



LOCAL HEALTH DEPARTMENT RECORDS RETENTION SCHEDULE

2013

Prepared by the Local Records Program
Public Records Division

Approved by the State Archives and Records Commission



Kentucky Department for
Libraries and Archives

Local Health Department Records Retention Schedule

This retention schedule may be used by all Local Health Departments in the Commonwealth. It lists records that are legally required for them to create and/or specific to the Health Department Office. The Local Health Department Records Retention Schedule should be used along with the Local Government General Records Retention Schedule, which lists those records that are common to all local government agencies, i.e. financial, personnel, payroll etc., although most of those common records have been listed in the Health Department schedule. The records retention schedule is the foundation of an effective records management program and must be used on regular basis. All retention schedules have been approved by the State Archives and Records Commission in accordance with KRS 171.410 – 740. This approval provides the legal basis for all local agencies to apply the appropriate schedule to their records management needs.

GLOSSARY OF TERMS For Records Retention Schedules

- Permanent (P)** Denotes records appraised as having historical, informational or evidential value that warrants preserving them permanently (forever) beyond the time needed for their intended administrative, legal or fiscal functions. These records may be destroyed **only** after the written permission is given by the State Archivist and after they are microfilmed according to specifications published by the Department for Libraries and Archives.
- Confidential (C)** Records deemed unavailable for review by the public after applying the state’s Open Records Law (KRS 61.878) and other state and federal statutes and regulations with specific restrictions. The (C) is added to appropriate record series descriptions as a reminder to agency personnel and does not bear any legal status. **It is important to note that the local government head has the responsibility of knowing all the appropriate confidentiality laws, statutes and regulations that apply to the records maintained in their office and to see that they are enforced.** Even though a record series may or may not be marked confidential on a records retention schedule, contradictory laws or regulations that are approved after the retention schedule has been completed may not be reflected but must be honored.
- Vital Record (V)** Records that are essential to the continued functioning of the local government during and after an emergency, as well as those records that are essential to the protection of the rights and interests of that local government and of the individuals for whose rights and interests it has a responsibility. Local Government should have a plan in place to identify those records and provide for their protection in case of a disaster (fire, flood, earthquake, etc.).
- Duplicates** Duplicate records that have not been assigned a retention period and function solely as reference and informational material may be destroyed when no longer useful. If the duplicate is considered the “copy of record”, it must be retained according to the retention period on the schedule.
- Destruction Certificate** A destruction certificate should be used to document the destruction of public records and may be found, along with the instructions at the Kentucky Department for Libraries and Archives website (www.kdla.ky.gov). It should be used when destroying records according to the appropriate records retention schedule. No record created or maintained by a local government agency may be destroyed unless it is listed on the retention schedule and a destruction certificate completed and the original copy sent to the Department for Libraries and Archives (Department).
- After Audit** A term used in the disposition instructions to denote a records series that shall only be destroyed after the retention period has expired and an official audit has been performed. Example: 3 years and audit: This means that the record series must be kept for 3 years after last activity or date in a file. The record must have gone through the annual audit before it can be destroyed.

RECORDS RETENTION SCHEDULE

Signature Page

Local Health Departments
Agency

June 13, 2013
Schedule Date

Unit

September 11, 2014
Change Date

September 11, 2014
Date Approved By Commission

APPROVALS

The undersigned approve of the following Records Retention Schedule or Change:

Agency Head

Date of Approval

Agency Records Officer

Date of Approval

Barbara Tye
State Archivist and Records Administrator
Director, Public Records Division

9/17/14
Date of Approval

Wayne Onkst
Chairman, State Archives and Records Commission

9/11/14
Date of Approval

The undersigned Public Records Division staff have examined the record items and recommend the disposition as shown:

Jay W. Carls
Records Analyst/Regional Administrator

Date of Approval

Ann Sings
Appraisal Archivist

9/11/2014
Date of Approval

Jay W. Carls
State/Local Records Branch Manager

Date of Approval

The determination as set forth meets with my approval.

Brian Hyatt
Auditor of Public Accounts

9/11/14
Date of Approval

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

STATE AGENCY RECORDS
RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
Administrative

Record Group
Number

Series	Records Title and Description	Function and Use
L2116	Establishment of Public Health Tax Rate	This serves as the official document establishing the annual public health tax rate in the county in accordance with KRS 212.720 thru KRS 212.755. Local taxes are imposed in order to support the programs of the local health department. Taxes are assessed in the amount of the assessed valuation of all property in the district. In the event an appropriate amount sufficient to meet the public health needs of the county is not received, a resolution is presented by the County Board of Health for additional public health dollars.
	Access Restrictions	None
	Contents	This record series may contain the name of county. Date and location of the meeting. Members present. Tax rate per \$100 of assessed valuation of property. Signature of all board members. Signature of the Secretary of the Board of Health. Signature of the Commissioner, Dept. for Health Services.
	Retention and Disposition	Retain permanently.
L2123	Financial Records File	During the course of any fiscal year, many documents are created to chart and explain the receipts and expenditures of a health department operation. These documents include (but are not limited to) purchase documents, invoices, receipts, transactions of bank account, contracts, travel vouchers, payroll, time reports, and various monthly, interim and annual reports. A copy of the Financial Management Manual prepared by the Division of Local Health, Dept. for Health Services, is attached to further explain local health department operations. All these records are used in administering federal grant monies and are filed together and audited as one unit.
	Access Restrictions	None
	Contents	In addition to items listed in #18: Statement of Income & Expenses by Cost Project Reporting Area - Current month & yr. to date; Statement of Income & Expenses for entire Health Department - Current month & yr. to date; Balance Sheet of all assets, liabilities and fund balances; Expenditure by Function Code.
	Retention and Disposition	Retain for six (6) years, then destroy after audit.
L2128	Internal Management Reports Other than Financial (e.g., Patient Appointments, Staff Schedules, Monthly Patient/Client Statistical Computer Reports)	Staff schedules, patient appointments and other computer generated patient count reports (monthly reports not part of budgeting or financial accounting) used for internal management of the clinics and health centers. These internal reports could be used for improving staff scheduling, work /management planning, problem identification and promoting efficiency.
	Access Restrictions	KRS 194A.060; KRS 61.878(1)(a)
	Contents	Appointment lists contain the names of all persons for whom appointments were made, birthdates, gender, race, date and time of appointment, appointed provider or provider discipline. Monthly statistical reports contain patient counts by race, gender, and age.
	Retention and Disposition	Retain until obsolete or no longer useful, then destroy.

