Cabinet for Health and Family Services

Office for Children with Special Health Care Needs

Records Retention Schedule

Prepared by the State Records Branch
Archives and Records Management Division
Approved by the State Libraries, Archives, and Records Commission

Kentucky Department for Libraries and Archives

This records retention schedule governs retention and disposal of records created, used, and maintained by this agency. **Government records in Kentucky can only be disposed of with the approval of the State Libraries, Archives, and Records Commission (the Commission). If records do not appear on a Commission-approved records retention schedule, agencies should not destroy those records.** This agency-specific schedule was drafted by agency personnel and Archives and Records Management Division staff and reviewed and approved by the Commission. This schedule provides the legal authority for this agency to destroy the records listed, after the appropriate retention periods have passed.

Agency personnel should use this agency-specific schedule in combination with the *General Schedule for State Agencies (General Schedule),* also approved by the Commission. The *General Schedule* applies to records that are created, used, and maintained by staff at all or most state agencies. Agency-specific retention schedules are used only by specific agencies and apply to records that are created only by a particular state agency, or to records that a state agency is required to retain longer than the approved time period on the *General Schedule*. The *General Schedule* and agency-specific retention schedule should cover all records for this agency.

This retention schedule applies to state agency records and information regardless of how it is created or stored. For example, information created and sent using e-mail is as much a public record as materials created or maintained in paper. Kentucky law defines public records, in part, as "documentary materials, *regardless of physical form or characteristics*, which are prepared, owned, used, in the possession of or retained by a public agency" (KRS 171.410[1]). This means that records management standards and principles apply to all forms of recorded information, from creation to final disposition, regardless of the medium. Records retention scheduling is important in developing, using, and managing computer systems and other electronic devices. Records management practices encourage cost-effective use of electronic media through accurate retention scheduling and legal destruction of records.

All state government employees are responsible for maintaining records according to the retention schedule, whether those records are stored electronically or in paper. Information must be accessible to the appropriate parties until all legal, fiscal, and administrative retention periods are met, regardless of the records storage medium.

Audits and Legal Action
Agency records may be subject to fiscal, compliance or procedural audit. If an agency should maintain records longer than the approved retention period, as may be the case with some federal audits, then all affected records should be retained until the audit has been completed and the retention period met. In no case should records that are subject to audit be destroyed until the audit has been completed and retention periods met, or the records have been officially exempt from any audit requirements.

Records may also be involved in legal or investigative actions, such as lawsuits, administrative hearings, or open records matters. These records must be retained at least until all legal or investigative matters have concluded, regardless of retention period. This includes all appeals of lawsuits.

Vital Records
Vital records are essential to the continued functioning of an agency during and after an emergency. Vital records are also essential to the protection of the rights and interests of an

agency and of the individuals for whose rights and interests it has a responsibility. Vital records are identified in the retention schedule with a (V).

Confidential Records
While all records created, used, and maintained by government agency personnel are public records, not all of those records are open to public inspection. Whether a record is open to public inspection is determined by the state's Open Records laws and other relevant state or federal statutes and regulations. Restriction of public inspection of confidential records may apply to the whole record or only to certain information contained in the record.

Kentucky's public records are considered open for public inspection unless there is some specific law or regulation that exempts them. Agency personnel who believe certain records are confidential should submit a citation from Kentucky Revised Statutes, Administrative Regulations, Code of Federal Regulations, or similar authority. **State agency heads have the responsibility to know all the appropriate confidentiality laws, statutes and regulations that apply to the records maintained by their agency and to see that those laws are enforced**. Even though a record series may or may not be marked confidential on a retention schedule, contradictory laws or regulations that are passed after the schedule has been approved must be honored.

Copies of Records
Agency personnel often make copies of records for internal use or reference purposes. Agencies should designate one copy as the official copy and make sure it is retained according to the records retention schedule. Agencies can destroy all other copies when no longer useful.

