LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Support Coordination Contact Documentation (SCD)

Participant Name:	**Service Log ID#**
Support Coordinator ID:	**Waiver:** ☐ CCW ☐ ADHC
Contact Type: ☐ Monthly ☐ Quarterly ☐ Annual ☐Interim	

SECTION A: CONTACT INFORMATION					
Date:		**Begin Time:** (hh:mm)		**End Time:** (hh:mm)	

Place of Service:	Select Code	**Type of Contact**	Select Code
Service Activity:	Select Code Select Code Select Code Select Code	**Service Participant:**	Select Code Select Code Select Code Select Code

Monthly Monitoring (Service Activity Code of 41)	**Monthly Remediation** (Service Activity Code of 41)	**Annual Monitoring**	**Annual Remediation**
Select Code Select Code	Select Code Select Code	Select Code Select Code	Select Code Select Code
Select Code Select Code	Select Code Select Code	Select Code Select Code	Select Code Select Code
Select Code Select Code	Select Code Select Code	Select Code Select Code	Select Code Select Code
Select Code Select Code	Select Code Select Code	Select Code Select Code	Select Code Select Code

Name of Individual(s) Providing Responses	**Relationship to Participant**
	Participant
	Responsible Representative
	Legally Responsible Representative
	Other:

☐ **Virtual Visit: I reviewed and explained the virtual visit procedure to the participant. The participant understands the procedure and consents to have this contact completed virtually.**

SECTION B: PARTICIPANT QUESTIONS

Answer all questions listed below for monthly and quarterly contacts. Obtain answers **ONLY** from the participant, responsible representative or legally responsible representative. If a question is checked Yes, provide details in the text box following the question.

1.	**Has the participant had problems receiving services as written in the Plan of Care?**	☐ Yes ☐ No
Action Needed	☐ POC Revision ☐ Resolution of Accessing POC Services ☐ Other: ☐ Referral for Service: _____	
Comments:		
2.	**Has the participant had problems with goals being met?**	☐ Yes ☐ No
Action Needed	☐ POC Revision ☐ Other ☐ Referral for Service: _____	
Comments:		
3.	**Has the participant had problems with their preferences being respected (i.e. services being delivered at their preferred times)?**	☐ Yes ☐ No
Action Needed	☐ POC Revision ☐ Team Meeting Needed ☐ Other	
Comments:		
4.	**Has the participant had problems accessing non-waiver health care services?**	☐ Yes ☐ No
Action Needed	☐ Other ☐ Referral for Service: _____	
Comments:		
5.	**Has the participant had problems getting a backup worker when a worker cannot report to work as scheduled?**	☐ Yes ☐ No
Action Needed	☐ Request a Revised Back-Up Staffing Plan ☐ Offer Freedom of Choice ☐ Continue to Monitor Services ☐ Other	
Comments:		
6.	**Has the participant had any falls, injuries, and hospitalizations, been restrained and/or been a victim of verbal abuse, physical abuse, neglect or exploitation?**	☐ Yes ☐ No
Action Needed	☐ CIR Entered ☐ Status Change Assessment Needed/Scheduled ☐ Schedule Team Meeting ☐ Reported to Protective Services ☐ Other	
Comments:		

7.	**Has the participant had a substantial change in medical condition?**	☐ Yes ☐ No
Action Needed	☐ Status Change Assessment Needed/Scheduled ☐ Other	
Comments:		
8.	**Has the participant had a substantial change in the ability to do things for themselves?**	☐ Yes ☐ No
Action Needed	☐ POC Revision ☐ Schedule Status Change Assessment ☐ Other ☐ Referral for Service: _____	
Comments:		
9.	**Does the participant have an identified need for an EAA and/or assistive device(s)?**	☐ Yes ☐ No
Action Needed	☐ Offer Freedom of Choice (Assessor and/or Provider) ☐ Schedule Status Change Assessment ☐ POC Revision ☐ Other	
Comments:		
10.	**Has the participant had a change in non-paid caregivers or living situation?**	☐ Yes ☐ No
Action Needed	☐ Revise Emergency Plan ☐ Status Change Assessment Needed/Scheduled ☐ Update LaSRS®/OPTS ☐ Enter form 148 ☐ Team Meeting Needed ☐ Other ☐ Referral for Service: _____	
Comments:		
11.	**Has the participant had a change in who will assist them in the event of an emergency?**	☐ Yes ☐ No
Action Needed	☐ Revise Emergency Plan ☐ Update LaSRS®	
Comments:		
12.	**Has the participant had a change in medications/treatments and/or who gives them?**	☐ Yes ☐ No
Action Needed	☐ RN Delegation Needed/Updated ☐ Requested/Received DSW Training for Medication Administration or Delegable Non-Complex Tasks ☐ Referral for Service: _____	
Comments:		

13.	**For Self-Directed CCW Participants:** • **Does the home book contain the last 3 months of service logs and progress notes?** • **Are all other required items, as specified in the CCW Self-Direction Employer Handbook, contained in the Home Book?**	☐ Yes ☐ No
Action Needed	☐ Need to Review Budget/POC with Employer ☐ Send POC/Budget to FEA ☐ Send Closure Decision Notice to FEA ☐ POC Revision	
Comments:		
14.	**If Service Activity Code 97 is used, explain what was done to assist with Medicaid Eligibility.**	
Comments:		

SECTION C: ADDITIONAL COMMENTS (Refer to SCD Instructions)

SECTION D: SIGNATURES

☐ **See attachment for additional documentation and/or signatures.**

_____ **Date:** _____

Participant/Responsible Representative/Legally Responsible Representative Signature

_____ **Date:** _____

Support Coordinator Signature

NOTE: Participant/Responsible Representative/Legally Responsible Representative signatures are required at quarterly in-person visits ONLY.