & safety considerations.

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More Basics

- Agencies must use all of the elements in the OPWDD developed Note Format
- Agencies may not remove any elements, but may add additional elements or convert the note into an electronic format
- The monthly service note, including a monthly summary, must be completed by the 15th day of the month following the service month
- Service Documentation must be retained for a period of at least six years from the date the service was delivered or from the date the service was billed, whichever is later

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Purpose and Outcome

- The goal is to describe...
 - What you did
 - Why you did it
 - What was the result
- All Medicaid services must have a purpose
- Outcome refers to the result of the action, it does not mean that a particular "Valued Outcome" from the ISP has to be met.

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Payment Standard

- To bill for a month of service, the service coordinator must deliver and document a certain number of activities from the following lists:
 - List A: When a service coordinator delivers and documents an activity from this list, only one activity is necessary to meet the billing minimum
 - List B: When a service coordinator delivers and documents an activity from this list, two activities are necessary to meet the billing minimum

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Willowbrook Class

- To bill for a month of service for a member of the Willowbrook Class, service coordinators must continue to deliver and document a minimum of one face-to-face service meeting per month.
- DQM surveys to ensure the monthly notes document that the Willowbrook class member receives monthly face to face meetings with the MSC and that a face to face meeting occurs in the individual's home at least quarterly.

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List A

- Face-to-face service meeting with individual
- Semi-annual ISP review
- Annual ISP meeting with the service coordinator, individual, parent/advocate (if appropriate), and major service providers
- Updates (addendum) to the ISP
- Completion of the ICF/MR level of care eligibility determination (or re-determination)

For activities from List A, only one is necessary to meet the billing minimum.

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List B

- Non-face-to-face contacts with the individual (e.g. phone calls)
- Direct contact with other agencies to maintain benefits eligibility or to obtain referrals for services that might be appropriate for the individual. This can include:
 - Phone call or personal contact
 - Email exchange
 - Letter/Correspondence exchange

For activities from List B, two are necessary to meet the billing minimum

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List B Continued

- Direct contact with a qualified contact during which the service coordinator gathers information to assess or to monitor the status of the individual. This can include:
 - Phone call or personal contact
 - Email exchange
 - Letter/correspondence exchange

For activities from List B, two are necessary to meet the billing minimum

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Definition of a Qualified Contact

Someone directly related to the identification of the individual's needs and care and who can help the service coordinator with the assessment, care plan development, referral, monitoring, and follow-up activities for the individual

Examples include family members, medical providers, social workers, educators, and service providers, including direct support professionals.

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MSC Monthly Note

The MSC Note (MSC-10 or MSC-10b) must be signed and dated by the 15th of the month following the service activity month.

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Review of Examples

Please refer to your participant manual for examples of completed monthly notes.

Note:
These are for training purposes only. Some of the examples even have MISSING required elements and are examples of notes that do NOT meet the minimum standard. These should not be used as models for a high quality note!

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Key Quality Considerations

- Major events, changes, issues in person's life?
- Response to person's needs, issues and concerns (include safety concerns)?
- Valued Outcomes being addressed?
- Enough information to provide continuity in the event of change in service coordinator?
- Face to Face and home visits – meeting the minimum and responding to additional need
- Satisfaction with services

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Frequently Asked Questions

- Do I have to write a note even if I didn't bill for that month?
- Can Signatures and initials be typed?
- Do I have to initial and date in the "ISP Review" section if no ISP review was held and I checked "no"?
- Can we attach additional notes, such as progress notes to the Monthly note?

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Frequently Asked Questions

- What if the "outcome" isn't achieved? Is the activity still "billable"?
- May I count multiple activities toward the same "purpose"?
- What do I write in the summary if there was no contact with the person that month?
- Do I have to rewrite everything I did in the summary even if I wrote it above?

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Frequently Asked Questions

- Where would you note that an addendum was completed?
- In the initial and date box, do I put the date the service was provided or the date I initialed it?
- How much "quality" information really needs to be in a note? Isn't the purpose of a MSC note really to support billing?

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Additional Resources

- ADM #2010-03: Medicaid Service Coordination (MSC) Documentation Requirements for Billing
- MSC-10: MSC Monthly Note and Instructions
- MSC-10b: MSC Monthly Note and Instructions
- MSC Vendor Manual
- DQI Protocol

www.opwdd.ny.gov

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EXAMPLE #1a
Medicaid Service Coordination Notes
Month and Year of Service: July 2011

Name of Individual: Darren Ross

Agency Name: ABC ARC

Initials Key

For each MSC Service Coordinator or other qualified staff who provided a MSC service or MSC activity this month, include their printed name, title, signature and their initials.