Updating the Retention Schedule
Per 725 KAR 1:010, the head of each state government agency is required to designate a member of his or her staff to serves as a records officer. The agency records officer represents that agency in its records-related work with the Archives and Records Management Division. The agency records officer is responsible for assisting the Archives and Records Management Division in drafting a records retention schedule, and in finding any schedule updates to bring before the Commission. The retention schedule should be reviewed on a regular basis to suggest appropriate changes to the Commission.

Cabinet for Health and Family Services
Department for Public Health
Office for Children with Special Health Care Needs

Effective July 1, 2024, the duties, responsibilities, and authority set out in KRS 200.460 to 200.490 shall be performed by the Department for Public Health. The Department for Public Health shall advocate for the rights of children with disabilities and, to the extent that funds are available, shall ensure the administration of services for children with disabilities as are deemed appropriate by this office pursuant to Title V of the Social Security Act.

The Office for Children with Special Health Care Needs provides comprehensive care to children and youth with special health care needs who:

- Are Kentucky residents
- Are younger than 21
- Meet medical eligibility
- Meet financial eligibility.

RECORDS RETENTION SCHEDULE

Signature Page

Commission for Children with Special Health Care Needs — Agency

September 13, 2012 — Schedule Date

Unit

Change Date

September 13, 2012 — Date Approved By Commission

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APPROVALS

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

Agency Head — 9/20/12 — Date of Approval

Agency Records Officer — 9/19/2012 — Date of Approval

State Archivist and Records Administrator
Director, Public Records Division — 9/13/2012 — Date of Approval

Chairman, State Archives and Records Commission — 9/13/2012 — Date of Approval

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

Pam Compton — Records Analyst/Regional Adminstrator — 9/13/2012 — Date of Approval

Appraisal Archivist — 9/13/2012 — Date of Approval

State/Local Records Branch Manager — 9/13/12 — Date of Approval

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The determination as set forth meets with my approval.

Auditor of Public Accounts — 9/13/12 — Date of Approval

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Department for Public Health
Children with Special Health Care Needs, Office for

Record Group Number
1270

Series	Records Title and Description	Function and Use
03195	**Client's Chart File**	CLOSED SERIES: This series documented the system for delivery of services for children with chronic illnesses and handicapping conditions in the Disabled Childrens Program. The children require continuous care over long periods, some from birth, some beginning later. The design of the program required planning and care for the total needs of the child. Both educational programming and treatment of physical and/or mental disabilities are considered. A major emphasis of the program was improvement of the childs ability to benefit from subsequent education or training, or otherwise improve opportunities for self-sufficiency or self-support as an adult. These services may have been provided by a variety of agencies, resulting in a services delivery system which is continuous, comprehensive, coordinated, and concerned with the whole child. The individual services plan was the essence of what made up the chart, measuring a childs progress. Age of eligibility was up to seven years old or prior to entering school. Although children were eligible up to 16 years of age, budget limitations made it necessary to limit services to children under seven. The clients over age seven who had not been placed in school were eligible if funds were available. The individual services plan shows the emphasis of each clients rehabilitation program. The plan functioned to organize and coordinated the goal-oriented care of each child. It was based on the interdisciplinary evaluation of the childs specific medical, education, developmental, social and rehabilitative needs. The plans were amended semiannually. Exceptions to this may be due to hospitalization. Necessary medications were prescribed by a physician. Objectives were to have a child ready for public school by age seven if at all possible.
	Access Restrictions	KRS 200.490. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: authorization for services/billing form; name of district office; refusal of service; individual service plan forms - include name of child, address, date of birth, Medicaid eligible, other payment sources, diagnosis, case history, location, service plans, evaluations of medical, educational, social, developmental, dates, strength, limitations, needs, goals and long-term objectives, activities, provider, beginning date, frequency, duration, achievement date, estimated cost by item or service, comments, signature of case manager, responsible agency, address, review dates, parent/guardian signature, objectives, requested equipment/service, ordered by, billing name and address, cost, psycho-social evaluation includes background information, current life situation, previous treatment history, recommendations, miscellaneous patient expense request; eligibility forms
	Retention and Disposition	Retain in Agency five (5) years; destroy after audit.
03240	**Grant Project Proposals and Guidelines (V)**	This series documents need assessments for program expansion and supplemental funding assistance within the Commission for Children with Special Health Needs (hereinafter "Commission"). The proposals are used as guidelines and reference for future proposals, and planning, writing, and reporting purposes. Some of the grants are to aid in the outreach and publicizing of Commission programs. Grants provide for program development, such as hearing conservation, client and family counseling, therapy, medical services, wheelchairs, and infant stimulation programs. The needs for supplemental funding are researched before it is determined which areas will use the financial resources. Proposals are made by the Director of Administrative and Financial Services Branch and the Director and/or Executive Director receive ideas from other program directors. Copies of the final form proposals are circulated to the Medical Director, Executive Director, and each Division Director. In making requests for funding, management may or may not grant it or will possibly modify the grant request. Stipulations may be attached, or a team of administrators may be dispatched to do a "cooperative" report before final decisions are made.
	Access Restrictions	Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Special project summaries; statistical data, as appropriate; program planning; supplemental funding requested.
	Retention and Disposition	Retain in Agency ten (10) years; destroy after audit.

