

HOUSTON HSDA – MEDICAL CASE MANAGEMENT  
CLIENT RECORD EVALUATION FORM

AGENCY: \_\_\_\_\_

FILE #: \_\_\_\_\_

CRITERIA	SATISFIED?	NOTES
<b>CONSENTS</b>		
Consent for service in the record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Consent for exchange/release of information in record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of Client Rights and Responsibilities.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of receipt of Grievance Procedure.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of receipt by client of client confidentiality policy.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
<b>ELIGIBILITY</b>		
HIV Diagnosis is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Residency in the Houston HSDA is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Income no greater than 300% of the Federal poverty level is documented.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Proof of identification.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
<b>INITIAL CONTACT</b>		
Contact attempted w/in five working days of the client's entry into Primary Care Services of case assignment.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
If contact not made, noted in record.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Subsequent attempts are noted.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
<b>INTAKE</b>		
Intake form is completed w/in acceptable timeframe of obtaining client's written consent for services.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
<b>SERVICE COORDINATION</b>		
Client services indicate coordination of activities.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Documentation of initial medical case management contact	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	
Documentation of medical case management assessment completed within 10 working days of initial contact	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Partial <input type="checkbox"/> NA	

SERVICE COORDINATION (CONT'D)		
Documentation of client reassessment within 6 month period if applicable	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation of medical case management service plan	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation that medical case management service plan was completed at the same time as assessment.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation of medical case management service plan within 6 month period if applicable	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation of all medical case management activities in progress notes in client file	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Documentation of a summary progress note within 3 days of medical case management client closure.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
FILE FORMAT		
One record/file per client.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Record is legible and in a consistent format.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Client name is on all records.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
Staff sign name on all entries in the client record.	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
DOCUMENTATION OF SERVICE		
TYPE OF SERVICE	DOCUMENTED?	NOTES
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA
	<input type="checkbox"/> Yes <input type="checkbox"/> Partial	<input type="checkbox"/> No <input type="checkbox"/> NA