Name: Sam Vines	Title: Medicaid Service Coordinator (MSC)	Signature: <i>Sam Vines</i>	Initials: <i>SV</i>
Name:	Title:	Signature:	Initials:

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input type="checkbox"/> no	Initial & Date (mth/dy/yr):

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
If Yes, Date LCED was completed: Initial & Date (mth/dy/yr):

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting	Initial & Date (mth/dy/yr):
7/13/11	Met with Darren to observe his home environment and discuss any concerns he may have. Darren stated that he had no concerns with his house or housemates and I observed no safety concerns during my meeting.	Darren's home, 222 80 th Street, Brooklyn	<i>SV</i> 7/13/11

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual	Initial & Date (mth/dy/yr):
7/15/11	I called Darren's house supervisor to ask if there were any health or safety issues that Darren had not mentioned. He stated that there weren't any and that Darren gets along great with his housemates.	Vic Zimmer, Darren's house supervisor	<i>SV</i> 7/16/11

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

<u>Darren indicated that he continues to be happy with his SEMP services and that his job is going well. He also stated that he likes where he lives and hopes that he can stay there as he likes being close to the movie theater. There were no significant events or changes in Darren's life this month. There are no concerns by me at this time and no follow-up activities are needed.</u>			
Signature: <i>Sam Vines</i>	Printed Name: <i>Sam Vines</i>	Title: <i>MSC</i>	Date (mth/dy/yr): <i>7/30/11</i>

Attach additional sheets if necessary

Note: by entering initials, staff attests that the activity was provided on that day.



EXAMPLE #1b
STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

Medicaid Service Coordination Notes
Month and Year of Service: July 2011

Name of Individual: Darren Ross

Agency Name: ABC ARC

The MSC Service Coordinator or other qualified staff that provided an MSC service or MSC activity this month, must include their printed name, title and signature at the bottom of the form no later than the 15th of the month following the service month.

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input type="checkbox"/> no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
If Yes, Date LCED was completed:

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting
7/13/11	Met with Darren to observe his home environment and discuss any concerns he might have. Darren stated that he had no concerns with his house or housemates and I observed no safety concerns during my meeting.	Darren's home 222 80 th Street, Brooklyn

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual
7/15/11	I called Darren's house supervisor to ask if there were any health or safety issues that Darren had not mentioned. The house supervisor stated that there weren't any issues and that Darren gets along great with his housemates.	Vic Zimmer, Darren's house supervisor

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

Darren indicated that he continues to be happy with his SEMP services and that his job is going well. He also stated that he likes where he lives and hopes that he can stay there as he likes being close to the movie theater. There were no significant events or changes in Darren's life this month. I have no concerns at this time and no follow-up activities are needed.

Signature: <u>Sam Vines</u>	Printed Name: Sam Vines	Title: MSC	Date (mth/dy/yr): <u>7/30/11</u>
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Attach additional sheets if necessary

Note: by signing this form, staff attests that the activity described above was provided on the dates indicated.

EXAMPLE #2a
Medicaid Service Coordination Notes
Month and Year of Service: August 2011

Name of Individual: Jake Chambers

Agency Name: Human Services, Inc.

Initials Key

For each MSC Service Coordinator or other qualified staff who provided a MSC service or MSC activity this month, include their printed name, title, signature and their initials.

Name: Gail Butcher	Title: Medicaid Service Coordinator (MSC)	Signature: <i>Gail Butcher</i>	Initials: <i>GB</i>
Name:	Title:	Signature:	Initials:

ISP Review

Was an ISP Review conducted this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of ISP Review: August 12, 2011
Was the Service Coordination Agreement reviewed this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of SCA Review: August 12, 2011
Was the Individual Present at Review? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	Initial & Date (mth/dy/yr): <i>GB 8/12/11</i>

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
If Yes, Date LCED was completed: _____ Initial & Date (mth/dy/yr): _____

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting	Initial & Date (mth/dy/yr):
8/12/11	A face-to-face ISP meeting was held with Jake and service providers to discuss his ISP. The ISP was reviewed and no changes were found to be needed. At this time, the Service Coordination Agreement was also reviewed.	Human Services, Inc. office in Manhattan	<i>GB</i> <i>8/12/11</i>

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual	Initial & Date (mth/dy/yr):

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

<u>Jake is satisfied with his services, including MSC. No major changes have occurred and he continues to receive Community Hab services from Human Services, Inc. There appears to be no health or safety concerns going on and I have no other concerns at this time.</u>
Signature: <i>Gail Butcher</i> Printed Name: Gail Butcher Title: MSC Date (mth/dy/yr): <i>9/1/11</i>

Attach additional sheets if necessary

Note: by entering initials, staff attests that the activity was provided on that day.