Series	Records Title and Description	Function and Use
03241	**Photographs**	This series documents a photographic representation of accumulated events, activities and exhibits that have taken place in the past. Many represent public relations or promotional efforts. Some of these are pictures of patients before and after surgery, and date back to the 1920s. More recent photographs of events that include patients are only utilized with consent. The same disposition will apply to the negatives as with the photographs.There may also be photographs within the Clients Medical Record (Series 03246). These photographs are medically related and are only used by clinical staff. The photographs within the medical record are destroyed based on the retention schedule of the Clients Medical Record (Series 03246) or, if requested, released to the family or physician of care for continuity of care when the patient ages out of the Commission program.
	Access Restrictions	KRS 61.878(1)(a). Agencies should consult legal counsel regarding open records matters.
	Contents	Series contains: Photographs and digital pictures
	Retention and Disposition	Retain in Agency and destroy upon approval of the State Archivist.
05762	**Clinic Service Slip**	The Clinic Service Slip is used to document services rendered in clinic and/or by a service provider. This information is gathered in the clinic as a patient signs in and sees different providers (physician, speech therapist, audiologist, clinic nurse, etc). A Clinic Service Slip is completed for each patient attending clinic. The information is entered into Computer Utilization Project (" CUP") so that the Commission for Children with Special Health Care Needs billing agency may access the appropriate information and send out bills.
	Access Restrictions	KRS 205.175; KRS 61.878 (1) (a) and HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Patients name; date of birth; height; weight; information changes (phone, address, insurance); party accompanying the patient; date of visit; Current Procedural Terminology (" CPT") codes for visit level, service, and procedures; International Classification of Diseases, Ninth Revision, Clinical Modification (" ICD-9-CM") diagnosis codes; physicians signature; billing information; pay category; balance due; check number; collected; and receipt number.
	Retention and Disposition	Retain in Agency for four (4) years; destroy after audit.