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LOCAL HEALTH DEPARTMENT
Administrative

Record Group
Number

Series	Records Title and Description	Function and Use
L2135	Vaccine Activity Worksheet & Order Record	Each local health department is required to maintain a vaccine inventory by antigen and number of doses/vials on hand. The report is to be tabulated at the close of each month. At that time, an order for Biological, drugs, and x-rays should be prepared in order to insure that an adequate supply of antigens is available at all times to properly immunize children and adults within the county.
	Access Restrictions	None
	Contents	Name of Health Center; Date inventory completed; Name of Private Physician/clinic if other than health department; name of individual completing inventory; number of vials/doses of each antigen; expiration date of each antigen; number of doses transferred outside of county which received the antigen or to local private physicians - and where. Number of doses wasted - broken vials, expired vials, etc.; number of doses on hand of each antigen at the end of month.
	Retention and Disposition	Retain for three (3) years, then destroy.
L5161	Reportable Disease Records	The reportable disease record is used by health professionals to report individual cases of diseases specified in the Kentucky Disease Surveillance Administrative Regulations 902 KAR 2:020. The Regulation states that the disease be reported to the local health department serving the jurisdiction in which the patient resides.
	Access Restrictions	KRS 194A.060; KRS 61.878(1)(a)
	Contents	The record includes: the disease or condition being reported; patient name and demographic information; physician's (or reporting institution's/person's) name, address and telephone number; clinical, epidemiological and laboratory information pertinent to the disease.
	Retention and Disposition	If the individual has a medical record, file the report in the medical record. If the individual does not have a record, destroy when no longer useful to the local health department.
L5207	Board of Health Minutes (V)	Each local governing board of health shall hold a regular meeting at least once every three months and such other special or regular meetings as are necessary to conduct business of the local health department. The local board elects one of its members as the chairman to serve for a term of one year. Minutes of board meetings shall be signed by the Board Secretary (or the person so designated in the absence of the Board Secretary) and by the Chairman of the Board. Every official action of the Board of Health shall be made a part of the permanent record of the County or District Board of Health.
	Access Restrictions	Mtgs. open to public; Sub. to Ky. open mtg. laws
	Contents	Members present; members absent; and all others present. Reading and approval/corrections of minutes of last meeting. Presentation of year to date financial report; Presentation of year to date program report; Presentation of Old Business; Presentation of New Business; Establishment of date of next meeting; Motion to Adjourn.
	Retention and Disposition	Retain permanently.
L5208	Official Correspondence	This file documents the major activities, functions, and programs of the office and the important events in the history of the agency. This file has historical and legal as well as administrative value to this agency. Transitory materials should be screened from the file periodically and prior to removal from active files.
	Access Restrictions	None
	Contents	All correspondence sent and received by the agency and deemed official.
	Retention and Disposition	Retain permanently.

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Number

Series	Records Title and Description	Function and Use
L5209	Routine Correspondence	This correspondence is not crucial to the preservation of the administrative history of the agency. It is a non-policy nature and without permanent value. It deals only with general and routine operations of the office. The operations are documented by other records maintained by the agency.
	Access Restrictions	None
	Contents	Incoming and outgoing correspondence of a non-policy nature without permanent value. May include: form letters, notice of meetings, intra-office memorandums, and duplicates of other correspondence, when the duplicates are made for reference purposes only.
	Retention and Disposition	Retain for two (2) years, then destroy.
L5210	Informational and Reference Material	Reference and informational materials are published and unpublished aids often not prepared by the agency itself, often of professional or technical nature, used in the official business of the department/center and in the professional enhancement of its employees. They are destroyed when they become obsolete or are no longer of use to the records officer or various offices within the agency.
	Access Restrictions	None
	Contents	Published and unpublished aids used in the conduct of the agency's business or the professional enhancement of its employees.
	Retention and Disposition	Retain until obsolete or no longer useful, then destroy.
L5211	Official Budget	Each local health department must project and prepare a budget, and operate within its total budget. Each budget must be approved by both the local board of health and the Div. of Local Health Dept. for Health Services. Each health department budget must include all estimated receipts and all estimated expenditures. Each health department is responsible for making any budget changes necessitated by deviations in financial position or the adding or deletion of any program.
	Access Restrictions	None
	Contents	Health Dept. Project Receipts Budget; Health Dept. Project Salaries & Fringe Benefits Budget; Health Dept. Project Independent Contract Expenditures Budget; Health Dept. Project Other Expenditures, i.e. travel, space occupancy, office operating, administrative charges, medical supplies & equipment, automotive, furniture & equipment, data processing equipment, land & bldgs.; Health Dept. Project Expenditures - i.e., leave time & holiday pay, fringe benefits, independent contracts.
	Retention and Disposition	Retain permanently.
L5212	Final Closeout Reports (V)	Each local health department projects activities on an annual basis, and prepares a budget to cover these activities. The final closeout report is simply an explanation of receipts and expenditures to promote the balanced budget. This is a report which is done at the end of the year and is the expenditures and receipts for the current year and this information is used to prepare the budget for the upcoming year. This is broken down into distinct accounts which are used in the general ledger.
	Access Restrictions	None
	Contents	Revenue and Expense By Reporting Area; Departmental Summary - Revenue and Expense; Departmental Balance Sheet; General Ledger.
	Retention and Disposition	Retain permanently.

