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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1738

TARGETED CASE MANAGEMENT SERVICES

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Historical Note: This chapter is based substantially upon chapter 17-1371. [Eff 6/29/92; am and comp 4/17/93; R 08/01/94 ]

## SUBCHAPTER 1

### GENERAL PROVISIONS

§17-1738-1 Purpose. (a) The purpose of this chapter shall be to establish the rules relating to the provision of targeted case management services for eligible recipients.

(b) The provisions of this chapter shall be covered under the fee-for-service basis. [Eff 08/01/94; am 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-2 REPEALED. [R 09/30/13]

## SUBCHAPTER 2

### DEVELOPMENTALLY DISABLED AND MENTALLY RETARDED PERSONS

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§17-1738-3 Eligibility requirements. An individual shall meet the following conditions to qualify for targeted case management services:

- (1) Is eligible for medical assistance from the department; and
- (2) Is eligible for developmental disability or mental retardation services from DOH. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-4 Provider requirements. (a) The provisions of chapter 17-1736 shall be applicable to the provider of targeted case management services.

(b) Case managers shall meet the state civil service requirements for the titles of Social Worker III or IV, or Registered Professional Nurse III or IV, or meet the definition of a Qualified Mental Retardation Professional as defined in 42 C.F.R. section 483.430.

(c) The case manager shall work under the direction of a supervisor who assigns, monitors, and evaluates the work performance of the case manager.

(d) Targeted case management services for the DD/MR shall be provided, purchased, or arranged by DOH. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-5 Covered services. (a) Covered services means services that are reimbursable by medicaid, and are grouped under the following three categories:

- (1) Case assessment;
- (2) Case planning; and
- (3) Ongoing monitoring and service coordination.

(b) The case assessment shall involve a face-to-face contact with the recipient and may involve family members and other interested persons as appropriate. It is a comprehensive assessment developed by the case manager which identifies the recipients' abilities, deficits, and needs, and shall include the following written documentation:

- (1) Identifying information;
- (2) A record of any physical, mental, or dental health assessments, and consideration of any potential for rehabilitation;

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- (3) A review of the recipient's performance in carrying out activities of daily living and degree of assistance required;
  - (4) Identification of social relationships and support including informal care givers such as family, friends, and volunteers, as well as formal service providers;
  - (5) If appropriate, the vocational and educational status, including prognosis for employment, rehabilitation;
  - (6) Legal status if appropriate, including whether there is a guardian, or any other involvement with the legal system; and
  - (7) Accessibility to community resources which the recipient needs or wants.
- (c) Case planning activities follow the case assessment and includes the development of an individual service plan in writing which addresses the needs of the recipient.
- (1) The development of the individual service plan shall be a collaborative process involving the recipient, the family or other interested persons, and the case manager.
  - (2) The service plan shall include:
    - (A) Problems identified during the case assessment;
    - (B) Priority goals to be achieved;
    - (C) Identification of all formal services which are to be arranged for the recipient, and the names of the service providers;
    - (D) Development of a support system, including a description of the recipient's informal support system;
    - (E) Identification of individuals who participated in the development of the service plan;
    - (F) Schedules of initiation and frequency of various services which are to be made available to the recipient; and
    - (G) Documentation of unmet needs and gaps in service.
- (d) Ongoing monitoring and service coordination shall include:
- (1) Establishment and maintenance of a supportive relationship with the recipient in order to assist the individual in problem-solving, and

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- development of necessary skills to remain in the community;
- (2) Face-to-face or telephone contacts with the recipient for the purpose of assessing or reassessing needs, or for planning or monitoring services;
  - (3) Face-to-face or telephone contacts with collaterals for the purposes of mobilizing services and support, advocating on behalf of the recipient, educating collaterals on the needs of the recipient, and coordinating services specified in the service plan;
  - (4) Periodic observation of service delivery to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the needs of the recipient; and
  - (5) Recordkeeping necessary for case planning, service implementation, monitoring, and coordination. This includes preparation of reports, updating service plans, making notes about case activities in the recipient's record, preparing and responding to correspondence with the recipient and collaterals. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-6 Limitation of services. (a) Reimbursement for case assessment and case planning shall be limited to no more than one each for a recipient in a calendar year unless the recipient requires a reassessment due to a major change in level of functioning due to health, socio-emotional or environmental factors, in which case a second assessment or case plan may be reimbursed.