Series	Records Title and Description	Function and Use
03246	**Client's Medical Record (V)**	This series documents the information collected during encounters with individuals who become patients of the Commission for Children with Special Health Care Needs. The Medical Record contains sufficient information to clearly identify clients, support diagnoses, justify treatment, and record accurate results. The information records clinic visits, physician office visits, lab reports, speech evaluations, audiological reports, psychologists reports, occupational and physical therapy evaluations, discharge summaries, consent for treatment, doctors orders, medical summaries, official correspondence, release of information forms.
	Access Restrictions	KRS 200.490 and HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: 1) Identifying information - name, address, phone number, date of birth, social security number, parents or guardian names; 2) Medical information - clinic notes (from the Commission or other clinics), office visits, lab reports, hospital visits, diagnosis, treatment, therapy recommendations, progress reports; 3) Social information - clients family, adopted or not, copy of birth certificate, custody papers (in the case of a divorce), divorce papers, name changes, declarations of the court, social workers notes; 4) Financial information, family income, whos responsible for payments, wage verification, tax forms, authorization for service, correspondence, acceptance into program; HIPAA related forms
	Retention and Disposition	Retain in Agency for seven (7) years after the child reaches the age of majority (21) and audit. Destroy.
03247	**Kardex File of Patients (V)**	This series documents and verifies the acceptance into the Commission for Children with Special Health Care Needs. It identifies the name of the program that the client will participate in (i.e., speech and hearing, physical therapy, occupational therapy, hemophilia, or specialized clinic) and the attending physician. This series also provides prompt reference information. If there is not a medical record on file, this record would be the next place for reference to determine if the child had been admitted in the Commission for Children with Special Health Care Needs program. The series provides long-term reference for research information and it documents disability status in adulthood as the original medical record (Series 03246) is not a permanent record.
	Access Restrictions	KRS 200.490; KRS 68.878 (1)(a). Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Clients name; address; telephone number; date-of-birth; date of application; type of services; attending physician; status (accepted, discharged, expired).
	Retention and Disposition	Retain permanently in agency.

STATE AGENCY RECORDS RETENTION SCHEDULE

Cabinet for Health and Family Services
Department for Public Health
Children with Special Health Care Needs, Office for
Administrative And Financial Services Division

Record Group Number
1270

Series	Records Title and Description	Function and Use
03245	**Eligibility Acceptance/Rejection File**	This series documents the children/young adults who have been accepted and rejected for service by a Commission for Children with Special Health Care Needs Eligibility Committee. After an initial medical evaluation, various aspects of an applicants family situation are reviewed to determine if the applicant meets the eligibility criteria established for acceptance into Commission for Children with Special Care Needs program. These aspects include the number of family members, family income, insurance coverage, and medical diagnosis of the applicant. When an applicant is accepted into the program, a pay category is assigned which determines if the family will be responsible for any, partial, or all of the medical bills. Eligibility determination is communicated by letter and the applications are kept in each district.
	Access Restrictions	KRS 200.490. Agencies should consult legal counsel regarding open records matters.
	Contents	Series contains: worksheets; clients name(s); date they were accepted/rejected; county district; (if rejected) reason for rejection; eligibility Committees application summary; totals of children accepted/rejected
	Retention and Disposition	Retain in Agency one (1) year; destroy.

Series	Records Title and Description	Function and Use
03204	**Patients' Statement of Account**	This series documents the charges of a patient that has accumulated services rendered from clinics, hospitals or insurance charges filed on their behalf. The Patients Statement of Account is mailed to the patients home address as identified in the Computer Utilization Program (CUP). Payments are processed at the Commission for Children with Special Health Care Needs. Copies of the check or money order are kept on file with the Commission for Children with Special Health Needs and the hard copy filed is only used to verify deposits and payments.
	Access Restrictions	Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Patient name; address; patient identification number; statement closing date; name and address of the Commission for Children with Special Health Care Needs; amount paid; dates of charges; description of services; previous balance; amount; current amount due - 30 days, 60 days, 90 days, 120 days or over; statement closing date; total amount due
	Retention and Disposition	Retain in Agency five (5) years; destroy after audit.