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LOCAL HEALTH DEPARTMENT
 Administrative

Record Group
 Number

Series	Records Title and Description	Function and Use
L5213	Audit Report	Beginning with the 1985-1986 fiscal year, the Division of Local Health mandated that each local health department be audited by a certified public accountant after the close of each fiscal year. The auditor will express an opinion on internal controls, the financial statements, and management's conformity with established laws, regulations and policies. Audits must be finalized no later than 180 working days after the close of fiscal year. The audit report must be prepared in accordance with generally accepted auditing standards which will include tests of the accounting records. The auditors must notify the Division of Local Health within ten days if records are determined to be inauditable. The auditors must immediately notify the Division of Local Health if evidence of possible fraud is discovered. There were audits prior to 1986, but they were not done on a yearly basis.
	Access Restrictions	None
	Contents	Management letter; Statement on accounting control; Financial statement; Detailed reports (restricted state and federal funds).
	Retention and Disposition	Retain permanently.
L5214	Individual Personnel Files	This record series is used to document an individual's employment with a local government. It is the master file and the primary source of their employment history. This file should document all the employment history which is deemed significant in determining job performance. This record series is used to provide on-going files for employee changes in status, salary, classification, name, address, insurance, retirement, taxes, etc.
	Access Restrictions	KRS 61.878 (1)(a)
	Contents	This record series may contain the application, resignation, exit interview, annual evaluations, attendance records, resume, disciplinary actions, worker's comp. Information, pension reports, copies of social security card, education verification, correspondence, position actions (P-2 and P-65) and vacation and sick leave reports.
	Retention and Disposition	Destroy the following sixty (60) years from date of hire: 1) Applications for positions 2) Name 3) Last known address 4) Social security # 5) Letters of resignation 6) Starting and ending dates of employment 7) Retirement information 8) Verification of positions held. Destroy the following five (5) years after termination of employment: 1) Employee evaluations 2) Letters of intent 3) Sign off for reading of policies/procedures 4) Health/life insurance membership 5) Job descriptions 6) W-4 8) Copies of contracts 7) Leave records 8) Criminal background checks 9) Experience verification forms 10) Copies of driver's license and birth certificates 11) Resumes 12) General correspondence/memos 13) Complaints 14) Commendations 15) Disciplinary actions taken.
L5215	Certification of Eligible's	The Local Health Department Merit System has established rules and regulations and all employment and personnel practices are governed by these rules and regulations. All vacancies are filled from a listing of individuals eligible by appropriate tests and/or education for the position. The Certification of Eligibles is the list from which employees are selected.
	Access Restrictions	None
	Contents	Name; Address; Position on Register as determined by test and/or educational background.
	Retention and Disposition	Retain one (1) year, then destroy.

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LOCAL HEALTH DEPARTMENT
Administrative

Record Group
Number

Series	Records Title and Description	Function and Use
L5216	Inventory of Equipment	Catalog of property/goods on hand within local health department. Each local health dept. must keep an equipment inventory; however, a form is not provided for this purpose. A sample inventory from Madison County Health Department is attached.
	Access Restrictions	None
	Contents	Date of Inventory Listing; Site; Description of Item; Date Item Purchased; Original Cost of Item; Assigned Inventory Number; Expected Life of Item; Replacement Value.
	Retention and Disposition	Retain for three (3) years after update is completed and audit, then destroy.
L5217	Open Records Request for Inspection/Disposition Record (V)	This record series documents requests for information from the public, press, or other governing agency. It is a joint form that also documents approval and/or denial of information and supporting documentation.
	Access Restrictions	None
	Contents	This record series may contain the date of request, requesting party name, information requested, copies needed or only viewing, disposition, supporting documentation for decision.
	Retention and Disposition	Retain for one (1) year, then destroy.
L6634	Individual Personnel Files (Deceased)	This record series is used to document an individual's employment with a local government. It is the master file and the primary source of their employment history. This file should document all the employment history which is deemed significant in determining job performance. This record series is used to provide on-going files for employee changes in status, salary, classification, name, address, insurance, retirement, taxes, etc.
	Access Restrictions	KRS 61.878 (1)(a)
	Contents	This record series may contain the application, resignation, exit interview, annual evaluations, attendance records, resume, disciplinary actions, worker's comp. Information, pension reports, copies of social security card, education verification, correspondence, position actions (P-2 and P-65) and vacation and sick leave reports.
	Retention and Disposition	Retain until five (5) years after death of employee, then destroy. (Note: All probate must be completed.)
L6635	Employment Eligibility Verification Form (I-9 Form)	This record series is used to verify that all newly-hired employees present "facially valid" documentation verifying the employee's identity and legal authorization to accept employment in the United States. This is provided by the federal government for that purpose according to The Immigration Reform and Control Act of 1986 (IRCA). This must be completed at the time of hire. Employees must complete one section of the form at the beginning of employment. The employer must complete another section within three days of starting work. The employer is responsible for ensuring that the forms are completed properly, and in a timely manner. The I-9 is not required for unpaid volunteers or for contractors. This may be completed and stored electronically and separately from the official personnel file.
	Access Restrictions	KRS 61.878 1(a)
	Contents	This record series may contain instructions, anti-discrimination notice, employee information and verification, name, address and employee's signature, preparer, employer review and verification, certification by employer, updating a reverification with employer signature and date.
	Retention and Disposition	Retain until three (3) years after termination or resignation, then destroy.