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

EXAMPLE #2b
Medicaid Service Coordination Notes
Month and Year of Service: August 2011

Name of Individual: Jake Chambers

Agency Name: Human Services, Inc.

The MSC Service Coordinator or other qualified staff that provided an MSC service or MSC activity this month, must include their printed name, title and signature at the bottom of the form no later than the 15th of the month following the service month.

ISP Review

Was an ISP Review conducted this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of ISP Review: August 12, 2011
Was the Service Coordination Agreement reviewed this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of SCA Review: August 12, 2011
Was the Individual Present at Review? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
If Yes, Date LCED was completed:

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting
8/12/11	A face-to-face meeting was held with Jake, his advocate and service providers to discuss his ISP. The ISP was reviewed and no changes are needed. The Service Coordination Agreement was also reviewed with Jake and his advocate.	Human Services, Inc. office in Manhattan

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

Jake is satisfied with his services, including MSC. No major changes have occurred and he continues to receive community hab from Human Services, Inc. There appears to be no health or safety concerns going on and I have no other concerns at this time.

Signature: Gail Butcher Printed Name: Gail Butcher Title: MSC Date (mth/dy/yr): 9/1/11

Attach additional sheets if necessary

Note: by signing this form, staff attests that the activity described above was provided on the dates indicated.

EXAMPLE #3a
WHAT IS WRONG WITH THIS EXAMPLE?

Medicaid Service Coordination Notes
 Month and Year of Service: September 2011

Name of Individual: Hope Emory

Agency Name: Capital Services

Initials Key

For each MSC Service Coordinator or other qualified staff who provided a MSC service or MSC activity this month, include their printed name, title, signature and their initials.

Name: Neil Pratchett	Title: Medicaid Service Coordinator (MSC)	Signature: <i>Neil Pratchett</i>	Initials: <i>NP</i>
Name:	Title:	Signature:	Initials:

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Initial & Date (mth/dy/yr):

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date LCED was completed: September 17, 2011	Initial & Date (mth/dy/yr): <i>NP</i>
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Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting	Initial & Date (mth/dy/yr):

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual	Initial & Date (mth/dy/yr):
9/15/11	Service Coordinator contacted Hope's IRA service provider to ascertain if there were any updated reviews on Hope in order to complete a new LCED for the next year period.	Jane Rogers at XYZ ARC	<i>NP</i>

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

The LCED was completed this month after review and contact was made with service provider and signed by the QMRP. No changes in Hope's life or services occurred this month. Since no concerns were noted, it has been determined that she continues to be satisfied with other services as I was not notified otherwise. I have no concerns and will follow up with a phone call to Hope next month to ensure her continued satisfaction.			
Signature: <i>Neil Pratchett</i>	Printed Name: Neil Pratchett	Title: MSC	Date (mth/dy/yr): <i>10/2</i>

Attach additional sheets if necessary

Note: by entering initials, staff attests that the activity was provided on that day.



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

EXAMPLE #3b
WHAT IS WRONG WITH THIS EXAMPLE?
Medicaid Service Coordination Notes
Month and Year of Service:

Name of Individual: Hope Emory

Agency Name: Capital Services

The MSC Service Coordinator or other qualified staff that provided an MSC service or MSC activity this month, must include their printed name, title and signature at the bottom of the form no later than the 15th of the month following the service month.

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input checked="" type="checkbox"/> yes <input type="checkbox"/> no
If Yes, Date LCED was completed: September 17, 2011

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual
9/15/11	Service Coordinator contacted Hope's IRA service provider to ascertain if there were any updated reviews on Hope in order to complete a new LCED for the next year's time period.	Jane Rogers at XYZ ARC

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

The LCED was completed this moth after review/contact was made with the service provider, and the redetermination was signed by the QMRP. No changes in Hope's life or services, and no health concerns noted this month. Since no concerns were noted, it has been determined that Hope continues to be satisfied with her services. I have no concerns and will telephone Hope next month.

Signature: <u>Neil Pratchett</u>	Printed Name: Neil Pratchett Title: MSC	Date (mth/dy/yr): <u>9/16/11</u>
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Attach additional sheets if necessary

Note: by signing this form, staff attests that the activity described above was provided on the dates indicated.

WHAT IS WRONG WITH THIS EXAMPLE?

Medicaid Service Coordination Notes
 Month and Year of Service: September 2011

Name of Individual: Jane Smith

Agency Name: Transitions, Inc.