Series	Records Title and Description	Function and Use
03242	**Licensed Professionals Continuing Education Records (V)**	This series documents the continuing education records the Commission for Children with Special Health Care Needs sponsorship of presentations that qualify for licensed professionals continuing education contact hours. Those receiving approved contact hours may include nurses, social workers, speech language pathologists, audiologists, pharmacists, pharmacy technicians, x-ray technicians, early childhood workers and other interested persons. Certificates are provided to participants as proof of their attendance, Each participant is responsible for individual records to present to his/her professional board when audited. The Commission for Children with Special Health Care Needs maintains status as an approved provider of nursing contact hours and follows 201 KAR 20:220 (Nursing Continuing Education Provider Approval). Beginning January 2007, each approval period will last for a five (5) year period.Approval from other professional boards is obtained by submitting an application for each presentation to each professional board for their approval. If approved, the approval letter is placed in the file for the individual presentation and the number of contact hours approved by the particular board is listed on the certificate of attendance.
	Access Restrictions	KRS 61.878 (1)(a) -Personal info and SS number. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain:Evaluation of - content, speakers, facility for conferences; copy of handouts given at presentations (if applicable); copies of communications to speakers and other agencies involved in producing the conference; sample certificates; programs and master content outline/objectives; participant roster of all Registered Nurses, Licensed Practical Nurses, and others attending conferences with social security numbers and Professional License Number (Kentucky) based on sign-in sheets containing names, addresses, agencies and license/certification numbers and Social Security numbers
	Retention and Disposition	Retain in Agency for twelve (12) years; destroy after audit.

Series	Records Title and Description	Function and Use
03251	**Early Hearing Detection and Intervention Program**	This series documents infants who have a risk of hearing impairment. Data is compiled by the Commission for Children with Special Health Care Needs by receiving Hearing Screen Reports from birthing hospitals in Kentucky that identify infants that refer on the physiologic hearing screening prior to discharge, not tested, or have a risk indicator for late onset or progressive hearing loss. The data is transferred electronically from the birthing hospital into the Computer Utilization Project (CUP). Some hospitals provide a paper copy to the Commission for Children with Special Health Care Needs which is manually entered into CUP. The data is used to develop statistical information, compile reports, disseminate information to families, provide follow-up to families, and for surveillance and tracking.Monthly, semi-annual and annual reports of aggregate data are compiled and may be sent or shared with the following: Early Childhood Appointing Authority; Kentucky Commission on Deaf or Hard of Hearing; Federal grant statistical data; Directors of Speech and Hearing Programs in State Health and Welfare Agencies.
	Access Restrictions	KRS 200.490,KRS 68.878 (1)(a) and HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series contains:This series may contain:Name of child; date-of-birth; sex; birth hospital; county; physician; parents name and address; hearing screen report results; risk factor checklist; scheduled appointments and if seen; the results, correspondence between staff and families.
	Retention and Disposition	Retain in Agency for three (3) years; destroy paper copies and discharge inactive information in the Computer Utilization Project.
03252	**Hearing Conservation Program File**	This series documents the hearing results of students being retested after an initial test has been done by the school system, health department, or trained volunteer. A referral letter is sent to parents by the school system requesting a follow-up evaluation or screening. Physicians or audiologist may retest, if necessary, if the child has failed the screening. If medical aid is desired, the parents make an application to the Handicapped Children Program, or pursue private means. The series maintains the names and results of the retesting services that are provided for the school systems. The students who are in need of further evaluation or medical intervention are sent letters by the schools.
	Access Restrictions	Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Name of student; school attending; date retested; results of the hearing retest and tympanometry screening; if student was referred for further intervention; name of tester; referral letter (E-8).
	Retention and Disposition	Retain in Agency for two (2) years; destroy.
03254	**Speech and Hearing Reports - Non-Medical**	This series documents original speech-language evaluation reports, treatment plan reports and audiological evaluation reports filed in the patient record. The summary notes regarding these reports are placed in the Computer Utilization Project (also known as "CUP"). Speech therapy progress notes are also documented in CUP after each therapy visit and the paper copies are kept in the patient file for planning and treatment purposes. All Speech and Hearing patient records are kept in the Treatment Center as these patients are not enrolled in the Commission for Children with Special Health Care Needs medical clinics.
	Access Restrictions	KRS 200.490 and HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Speech, language and voice evaluation; speech therapy logs; hearing evaluations; intake/eligibility documentation (application, financial form, insurance verification, authorization for treatment, correspondence, acceptance or non-acceptance into the program), HIPAA privacy notice
	Retention and Disposition	Retain in Agency seven (7) years after child reaches the age of majority (21); destroy.