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 RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
 Food and Sanitation

Record Group
 Number

Series	Records Title and Description	Function and Use
L2175	Establishment Files (Businesses which have obtained operating permits)	Establishment files are the official documentation of services provided by the health department and a compliance record for the facility. Regulated facility types include: food services, vending machine companies, frozen food lockers, retail food markets, food manufacturing, schools, youth camps, mobile homes and recreational vehicle parks, public buildings, and recreational facilities, hotels/motels, septic tank cleaners, on-site sewage, nuisance control, private water supplies, swimming pools, and confinement facilities. Documents are reviewed by state during district and county surveys and program evaluations.
	Access Restrictions	Some records are exempted by the Open Records Act: KRS 61.878
	Contents	Listing of all forms included in the establishment files are attached.
	Retention and Disposition	Retain two (2) years after all activity has ceased, then destroy.
L2176	Onsite Sewage Files	The onsite sewage program was implemented by the Division of Food and Sanitation in 1984. The program certifies the installers and persons to conduct percolation tests, conduct site evaluations on the property, issues permits to construct an onsite sewage disposal system, assists installers and property owners in designing a proper system for their specific site, and provides surveillance of the installation. The onsite sewage files are documentation of all such activities.
	Access Restrictions	None
	Contents	Contents: See attached list; File: See attached list; Content of Forms: Detailed specifies relative to site for a sewage disposal system, type of system approved, layout of system and inspection records.
	Retention and Disposition	Retain permanently.
L2177	Applications for Permit to Operate	Original or renewal applications for a permit to operate and any required fees are mandatory by regulation, prior to issuance of the permit. All original applications are completed by representatives of the local health department. Renewal applications are computer generated at data entry sites throughout the state. Original applications are approved by local health department environmentalists based upon an inspection of the facility and receipt of any required fee payment. Records are based upon compliance of facility at time of last routine inspection and receipt of any required fee payment. Payments are process and forwarded to the Division of Public Health and Safety for deposit to the Kentucky State Treasurer (mandated). Programs requiring applications to operate are food service, vending machine companies, temporary food establishments, or fee exempt establishments, youth camps, septic tank cleaning companies and vehicles, mobile homes and recreational vehicle park construction, mobile home parks, sewage disposal, salvage processing plant, hotels, carbonated beverage plant, frozen food lockers, onsite sewage, and registration to conduct perk test. Fees collected are utilized to affect the cost of programs. See Environmental Health Management Information System Manual.
	Access Restrictions	Any records contained in file which are exempted under Open Records Act: KRS 61.878.)
	Contents	Applications. Page H2 and Page H3 of the Environmental Health Management System Manual Lists all possible file contents. Information includes District name, county name, number of seats, spaces, bedroom, etc. (whenever applicable), permit number, amount of fee required (whenever applicable), invoice number, and the name and address of the facility.
	Retention and Disposition	Retain for two (2) years, then destroy after audit.

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STATE AGENCY RECORDS
 RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
 Food and Sanitation

Record Group
 Number

Series	Records Title and Description	Function and Use
L2181	Environmental Health Management Information System Reports	The Environmental Health Management Information System is an on-line system designed to collect data on 30 environmental programs carried out by local health departments. The system consists of the following components: facility master file, accounts receivable, inspections, and environmentalists activity reporting. Renewal applications and invoices are generated, all fees are processed and permits are generated. In addition to daily audit trails the twice monthly roster of inspections to be conducted, and monthly collection sheets detailing all funds collected, quarterly and annual statement reports are also generated. These reports are utilized for evaluation of programs by state and local health departments and as a management tool by directors/administrators of local health departments. Data is entered from 19 sites throughout the state. Quarterly reports are accumulative and are maintained until updated by the next quarter. All generated reports are not required to be maintained. The annual reports which are maintained for five years is listed in Item #19. See Environmental Health Management Information System Manual.
	Access Restrictions	None
	Contents	Reports: Current facility profile listing (Report. 40); Annual Inspections Report (Report 68); Monthly Cash Entry Register (Report 49); Report of Cash Receipts (Report 50). Data Elements: record of all services provided, activities conducted, enforcement actions taken, cash receipts by program area, by sanitarian, by district, by county.
	Retention and Disposition	Retain for five (5) years, then destroy after audit.
L2182	Plats, Maps, Surveys, Blueprints and Plan Review Sheets -- (other than onsite)	Prior to construction of public facilities, a copy of the blueprint is submitted to the local health departments for approval and a plan survey sheet is completed. Approval by the Div. of Plumbing and the local health department results in issuance of a permit to construct (if mandated by law) or authorization to proceed. Also, submitted to the health department are copies of real estate plans and maps for their review, information and/or approval submitted by owners or builders. Original residential maps and surveys are maintained at the county courthouse or by the county planning commission (if established). A copy is submitted to the local health department for their review, information and/or approval. The purpose for these documents is to determine compliance with appropriate regulations and zoning restrictions (when applicable) for public and residential buildings.
	Access Restrictions	None
	Contents	Copies of submitted real estate plats, maps, surveys and blueprints for construction of public or residential buildings. A copy of the construction plan review sheets, which was completed by the local health department is also included. Information is detailed drawings of building, subdivision, mobile home park, etc., which is to be constructed. The plan review sheet is utilized to record comments of deficiencies in the proposal.
	Retention and Disposition	Retain for three (3) years, then destroy.