(b) Reimbursement for ongoing monitoring and service coordination shall be limited to one claim for each recipient per month, and shall be only for the services rendered by or under the supervision of the recipient's designated case manager.

(c) Ongoing monitoring or service coordination shall not be available to recipients who are inpatients in acute hospitals, or residents of nursing or ICF-MR facilities.

(d) Case management services are not reimbursable

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when rendered to a recipient who, on the date of service, is enrolled in a health maintenance organization.

(e) Recipients receiving services under Home & Community-Based Waiver Services shall be eligible to receive non-duplicative case management services as targeted case management services under section 17-1738-5.

(f) The following activities are considered necessary for the proper and efficient administration of the medicaid state plan, and are not reimbursable:

- (1) Medicaid eligibility determinations and re-determinations;
- (2) Medicaid pre-admission screening;
- (3) Prior authorization for medicaid services;
- (4) Medicaid utilization review;
- (5) EPSDT administration; and
- (6) Activities associated with the lock-in provisions of section 17-1741-8.

[Eff 08/01/94; am 02/10/97; am 12/27/97 ]

(Auth: HRS §346-14; 42 C.F.R. §431.10)

(Imp: 42 U.S.C. §1396n)

§17-1738-7 Reimbursement for services. (a) Payment for targeted case management services shall be based on a rate negotiated by the department.

(b) Services shall be reimbursable only for calendar months during which at least one face-to-face or telephone contact is made with the recipient or collaterals.

(c) Payment shall not be made for services for which another payer is liable, nor for services for which no payment liability is incurred.

(d) Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

(e) Requests for payments shall be submitted on a form specified by the department and shall include the:

- (1) Date of service;
- (2) Recipient's name and identification number;
- (3) Name of the provider and person who provided the service;
- (4) Nature, procedure code, units of service; and
- (5) Place of service. [Eff 08/01/94; am 02/10/97; am 12/27/97 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

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§17-1738-8 Funding for services. Funding for targeted case management services is shared by the federal and state governments. The State's share of the funds shall be met by DOH. [Eff 08/01/94 ]  
(Auth: HRS §346-14; 42 C.F.R. §§431.10; 435.1002)  
(Imp: 42 C.F.R. §1396n)

§17-1738-9 Documentation requirements. The provider shall be responsible for maintaining an accurate and current written documentation in the recipient's case record of services and activities, including but not limited to the following:

- (1) Copies of ISP developed through case management;
- (2) Copies of any change or revisions to the ISP as developed through a client and team meeting, or otherwise with the consent of the recipient or guardian;
- (3) Progress notes on objectives for which the case manager has primary responsibility at the frequency called for in the ISP;
- (4) Documentation of case management activities designed to locate, refer, obtain, and coordinate services outside and inside the agency, as needed by the individual whether for placement in residential alternatives, day program, respite, recreational, and social activities and other programs and services as appropriate and needed;
- (5) Copies of significant correspondence concerning contacts within the past year with the recipient or guardian, service providers, physicians, attorneys, state and federal agencies, family members, and significant others in the recipient's life;
- (6) Correspondence or memoranda concerning any significant events in the recipient's life which required case management assistance; and
- (7) Service logs to summarize monthly case management activities on behalf of the recipient. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-10 to §17-1738-11 (Reserved).

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§17-1738-12 Termination of services. Services shall be terminated when any of the following occurs:

- (1) The recipient is determined ineligible for medical assistance;
- (2) The recipient no longer meets the requirement of section 17-1738-3(2);
- (3) The recipient and the case manager mutually decide that services are no longer necessary;
- (4) The recipient refuses to continue receiving services in the manner specified in the service plan; or
- (5) There has been no face-to-face contact between the recipient and the case manager for ninety consecutive days unless the recipient is institutionalized. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-13 Appeals and hearings. (a) The provider shall be entitled to the appeal and hearing process in accordance with the provisions of chapter 17-1736.