Series	Records Title and Description	Function and Use
03253	**Speech and Hearing Reports - Medical**	This series represents records of patients who receive speech therapy. The series contains sufficient information to clearly identify the patient, to support the diagnosis, and justify treatment based on speech-language evaluation reports, audiological evaluation reports, and treatment plans. Original speech-language evaluation reports, treatment plan reports, and audiological evaluation reports are filed in the Clients Medical File (series 03246) with summary notes regarding these reports placed in the Computer Utilization Program (CUP). Speech therapy progress notes are documented in CUP after each therapy visit and paper copies of these notes are kept within this series for planning and treatment purposes.
	Access Restrictions	KRS 200.490, KRS 68.878 (1) (a). Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: speech; language; voice evaluations; speech therapy logs; hearing evaluations; hearing aid evaluations; hearing aid check reports
	Retention and Disposition	Retain in Agency for five (5) years after last date of service; destroy.
03258	**Patient Progress File - Physical Therapy**	This series documents the physical therapy history of clients for Commission for Children with Special Health Care Needs, including a physical therapy evaluation. The physical therapy history consists of each psical therapy visit, the beginning date, progress, dates of therapy, length of therapy and frequency. The physical therapy evaluation consists of a patient history, diagnoses, neuromuscular status, all pertinent tests, assessments, goals and plan of treatment. Length of therapy is individualized for each patient and determined by the doctors orders and goals to be achieved. A physician referral is required prior to every evaluation including patients who were previously seen by physical therapy and discharged. The prescription can be written for evaluation and/or treatment or specify a treatment area to be addressed. Copies may be kept at the treatment center to document patients progress or for insurance purposes. Original records are placed in the Clients Medical Record (series 03246) by discharge.Each physical therapy visit is documented in the Computer Utilization Project (CUP).
	Access Restrictions	KRS 200.490; KRS 68.878 (1) (a); HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Patients name; Date of birth; parents; address; authorization for physical therapy; diagnosis; referring physician; date of referral; records of therapy at each visit; changes in progress
	Retention and Disposition	Retain in Agency five (5) years after last date of service; destroy.
03260	**Wheelchair Prescription File**	This series documents the necessary information that a vendor needs to bid on a wheelchair. In the event that the child is not covered by insurance or the insurance does not cover the cost of the wheelchair or only a portion of the cost, a wheelchair may be put out on bid. The child will need to have the wheelchair ordered by their physician in the clinic and must be seen by a physical therapist for an evaluation. A physical therapist will need to complete the wheelchair evaluation form. The form describes the childs posture, medical condition, type of chair required, modifications required on the chair, and any other pertinent information. Copies of the form are attached to each bid and sent out to all the vendors on the Commissions bid list, which consists of vendors in that particular geographic area from which the chair is being ordered. Bids are sent out through the Providers Relations Branch at the Commission. Once the bid is awarded, that vendor must meet with patient, family, and therapist to re-measure the patient and at that time the wheelchair is ordered. Payment is made when the wheelchair has been delivered to the patient and is determined to fit appropriately.
	Access Restrictions	Agencies should consult legal counsel regarding open records matters.
	Contents	Series may contain: Request for Equipment Form; clients name; date; age; address; diagnosis; name of referral and plan treatment; physician; motor control (head control, trunk and hip control, leg control, functional activities); environment (means of transportation, home, classroom, school, child has (not) ability to lift or maneuver wheelchair); childs measurements; accessories and attachments (head support, lateral trunk supports, back modifications, seat modifications, arm supports, leg rests, foot rests, miscellaneous, basic chair needs); specific brand of chair; physical therapists signature and phone number.
	Retention and Disposition	Retain in Agency for two (2) years; destroy.