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LOCAL HEALTH DEPARTMENT
 Home Health

Record Group
 Number

Series	Records Title and Description	Function and Use
L2142	Adult Patient Home Health Medical Record	The record is the documentation maintained on the home health care of patients 18 years of age and older. It provides information and communication necessary for the continuity of care for the patient as well as documentation necessary to justify the home health care as required by the Medicare and Medicaid rules and regulations.
	Access Restrictions	KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)
	Contents	Included in the record is patient identifying/demographic information, health insurance information, consent for home health services, Outcome Assessment Information Set (OASIS), pertinent past and current findings, name of physician, physician's plan of treatment, medication, dietary, treatment and activity orders, provider's progress notes, summary reports sent to the physician and hospital discharge summary (when applicable).
	Retention and Disposition	Retain until seven (7) years after last date of service, then destroy.
L5158	Minor Patient Home Health Medical Record	The record is the documentation maintained on the home health care of patients less than 18 years of age. It provides information and communication necessary for the continuity of care for the patient as well as documentation necessary to justify the home health care as required by the Medicare and Medicaid rules and regulations.
	Access Restrictions	KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)
	Contents	The record includes patient identifying/demographic information, health insurance coverage information, consent for home health services, Outcome Assessment Information Set (OASIS), pertinent past and current findings, name of physician, physician's plan of treatment, medication, dietary, treatment and activity orders, provider's progress notes, summary reports sent to the physician and the hospital discharge summary (when applicable).
	Retention and Disposition	Retain seven (7) years after the patient reaches 18 years of age or seven (7) years from last date of service whichever is greater, then destroy.
L5218	Home Health Advisory Committee Minutes	The Home Health Advisory Committee consists of a group of professional personnel, which includes at least one practicing physician and one registered nurse, that meets frequently to advise the Home Health Agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the community and in its community information program. Its meetings are documented by dated minutes. Each Home Health Agency is required by Medicare's Federal Regulations to establish a Home Health Advisory Committee. The committee is required to meet frequently and to keep minutes of each meeting.
	Access Restrictions	None
	Contents	The Home Health Advisory Committee Minutes are a record of the activity of each meeting which includes, but is not limited to: establishing and annually reviewing the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of treatment, emergency care, clinical records, personnel qualifications and program evaluations.
	Retention and Disposition	Retain permanently.

STATE ARCHIVES AND RECORDS COMMISSION
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LOCAL HEALTH DEPARTMENT
Medical Information

Record Group
Number

Series	Records Title and Description	Function and Use
L2139	Master Patient Index	The master patient index is an index/locator system for the patients' medical record at each service delivery site. Each patient served by the health center for which a medical record was established is to be included in the index. The index provides the mechanism for locating the record.
	Access Restrictions	KRS 194.060.KRS 61.878(1)(a)
	Contents	Includes the patient's name, sex, race, birthdate, a unique id number and the location of the medical record.
	Retention and Disposition	Retain permanently.
L2140	Adult Patient Medical Record	The adult patient medical record is the documentation kept on the medical/health care of patients 18 years of age and older. Documentation contains sufficient information to identify and assess patients and to furnish evidence of the course of the patient's health care by the provider responsible for the delivery of the care. The record includes documentation of assessments, tests, results and treatment. The record contains a description of services rendered, the date rendered, and the service provider's signature. The record also contains documentation of eligibility determination and other required documentation for certification of WIC participation.
	Access Restrictions	KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)
	Contents	The medical record contains all the documentation necessary for the health care provided the patient for/by the health department. Information consists of patient identifying and demographic data; financial eligibility and case management data; social and medical histories; documentation of all nursing, medical, social, educational, nutrition, laboratory and radiology services.
	Retention and Disposition	Retain until ten (10) years after the last date of service, then destroy. Exception - if the patient has had tuberculosis infection and/or disease such as HIV/AIDS, STD and the treatment regimen, allergies, sensitivities and reactions have not been extracted and documented on the Immunization/Mastercard, the record must be kept permanently.
L2144	Pap Smear, Mammogram and Abnormal CBE Logs	The logs are used by clinic staff to track and account for Pap Smears and mammograms and to follow-up on abnormal clinical breast exams (CBEs) of all female patients who have had the cancer screenings. Each of these cancer screening procedures must be logged to assure that reports are received and all recommended follow-up steps are completed.
	Access Restrictions	KRS 194A.060; KRS 214.420; KRS 61.878(1)(a)
	Contents	Each log contains: patient name; patient ID number; birthdate; date of scheduled screening or diagnostic mammogram; date and results of the Clinical Breast Exam (CBE); date the Pap Smear was taken and date mammogram was done; date results received; results of test/procedure; supplementary evaluation of breast cancer screening (date of surgeon appointment, further views, ultrasound, biopsy); final diagnosis; date patient was contacted; date of colposcopy appointment; date diagnostic/treatment records received, Month/year next Pap and/or mammogram due.
	Retention and Disposition	Retain until one (1) year from follow-up service date, then destroy.
L2145	Patient Drug and Device Log	The Patient Drug and Device Log is used to track and account for medication and devices provided in the clinics. If there is a drug/device recall, the log identifies the patients who received the specific drug or device.
	Access Restrictions	KRS 194A.060; KRS 61.878(1)(a)
	Contents	The log contains the patient's name and ID number, the date provided, the name of the specific drug/device, lot number, amount provided, provider's signature, date and local health department county/clinic name.
	Retention and Disposition	Retain for five (5) years, then destroy after audit.