(b) The applicant or recipient who is denied eligibility for medical assistance or whose eligibility is terminated shall be entitled to the appeal and hearing process in accordance with chapter 17-1703. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

### SUBCHAPTER 3

#### SEVERELY DISABLED MENTALLY ILL

§17-1738-14 Eligibility requirements. An individual shall meet the following conditions to qualify for targeted case management services:

- (1) Is eligible for medical assistance from the department; and
- (2) Is eligible for mental health services from DOH for persons with severe, disabling mental illness. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)



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§17-1738-15 Provider requirements. (a) The provisions of chapter 17-1736 shall be applicable to the provider of targeted case management services.

(b) Case managers shall meet the state civil service requirements for one of the following titles:

- (1) Social Worker III or IV;
- (2) Registered Professional Nurse III or IV;
- (3) Case Manager I, II, III, IV, or V; or
- (4) Qualified Mental Health Professional as defined by DOH.

(c) The case manager shall work under the direction of a supervisor who assigns, monitors, and evaluates the work performance of the case manager.

(d) Targeted case management services for persons with severe, disabling mental illness shall be provided, purchased, or arranged by DOH. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-16 Covered services. (a) Covered services means services that are reimbursable by medicaid, and are grouped under the following three categories:

- (1) Case assessment;
- (2) Case planning; and
- (3) Ongoing monitoring and service coordination.

(b) The case assessment shall involve a face-to-face contact with the recipient and may involve family members and other interested persons as appropriate. It is a comprehensive assessment developed by the case manager which identifies the recipients' abilities, deficits, and needs, and shall include the following written documentation:

- (1) Identifying information;
- (2) A record of any physical, mental, or dental health assessments, and consideration of any potential for rehabilitation;
- (3) A review of the recipient's performance in carrying out activities of daily living and degree of assistance required;
- (4) Identification of social relationships and support including informal care givers such as family, friends, and volunteers, as well as formal service providers;
- (5) If appropriate, the vocational and educational status, including prognosis for employment, rehabilitation;

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- (6) Legal status if appropriate, including whether there is a guardian, or any other involvement with the legal system; and
  - (7) Accessibility to community resources which the recipient needs or wants.
- (c) Case planning activities follow the case assessment and includes the development of an individual service plan in writing which addresses the needs of the recipient.
- (1) The development of the individual service plan shall be a collaborative process involving the recipient, the family or other interested persons, and the case manager.
  - (2) The service shall include:
    - (A) Problems identified during the case assessment;
    - (B) Priority goals to be achieved;
    - (C) Identification of all formal services which are to be arranged for the recipient, and the names of the service providers;
    - (D) Development of a support system, including a description of the recipient's informal support system;
    - (E) Identification of individuals who participated in the development of the service plan;
    - (F) Schedules of initiation and frequency of various services which are to be made available to the recipient; and
    - (G) Documentation of unmet needs and gaps in service.
  - (d) Ongoing monitoring and service coordination shall include:
    - (1) Establishment and maintenance of a supportive relationship with the recipient in order to assist the individual in problem-solving, and development of necessary skills to remain in the community;
    - (2) Face-to-face or telephone contacts with the recipient for the purpose of assessing or reassessing needs, or for planning or monitoring services;
    - (3) Face-to-face or telephone contacts with collaterals for the purposes of mobilizing services and support, advocating on behalf of the recipient, educating collaterals on the

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- needs of the recipient, and coordinating services specified in the service plan;
- (4) Periodic observation of service delivery to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the needs of the recipient; and
  - (5) Recordkeeping necessary for case planning, service implementation, monitoring, and coordination. This includes preparation of reports, updating service plans, making notes about case activities in the recipient's record, and preparing and responding to correspondence with the recipient and collaterals. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-17 Limitation of services. (a) Reimbursement for case assessment and case planning shall be limited to no more than one each for a recipient in a calendar year unless the recipient requires a reassessment due to a major change in level of functioning due to health, socio-emotional, or environmental factors, in which case a second assessment or case plan may be reimbursed.