Series	Records Title and Description	Function and Use
03261	**Patient Progress File - Occupational Therapy**	This series documents occupational therapy progress, dates of therapy, when it begins, length of therapy and frequency for clients of the Commission for Children with Special Health Care Needs. Also included in this series are a brief medical history, diagnoses, neuromuscular status, skill level, and plan of treatment. The plan of treatment consists of prognosis, amount of time seen per visit, and times to be seen per week or month. Length of therapy varies and is determined by progress of patient, a one time visit for splint fabrication or if the patient has had surgery. Should a patient plateau in therapy for an extended period, therapy is discontinued until another physician referral is made due to parental request or change in patients functional status. The Commission for Children with Special Health Care Needs requires a written prescription for occupational therapy with the physicians signature. Each patient visit is also documented in the Computer Utilization Project (CUP). The originals records are placed in Clients Medical Record (03246) by discharge.
	Access Restrictions	KRS 200.490; KRS 68.878 (1) (a); HIPAA. Agencies should consult legal counsel regarding open records matters.
	Contents	Series contains: name; Occupational Therapy Evaluations; Treatment Plans, Therapy Progress Notes diagnosis; patients name; parents; address; date of birth; referring physician; date of referral; date of visits
	Retention and Disposition	Retain in Agency five (5) years after last date of service; destroy.

Electronic System With Included Records Series

Cabinet for Health and Family Services

Department for Public Health

Children with Special Health Care Needs, Office for

System Description: A web-based data entry system designed to be accessed by CCSHCN staff across the state to allow continuity of care for patients. NOTE: The following series are exclusively contained in CUP - 05770 and 03251. CUP contains a portion of data making up the following series - 03204, 03246, 03253, 03254, 03255, 03258 and 03261. These series have information that may be found in CUP such as demographic data but the hardcopy record needs to be retained - 03247 and 05762. Series 03247 and 03255 are the only permanent records. They are preserved in a paper format in the agency.

System Contents: Patient/contact finder, clinic finder, International Classification of Diseases, Ninth edition, Clinical Modification (ICD-9-CM) look up, patient demographics, notes, social history, insurance, services, appointments, transition milestones, hemophillia data, early hearing and detection results, diagnoses, financial, hearing tests, dental information, medications, images, contact and contracting information for physicians and providers, ICD-9 coding, clinic dates and locations, appointments, medical alerts, insurance infor., social data. It also includes a message and tasking system.

Gen. Schedule Items:

System Title: **Computer Utilization Project** Alternate Title: **CUP**

Series #	*Series Title:*	*Disposition Instructions:*
03204	Patients' Statement of Account	Retain in Agency five (5) years; destroy after audit.
03246	Client's Medical Record	Retain in Agency for seven (7) years after the child reaches the age of majority (21) and audit. Destroy.
03247	Kardex File of Patients	Retain permanently in agency.
03251	Early Hearing Detection and Intervention Program	Retain in Agency for three (3) years; destroy paper copies and discharge inactive information in the Computer Utilization Project.
03253	Speech and Hearing Reports - Medical	Retain in Agency for five (5) years after last date of service; destroy.
03254	Speech and Hearing Reports - Non-Medical	Retain in Agency seven (7) years after child reaches the age of majority (21); destroy.
03258	Patient Progress File - Physical Therapy	Retain in Agency five (5) years after last date of service; destroy.
03261	Patient Progress File - Occupational Therapy	Retain in Agency five (5) years after last date of service; destroy.
05762	Clinic Service Slip	Retain in Agency for four (4) years; destroy after audit.