STATE ARCHIVES AND RECORDS COMMISSION
Public Records Division
Kentucky Department for Libraries and Archives

STATE AGENCY RECORDS
RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
Medical Information

Record Group
Number

Series	Records Title and Description	Function and Use
L2146	Chest X-Rays for Tuberculosis Infection and/or Disease Access Restrictions Contents Retention and Disposition	Tuberculosis chest x-rays are made on patients with tuberculosis to provide physicians with an image and information on the lungs which facilitates the determination of diagnosis and treatment of the disease. KRS 194A.060; KRS 61.878(1)(a) Patient Name, patient identification number, sex, race, birthdate, date of X-ray and the X-ray film. Retain permanently.
L5157	Minor Patient Medical Record Access Restrictions Contents Retention and Disposition	The minor patient medical record is the documentation kept on the medical/health care of patients less than 18 years of age. Documentation contains sufficient information to identify and assess patients and to furnish evidence of the course of the patient's health care by the provider responsible for the delivery of the care. The record includes documentation of assessments, tests, results and treatment. The record contains a description of services rendered, the date rendered, and the service provider's signature. The record also contains documentation of eligibility determination and other required documentation for certification of WIC participation. KRS 194A.060; KRS 214.420; KRS 61.878(1)(a) The medical record contains all the documentation necessary for the personal health care provided the patient by the health department. Information consists of patient identifying and demographic data; financial eligibility and case management data; social and medical histories; documentation of all nursing, medical, social, educational, nutrition, laboratory and radiology services. Retain until five (5) years after the patient reaches eighteen years of age or ten (1)0 years from last date of service, whichever is longer, then destroy. Exception - if the patient has had tuberculosis infection and/or disease, and the treatment regimen, allergies, sensitivities and reactions have not been extracted and documented on the Immunization/MasterCard, the record must be kept permanently.
L5159	Immunization Record (Master Record) Access Restrictions Contents Retention and Disposition	The record provides permanent documentation of all vaccinations as well as tests and treatments the patient has had for tuberculosis. This information is essential for the patient, the health care provider as well as for the public health of the total population. KRS 194A.060; KRS 61.878(1)(a) The record consists of one single document of card stock. The record includes patient identifying information, vaccine type, date, site of injection, lot number, manufacturer, dosage, signature of vaccine administrator, adverse reactions and allergies. Tuberculin skin tests/results, completed/recommended treatment regimen, medications, sensitivities, and reactions. This record may also be used as the Master Patient Index. When used for the Patient Master Index it includes the location of the medical record. Retain permanently.
L5160	Prenatal Hepatitis B Prevention Form for Infants Access Restrictions Contents Retention and Disposition	The Prenatal Hep B Prevention Form for Infants is 1) a record of treatment given to infants born to Hepatitis B positive mothers immediately following delivery. 2) The record provides a mechanism to track household contacts of Hepatitis B positive women. 3) The record provides information which increases awareness of Hepatitis B and specific needs of high-risk infants in comparison with infants born to HBsAg negative mothers. KRS 214.420; KRS 194A060 The form contains: Name of patient (infant), Date of Birth, Time of Birth, Name, address, county of residence of parents, weight at vaccination of Infant, Obstetrician and Pediatrician Name, Immunizations given, i.e., Hepatitis B and/or HBIG with date, time, manufacturer & lot number with the signature of person who administered. HBsAg test; Mother's HBsAg Status and date of lab work; Name and phone number of Birthing Facility. File the form in the infant/child's chart if a chart is created. If the infant/child never becomes a patient of the LHD, retain for two (2) years, then destroy.

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LOCAL HEALTH DEPARTMENT
 Medical Information