Initials Key

For each MSC Service Coordinator or other qualified staff who provided a MSC service or MSC activity this month, include their printed name, title, signature and their initials.

Name: Tally Tyler	Title: Medicaid Service Coordinator (MSC)	Signature: <i>Tally Tyler</i>	Initials: <i>TT</i>
Name: Marion Speare	Title: MSC Supervisor	Signature: <i>Marion Speare</i>	Initials: <i>MS</i>

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	Initial & Date (mth/dy/yr):

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date LCED was completed: <input type="checkbox"/> yes <input checked="" type="checkbox"/> no
Initial & Date (mth/dy/yr):	

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting	Initial & Date (mth/dy/yr):

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual	Initial & Date (mth/dy/yr):
9/20/11	Jane wants to pursue additional activities and increase her cooking skills, so I called and spoke with staff at the Town of Jayville to see if they had openings as they offer a day hab that teaches art and cooking. Jayville indicated that they had openings.	Deborah Sampson, Day Hab Supervisor	<i>MS</i> <i>10/4/11</i>

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

<p>Jane continues to be satisfied with her GDH program when she is involved in volunteer activities. However, she wants to have more hobbies, i.e. leisure activities, and improve her cooking, i.e. independent living skills. Tally, her service coordinator and I researched several SGDH programs and found that the Town of Jayville's SGDH program offered art and cooking. Jane seems excited about this new service. No other changes or health concerns this month. Outcomes to the visit will be noted in the next MSC note.</p>
<p>Signature: <i>Marion Speare</i> Printed Name: Marion Speare Title: MSC Supervisor Date (mth/dy/yr): <i>10/11</i></p>

Attach additional sheets if necessary

Note: by entering initials, staff attests that the activity was provided on that day.



STATE OF NEW YORK
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

EXAMPLE #4b
Medicaid Service Coordination Notes
WHAT IS WRONG WITH THIS EXAMPLE?
Month and Year of Service: September 2011

Name of Individual: Jane Smith

Agency Name: Transitions, Inc.

The MSC Service Coordinator or other qualified staff that provided an MSC service or MSC activity this month, must include their printed name, title and signature at the bottom of the form no later than the 15th of the month following the service month.

ISP Review

Was an ISP Review conducted this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of ISP Review:
Was the Service Coordination Agreement reviewed this month? <input type="checkbox"/> yes <input checked="" type="checkbox"/> no	If Yes, Date of SCA Review:
Was the Individual Present at Review? <input type="checkbox"/> yes <input type="checkbox"/> no	

ICF/MR Level of Care Eligibility Determination

Was the Level of Care Eligibility Determination (LCED) completed this month? <input type="checkbox"/> yes <input type="checkbox"/> no
If Yes, Date LCED was completed:

Face-to-Face Contact(s) with the Individual

Date of Contact	Purpose and Outcome of Contact	Location of Service Meeting

Referral / Linkage, Benefits Management, or Monitoring Activities (see instructions)

(Note: A minimum of two activities are needed to meet the billing standard if all activities fall under this section)

Date of Activity	Purpose and Outcome of Contact	Identify person contacted and relationship to individual
9/20/11	Jane wants to pursue additional activities and increase her cooking skills, so I called and spoke with staff at the Town of Jayville to see if there were any openings at their day hab, which teaches art and cooking. Jayville indicated they did have openings.	Deborah Sampson, Day Hab Supervisor
9/28/11	Sent Town of Jayville an e-mail asking for dates that Jane could visit the day hab program. They e-mailed me back listing several dates when Jane could visit.	Deborah Sampson, Day Hab Supervisor
9/29/11	Called Jane to see which dates are best for her to visit Jayville's day hab site. Jane stated that October 10 th worked best for her.	

Monthly Summary

Include the person's satisfaction with services along with any follow-up actions, any significant changes in the person's life, and any concerns regarding health and safety.

Jane continues to be satisfied with her GDH program when she is involved in volunteer activities. However, she wants to have more activities, i.e. leisure activities, and also to improve her cooking skills (independent living skills). Her service coordinator Tally and I researched several SGDH programs and found that the Town of Jayville's SGDH program offered arts and cooking. Jane seems excited about the new service. No other changes or health concerns this month. Outcomes to the SGDH visit will be noted in the next MSC note.

Signature: <u>Marion Speare</u>	Printed Name: Marion Speare	Title: MSC Supervisor	Date (mth/dy/yr): <u>9/2011</u>
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Attach additional sheets if necessary

Note: by signing this form, staff attests that the activity described above was provided on the dates indicated.