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:		**Type of Contact**	
Service Activity:		**Service Participant:**	

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

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.