Record Group
 Number

Series	Records Title and Description	Function and Use
L5162	Laboratory Records for CLIA	For laboratory services provided by or through the local health departments, there are three types of records which must be maintained. First, there are laboratory test requisitions which are individual laboratory requests for each type of test conducted. The requisition provides authorization for the test to be conducted. Second, documentation and records of all quality control activities for the laboratory procedures must be maintained. Third, records must be maintained for all quality assurance activities of laboratory services including identification of problems and corrective actions taken.
	Access Restrictions	KRS 214.420; KRS 194A.060
	Contents	(1) Laboratory test requisitions contain: patient's name /identifier, name and address or identifier of authorized person requesting the test, name and address of the individual ordering or responsible for utilizing test result, name and address of submitter of specimen, the test to be performed, and date of specimen collection. (2) Quality control records contain: instrument charts, graphs, printouts, transcribed data, manufacturer's assay information sheets for control and calibration materials. (3) Quality assurance (QA) records contain proof that there are monitoring and evaluation activities conducted of laboratory services to include identification of problems and any corrective action taken.
	Retention and Disposition	Retain for two (2) years, then destroy.
L5163	HIV/AIDS Care Coordinator Client Record	The record documents services rendered and costs incurred for clients receiving services. They are used for care coordination, budgeting, case management, referrals, facilitation of medical care and follow-up.
	Access Restrictions	KRS 214.420; KRS 61.878(1)(a); KRS 194A.060
	Contents	The record contains: intake, eligibility information to include identifying information, income and HIV status; care coordinator's progress notes, referrals, client budgeting information, care plan and updates, documentation of services rendered, billings, and receipts
	Retention and Disposition	Retain for (3) years, then destroy.
L5164	Incident/Accident/Complaint Reports	The report is used to inform the administration of an incident/accident/complaint so management can prevent similar incidents in the future. It alerts administration and the facility's insurance company to a potential claim and the need for investigation. To satisfy OSHA regulations for agencies with more than ten employees, records must be maintained of recordable occupational injuries and illnesses.
	Access Restrictions	KRS 61.878(1)(a)
	Contents	The reports contain: Name, address, phone number, age, sex, and Social Security of person involved, Date, time and exact location of incident, type of accident, safety, medical device failure, adverse drug reaction, vehicle accident, needle stick, clerical/data entry error, communications problem, testing process, result reporting, exposure to hazardous substance, policy/procedural violations and medication error. If an employee was involved, the name and their employment history, a description of incident/complaint, action taken by staff members, witness name, phone number and address, medical follow-up, type medical treatment sought (if any), dates of treatment, treating physician, and address, dates off work and return to work and if duties restricted, is so, how.
	Retention and Disposition	For adults, retain until five (5) years after accident/incident occurred for adults. For children, retain until age eighteen plus 5 years or until litigation is complete whichever time period is longer, then destroy.

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STATE AGENCY RECORDS
RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
Rabies Control

Record Group
Number

Series	Records Title and Description	Function and Use
L2163	Rabies Vaccination Certificate	This record series is used to document the vaccination of dogs according to Kentucky Revised Statutes Chapter 258, KRS 258:015. Every owner shall have his dog initially vaccinated by the age of four months and re-vaccinated against rabies at the expiration of the immunization period as certified by the veterinarian. The vaccination could either be a 1 year or 3 year shot. This document confirms that the dog has been vaccinated as required by law.
	Access Restrictions	None
	Contents	This record series may contain the Rabies Tag Number, Owner's name & address and telephone number, species: sex, age, size, predominant breed, colors, vaccine producer - one or three year vaccine - vacc. Serial lot number, date vaccinated, vaccination expires, veterinarian's license number, and signature and address of veterinarian.
	Retention and Disposition	Retain records of one-year vaccinations for one (1) year, then destroy. Retain records of three-year vaccinations for three (3) years, then destroy.
L2164	Animal Quarantine Notice	Kentucky Revised Statutes Chapter 258, KRS 258-085. A health officer or his agent shall have the authority to quarantine for a period not to exceed 10 days any animal which has bitten a human being or which exhibits symptoms of rabies. An animal so quarantined by be confined by the health officer at a designated place at the owner's expense. At the owner's expense if the dog dies or is suspected of having rabies the head is sent to the laboratory for testing.
	Access Restrictions	None
	Contents	Name of animal, species, breed, sex, color, date of rabies vaccination, tag number, name of owner, address, telephone number. Reason for quarantine and place animal is to be quarantined, date quarantine, quarantine period, release date, name of health department, by and date.
	Retention and Disposition	Retain for one (1) year, then destroy.
L2165	Notice and Order to Vaccinate Dog Against Rabies	Official notice to dog owner to have his dog(s) vaccinated against rabies upon release of quarantine.
	Access Restrictions	None
	Contents	Date, name and address of owner and signature, name of dog, license number, age, sex, breed, color. County health department, signature of person authorizing notice and title.
	Retention and Disposition	Retain for one (1) year, then destroy.

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STATE AGENCY RECORDS
 RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
 Vital Statistics

Record Group
 Number

Series	Records Title and Description	Function and Use
L2153	Certificate of Live Births (V)	Provides birth verification to local residents as needed for driver's license, etc. Resource for county offices to collect data regarding number of births for county and to plan health programs beneficial to each community in providing adequate prenatal care. Used to project future needs of community as to housing needs projected, number of schools needed in future, etc. Back-up copy to the original retained in Office of Vital Statistics.
	Access Restrictions	None
	Contents	Child's name, date of birth, hr. of birth, sex, single or multiple birth, co. of birth, city of birth, within city limits, hospital other place where birth occurred, maiden name of mother, age of mother at baby's birth, state of mother's birth, mother's soc. sec. #, mothers state, co. & city of residence at time of birth, within city limits, father's name, father's age at time of baby's birth, father's state of birth, father's soc. sec. #, informant, relationship of informant to baby, signature of certifier of birth, date certifier signed, type of attendant at birth, certifier's typed name & mailing address, signature of local registrar, date registered at co. office, race of mother, race of father, baby's birth weight, legitimacy of birth, mailing address of mother, pregnancy history as to previous live births now living and now dead, other pregnancy terminations under and over 20.
	Retention and Disposition	Retain permanently.
L2154	Certificate of Stillbirth (V)	To aid in planning prenatal care and to collect data to implement health programs within the community. To collect data to study possible causes of fetal deaths. To determine the number of fetal deaths within the community. To act as back-up for the original certificate filed in Frankfort.
	Access Restrictions	None
	Contents	Name of fetus, date & hr. of delivery, sex of fetus, single or multiple births; co. of delivery; city of birth; within city limits, hospital or other place where delivery took place, maiden name of mother, age of mother at time of delivery, state of birth of mother, soc. sec. # of mother; state, county and city of mother's residence, name of father, age of father at time of delivery of fetus, state of birth of father, soc. sec. # of father, cause of death, other significant conditions of fetus or mother, when fetus died (before, during labor or unknown), autopsy, gestational weeks, signature of certifier, date certified, specialty of attendant at delivery, mailing address of certifier, authorized official if not attended by physician, method of disposition of remains, name of cemetery or crematory, location of cemetery or crematory, signature of funeral director or person acting in that capacity.
	Retention and Disposition	Retain permanently.
L2155	Death Index-Report 677 (V)	1. To locate year, certificate and volume number of original death certificate in order to destroy the provisional report of death and to notify state office if death certificate is not filed. Used to study genealogy.
		Note: From 1911 until 1993, the Death Index was stored on microfiche and has a permanent retention in local health departments. In 1993 the microfiche was discontinued and we now use Report 677 computer printouts.
	Access Restrictions	None
	Contents	Name of deceased, date of death, county of death, age at time of death, volume number, certificate number, year filed, county of residence and social security #.
	Retention and Disposition	Retain permanently.