(b) Reimbursement for ongoing monitoring and service coordination shall be limited to one claim for each recipient per month, and shall be only for the services rendered by or under the supervision of the recipient's designated case manager.

(c) Ongoing monitoring or service coordination shall not be available to recipients who are inpatients in acute hospitals, or residents of nursing or ICF-MR facilities.

(d) Case management services are not reimbursable when rendered to a recipient who, on the date of service, is enrolled in a health maintenance organization.

(e) Recipients receiving services under Home & Community-Based Waiver Services shall be eligible to receive non-duplicative case management services as targeted case management services under section 17-1738-5.

(f) The following activities are considered necessary for the proper and efficient administration of the medicaid state plan, and are not reimbursable:

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- (1) Medicaid eligibility determinations and re-determinations;
- (2) Medicaid pre-admission screening;
- (3) Prior authorization for medicaid services;
- (4) Medicaid utilization review;
- (5) EPSDT administration; and
- (6) Activities associated with the lock-in provisions of section 17-1741-8.  
[Eff 08/01/94; am 02/10/97;  
am 12/27/97 ] (Auth: HRS §346-14;  
42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-18 Reimbursement for services. (a) Payment for targeted case management services shall be based on a rate negotiated by the department.

(b) Services shall be reimbursable only for calendar months during which at least one face-to-face or telephone contact is made with the recipient or collaterals.

(c) Payment shall not be made for services for which another payer is liable, nor for services for which no payment liability is incurred.

(d) Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

(e) Requests for payments shall be submitted on a form specified by the department and shall include the:

- (1) Date of service;
- (2) Recipient's name and identification number;
- (3) Name of the provider and person who provided the service;
- (4) Nature, procedure code, units of service; and
- (5) Place of service. [Eff 08/01/94;  
am 02/10/97; am 12/27/97 ] (Auth: HRS  
§346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C.  
§1396n)

§17-1738-19 Funding for services. Funding for targeted case management services is shared by the federal and state governments. The State's share of the funds shall be met by DOH. [Eff 08/01/94 ]  
(Auth: HRS §346-14; 42 C.F.R. §§431.10; 435.1002)  
(Imp: 42 C.F.R. §1396n)

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§17-1738-20 Documentation requirements. The provider shall be responsible for maintaining an accurate and current written documentation in the recipient's case record of services and activities, including but not limited to the following:

- (1) Copies of ISP developed through case management;
- (2) Copies of any change or revisions to the ISP as developed through a client and team meeting, or otherwise with the consent of the recipient/guardian;
- (3) Progress notes on objectives for which the case manager has primary responsibility at the frequency called for in the ISP;
- (4) Documentation of case management activities designed to locate, refer, obtain, and coordinate services outside and inside the agency, as needed by the individual whether for placement in residential alternatives, day program, respite, recreational/social activities, and other programs/services as appropriate and needed;
- (5) Copies of significant correspondence concerning contacts within the past year with the recipient/guardian, service providers, physicians, attorneys, state and federal agencies, family members, and significant others in the recipient's life;
- (6) Correspondence or memoranda concerning any significant events in the recipient's life which required case management assistance; and
- (7) Service logs to summarize monthly case management activities on behalf of the recipient. [Eff 08/01/94 ]  
(Auth: HRS §346-14; 42 C.F.R. §431.10)  
(Imp: 42 U.S.C. §1396n)

§17-1738-21 to §17-1738-22 (Reserved).

§17-1738-23 Termination of services. Services shall be terminated when any of the following occurs:

- (1) The recipient is determined ineligible for medical assistance;
- (2) The recipient no longer meets the requirement of section 17-1738-14(2);

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- (3) The recipient and the case manager mutually decide that services are no longer necessary;
- (4) The recipient refuses to continue receiving services in the manner specified in the service plan; or
- (5) There has been no face-to-face contact between the recipient and the case manager for ninety consecutive days unless the recipient is institutionalized.  
[Eff 08/01/94 ] (Auth: HRS §346-14;  
42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-24 Appeals and hearings. (a) The provider shall be entitled to the appeal and hearing process in accordance with the provisions of chapter 17-1736.

