

Medicaid Service Coordination Notes Instructions

| Element | Instruction |
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| Month and Year of Service: | Enter the month and year for which MSC is being provided. |
| Name of Individual: | Enter the individual's first and last names. |
| Agency Name: | Enter the name of the agency that is providing MSC. |

The sections below must be completed by staff providing the MSC activities

| Initials Key | |
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| Name: | Print first and last name. |
| Title: | Print title. |
| Signature: | Sign first and last name. |
| Initials: | Enter initials used to sign the documentation. |
| ISP Review | |
| Was an ISP review conducted this month? | Check "yes" if the ISP was reviewed or check "no" if the ISP was not reviewed during the service month. The ISP should be reviewed at least twice annually. If "no" is indicated, the remaining fields in this section are left blank. An ISP review includes updates or addendums. |
| If Yes, Date of ISP Review: | If the ISP was reviewed within this service month, provide the date of the review. |
| Was the Service Coordination Agreement reviewed this month? | Check "yes" if the Medicaid Service Coordination Agreement was reviewed or check "no" if the MSC Agreement was not reviewed during the service month. |
| If Yes, Date of SCA Review: | If the Service Coordination Agreement was reviewed within this service month, provide the date of the review. |
| Was the Individual Present at ISP Review? | Check "yes" if the individual was present at the ISP review or check "no" if the individual was not present. The individual should be present at an ISP review at least once annually. |
| Initial & Date (mth/dy/yr): | After the ISP Review Section is completed, initial and enter the full date. The date initialed must include the month, day and year. Initials and date are not required if no activity occurred. |
| ICF/MR Level of Care Eligibility Determination | |
| Was the Level of Care Eligibility Determination (LCED) completed this month? | Check "yes" if the LCED was completed during the service month or "no" if the LCED was not completed during the service month. MSC staff must ensure that the LCED and subsequent redeterminations are completed and signed within 365 days from the prior review and authorized signature date, if the individual is enrolled in the HCBS waiver. |
| If Yes, Date LCED was completed: | Enter the date that the LCED was completed in that month. The date must include the month, day and year. |
| Initial & Date (mth/dy/yr): | After the section is completed, initial and enter the full date including the month, day and year. Initials and date are not required if no activity occurred. |
| Face-to-Face Contact(s) with the Individual | |
| Date of Contact | Enter the date on which a face-to-face service meeting was held with the individual. |
| Purpose and Outcome of Contact | Include a brief description of the service coordination activities provided and the outcome of the contact. The purpose of the contact must serve to develop, monitor and/or implement the valued outcomes of the person's ISP and should not be purely social in nature. |
| Location of Service Meeting | Describe the location of the face-to-face service meeting (e.g., in the person's home, day program, or community location) |
| Initial & Date (mth/dy/yr) | After the section is completed, initial and put the full date. The initials date must include the month, day and year. |

| Referral/Linkage, Benefits Management or Monitoring Activities | |
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| Date of Activity | Enter the date on which the activity occurred. The date must include the month, day and year. |
| Purpose and Outcome of Contact | Include a brief description of the activities provided and outcome of the activities. The purpose of an activity must be related to referral, linkage, and/or monitoring to ensure that the ISP is implemented and addresses the needs of the person. Contacts may include a phone call, personal contact, meetings, email exchange, or letter/correspondence exchange. |
| Identify person contacted and relationship to individual | Enter the name of the individual and the relationship to the individual. The person should be a qualified contact. A qualified contact is defined as 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, linkage, referral, monitoring, and follow-up activities for the individual. |
| Initial & Date (mth/dy/yr) | After the section is completed, initial and put the full date (month/day/year). |
| Monthly Summary | |
| Monthly Summary | <p>Complete this section to include:</p> <ol style="list-style-type: none"> 1. Information about the individual's satisfaction/dissatisfaction with the supports and services in his or her ISP. Any follow-up activities taken by the service coordinator to address any concerns that the individual may have about his or her supports or services must also be noted. 2. Significant changes or events in the individual's life. This might include changes in valued outcomes, employment, home, personal relationships, health and other person-centered information. If no changes or events occurred during the month, then this should be noted. 3. Any concerns regarding the health and safety of the individual and individual's environment and actions taken by the service coordinator to correct the situation. If there were no concerns about the individual's health or safety during the month, then this should be noted. <p>The monthly summary may also be used to document outcomes of an ISP review meeting and other relevant information.</p> |
| Signature: | Sign first and last name |
| Printed Name: | Print first and last name |
| Title: | Enter title |
| Date (mth/dy/yr): | Enter the date signed. The date must include the month, day and year. |