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STATE AGENCY RECORDS
RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
Vital Statistics

Record Group
Number

Series	Records Title and Description	Function and Use
L2156	Birth Index by Name of Child (V)	To locate copy of certificate of live birth; to give verification of birth to local residents and for genealogy studies.
	Access Restrictions	None
	Contents	Name of child, date of birth, county of birth, mother's full maiden name, volume number, certificate number, and year filed.
	Retention and Disposition	Retain permanently.
L2157	Birth Index by Maiden Name of Mother (V)	To give verification of birth to local residents. To locate copy of certificate of live birth. For genealogy studies.
	Access Restrictions	None
	Contents	Name of child, date of birth, county of birth, mother's full maiden name, volume number, certificate number, year filed.
	Retention and Disposition	Retain permanently.
L2158	Permit for Disinterment and Reinterment in the Same Cemetery (V)	To document a removal of human remains and establish where and when the remains were reburied.
	Access Restrictions	None
	Contents	County health department, name, age, race, sex and date of death of the deceased, name of firm/person making disinterment and making agreement to reinter, the name of the cemetery where the disinter and reinterment took place, permit number, signature of registrar (local) date permit given, date disinterred and reinterred, person in charge of disinterment and reinterment signature of sexton or other cemetery official, signature showing local registrar has received permit back in and the date she received same back.
	Retention and Disposition	Retain permanently.
L2159	Application for Permit to Disinter and Reinter in Same Cemetery (V)	Documents the applicant has made or will make, a reasonable effort to contact and obtain written permission from the next-of-kin for the removal of the remains and that he is familiar with and will abide by all applicable laws, regulations, and policies relating to the establishment and abandonment of cemeteries and the custody, handling, and disposal of human remains.
	Access Restrictions	None
	Contents	Date of application, name of deceased, place and date of death, burial site, date of removal, name, address, signature and license number of person making application for removal, permit number.
	Retention and Disposition	Retain permanently.

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STATE AGENCY RECORDS
RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
Vital Statistics

Record Group
Number

Series	Records Title and Description	Function and Use
L2162	Provisional Certificate of Death (V)	Allows local registrar to monitor deaths within county and assure a legal certificate of death is filed accurately and timely. Acts as tickler to notify state office if certificate is not filed in accordance with the laws of the State of Kentucky.
	Access Restrictions	None
	Contents	Name of deceased, date of death, attending physician, address of physician, county of death, hospital or other place of death, residence at time of death, sex and age of deceased, name and person assuming responsibility for remains, name of funeral home involved, signature of person making removal, signed statement of person making removal to file a certificate with the registrar of county in which death occurred. Signature of person issuing certificate and where issued.
	Retention and Disposition	Retain until death appears on Death Index Report 677, then destroy.

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STATE AGENCY RECORDS
 RETENTION SCHEDULE

LOCAL HEALTH DEPARTMENT
 Women, Infant, and Children

Record Group
 Number

Series	Records Title and Description	Function and Use
L2171	WIC Revalidation Information	Provides a record of WIC Food Instruments which have been approved for payment by the local agency.
	Access Restrictions	None
	Contents	Agency, vendor name, vendor number, serial number of food instrument, date of revalidation, reason for revalidation.
	Retention and Disposition	Retain for three (3) years, then destroy after audit.
L2174	WIC Vendor File	Vendor files provide documentation of: (1) an agreement between the local health department and a participating WIC Vendor for the provision of supplemental food to women, infants and children as qualified to participate in accordance with federal and state regulations; (2) any problems and resolutions to problems dealing with food instruments and the vendor; and (3) a review conducted of the qualifications of all authorized food vendors at least biannually in accordance with Federal Regulations.
	Access Restrictions	None
	Contents	The file contains: The agreement with date, health dept. name, vendor name, clauses of agreement, health dept. , vendor and state agency signatures. Store name, owner of store, contact person and position, price list, review of inventory, valid Ky. Retail market permit, review of revalidation problems, participant complaints, review of checkout procedures, review of food instruments, review of vendor stamp, name of reviewer and date, vendor correction forms. All documentation as listed in the requirements from the state and federal agencies to participate as a WIC vendor.
	Retention and Disposition	Retain for three (3) years, then destroy after audit.