(b) The applicant or recipient who is denied eligibility for medical assistance or whose eligibility is terminated shall be entitled to the appeal and hearing process in accordance with chapter 17-1703.  
[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

### SUBCHAPTER 4

#### INFANTS AND TODDLERS

§17-1738-25 Eligibility requirements. An individual shall meet the following conditions to qualify for targeted case management services:

- (1) Is eligible for medical assistance from the department; and
- (2) Is eligible for early intervention services from DOH for infant and toddlers age zero to three who have special needs.  
[Eff 08/01/94 ] (Auth: HRS §346-14;  
42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-26 Provider requirements. (a) The provisions of chapter 17-1736 shall be applicable to the provider of targeted case management services.

(b) Case managers shall meet the state civil service requirements for the titles of Social Worker III or IV, or Registered Professional Nurse III or IV,

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or meet the definition of a Qualified Care Coordinator as defined at 20 U.S.C. section 1472.

(c) The case manager shall work under the direction of a supervisor who assigns, monitors, and evaluates the work performance of the case manager.

(d) Targeted case management services for infant and toddlers age zero to three who have special needs shall be provided, purchased, or arranged by DOH.  
[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-27 Covered services. (a) Covered services means services that are reimbursable by medicaid, and are grouped under the following three categories:

- (1) Case assessment;
- (2) Case planning; and
- (3) Ongoing monitoring and service coordination.

(b) The case assessment shall involve a face-to-face contact with the recipient and may involve family members and other interested persons as appropriate. It is a comprehensive assessment developed by the case manager which identifies the recipients' abilities, deficits, and needs, and shall include the following written documentation:

- (1) Identifying information;
- (2) A record of any physical, mental, or dental health assessments, and consideration of any potential for rehabilitation;
- (3) A review of the recipient's performance in carrying out activities of daily living and degree of assistance required if appropriate;
- (4) Identification of social relationships and support including informal care givers such as family, friends, and volunteers, as well as formal service providers;
- (5) If appropriate, the vocational and educational status, including prognosis for employment, rehabilitation;
- (6) Legal status if appropriate, including whether there is a guardian, or any other involvement with the legal system; and
- (7) Accessibility to community resources which the recipient needs or wants.

(c) Case planning activities follow the case assessment and includes the development of an

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individual family support plan or IFSP in writing which addresses the needs of the recipient.

- (1) The development of the IFSP shall be a collaborative process involving the recipient, the family or other interested persons, and the case manager.
- (2) The IFSP shall include:
  - (A) Problems identified during the case assessment;
  - (B) Priority goals to be achieved;
  - (C) Identification of all formal services which are to be arranged for the recipient, and the names of the service providers;
  - (D) Development of a support system, including a description of the recipient's informal support system;
  - (E) Identification of individuals who participated in the development of the service plan;
  - (F) Schedules of initiation and frequency of various services which are to be made available to the recipient; and
  - (G) Documentation of unmet needs and gaps in service.
- (d) Ongoing monitoring and service coordination shall include:
  - (1) Establishment and maintenance of a supportive relationship with the recipient in order to assist the individual in problem-solving, and development of necessary skills to remain in the community;
  - (2) Face-to-face or telephone contacts with the recipient for the purpose of assessing or reassessing needs, or for planning or monitoring services;
  - (3) Face-to-face or telephone contacts with collaterals for the purposes of mobilizing services and support, advocating on behalf of the recipient, educating collaterals on the needs of the recipient, and coordinating services specified in the IFSP;
  - (4) Periodic observation of service delivery to ensure that quality service is being provided and shall evaluate whether a particular service is effectively meeting the needs of the recipient; and



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- (5) Recordkeeping necessary for case planning, service implementation, monitoring, and coordination, including the six month and annual re-evaluation of the IFSP. Recordkeeping includes preparation of reports, updating service plans, making notes about case activities in the recipient's record, preparing and responding to correspondence with the recipient and collaterals. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-28 Limitation of services. (a) Reimbursement for case assessment and case planning shall be limited to no more than one each for a recipient in a calendar year unless the recipient requires a reassessment due to a major change in level of functioning due to health, socio-emotional, or environmental factors, in which case a second assessment or case plan may be reimbursed.

(b) Reimbursement for ongoing monitoring and service coordination shall be limited to one claim for each recipient per month, and shall be only for the services rendered by or under the supervision of the recipient's designated case manager.

(c) Ongoing monitoring or service coordination shall not be available to recipients who are inpatients in acute hospitals, or residents of nursing or ICF-MR facilities.

(d) Case management services are not reimbursable when rendered to a recipient who, on the date of service, is enrolled in a health maintenance organization.

(e) Recipients receiving services under Home & Community-Based Waiver Services shall be eligible to receive non-duplicative case management services as targeted case management services under section 17-1738-5.

(f) The following activities are considered necessary for the proper and efficient administration of the medicaid state plan, and are not reimbursable:

- (1) Medicaid eligibility determinations and re-determinations;
- (2) Medicaid pre-admission screening;
- (3) Prior authorization for medicaid services;
- (4) Medicaid utilization review;

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- (5) EPSDT administration; and
- (6) Activities associated with the lock-in provisions of section 17-1741-8.  
[Eff 08/01/94; am 02/10/97;  
am 12/27/97 ] (Auth: HRS §346-14; 42  
C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-29 Reimbursement for services. (a) Payment for targeted case management services shall be based on a rate negotiated by the department.

(b) Services shall be reimbursable only for calendar months during which at least one face-to-face or telephone contact is made with the recipient or collaterals.

(c) Payment shall not be made for services for which another payer is liable, nor for services for which no payment liability is incurred.

(d) Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

(e) Requests for payments shall be submitted on a form specified by the department and shall include the:

- (1) Date of service;
- (2) Recipient's name and identification number;
- (3) Name of the provider and person who provided the service;
- (4) Nature, procedure code, units of service; and
- (5) Place of service. [Eff 08/01/94;  
am 02/10/97; am 12/27/97 ] (Auth: HRS  
§346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C.  
§1396n)

§17-1738-30 Funding for services. Funding for targeted case management services is shared by the federal and state governments. The State's share of the funds shall be met by DOH. [Eff 08/01/94 ]  
(Auth: HRS §346-14; 42 C.F.R. §§431.10; 435.1002)  
(Imp: 42 C.F.R. §1396n)

§17-1738-31 Documentation requirements. The provider shall be responsible for maintaining an accurate and current written documentation in the recipient's case record of services and activities, including but not limited to the following:

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- (1) Copies of IFSP developed through case management;
- (2) Copies of any change or revisions to the IFSP as developed through a client and team meeting, or otherwise with the consent of the recipient/guardian;
- (3) Progress notes on objectives for which the case manager has primary responsibility at the frequency called for in the IFSP;
- (4) Documentation of case management activities designed to locate, refer, obtain, and coordinate services outside and inside the agency, as needed by the individual whether for placement in residential alternatives, day program, respite, recreational/social activities, and other programs/services as appropriate and needed;
- (5) Copies of significant correspondence concerning contacts within the past year with the recipient/guardian, service providers, physicians, attorneys, state and federal agencies, family members, and significant others in the recipient's life;
- (6) Correspondence or memoranda concerning any significant events in the recipient's life which required case management assistance; and
- (7) Service logs to summarize monthly case management activities on behalf of the recipient. [Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-32 to §17-1738-33 (Reserved).

§17-1738-34 Termination of services. Services shall be terminated when any of the following occurs:

- (1) The recipient is determined ineligible for medical assistance;
- (2) The recipient no longer meets the requirement of section 17-1738-25(2);
- (3) The recipient and the case manager mutually decide that services are no longer necessary;

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- (4) The recipient refuses to continue receiving services in the manner specified in the IFSP;  
or
- (5) There has been no face-to-face contact between the recipient and the case manager for ninety consecutive days unless the recipient is institutionalized.  
[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)

§17-1738-35 Appeals and hearings. (a) The provider shall be entitled to the appeal and hearing process in accordance with the provisions of chapter 17-1736.

(b) The applicant or recipient who is denied eligibility for medical assistance or whose eligibility is terminated shall be entitled to the appeal and hearing process in accordance with chapter 17-1703.  
[Eff 08/01/94 ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396n)