
Series: Operating Procedures COA: RPM
7.01, 7.02, 7.03, 7.04, 7.05, CM 8, FPS 9

Procedure Name: Documentation

Procedure Number: OP BC 1008

Revision #/Date: (1)11/12/2012, (2) 6/26/2017, (3) 03/12/2021,
(4) 3/23/2026

Effective Date: 01/15/09, 3/23/2026

Applicable to: Family Partnerships of Central Florida Staff

SUBJECT: Program Procedure for Documentation

PURPOSE: To outline FPOCF procedure for the documentation of activities with families served at CARES. To outline the protocols and steps to be taken by the FPOCF staff to ensure the proper application of this procedure and ,to meet our its commitment to care for families using the strength-based wraparound principles of care. FPOCF staff will ensure clear, ongoing communication and understanding that all contacts with clients, service providers, and other involved parties be documented in the client's file.

PROCEDURE:

References:

Operating Procedures: OP BC 1001, OP BC 1002, OP BC 1004, OP BC 1005, OP BC 1006, OP BC 1012, OP BC 1026, OP BC 1034, OP BC 1040, OP BC 1047, OP BC 1045

FL Statutes 839.13, 39

Case Record Guideline and Best Practice Standards

FPOCF maintains an electronic case record for each family served. Case records comply with all legal requirements and contain information necessary to provide services. In addition, FPOCF complies with the following case record guidelines and best practice standards related to documentation of case elements:

1. All decisions made regarding case closure or redirection, along with the rationale for the decisions reached, are clearly documented in the case record in the identified database.
2. All decisions made regarding services and compliance are clearly documented.

3. All contact with clients, including telephone conversations and visits are clearly documented.
4. Case records contain all essential legal and medical information as applicable such as psychological, psychiatric, and medical or other evaluations deemed necessary and appropriate for families.
5. Any applicable court reports or documents of guardianship or legal custody, power of attorney or legal directives related to the service being provided.
6. Recording should be accomplished no later than 48 hours of the activity.
7. Documentation includes:
 - a. Demographic and contact information
 - b. The reason for requesting or being referred for services
 - c. Up-to-date assessments
 - d. The service plan (Care Plan) including mutually developed goals and objectives
 - e. Copies of all signed consent forms
 - f. A description of services provided directly or by referral
 - g. Routine documentation of ongoing services
 - h. Documentation of regular supervisory reviews
 - i. Discharge, transition or after care plan
 - j. Recommendations for ongoing and/or future service needs and assignment of aftercare or follow up responsibility
 - k. A discharge summary entered within 30 days of termination of services
 - l. Case chronological information that includes:
 - Who was present
 - Where the meeting and contact occurred
 - Type of contact
 - The nature of the meeting and content of discussion
 - Date and time of meeting/contact
8. Among the activities that should be documented include:

- a. The Strength and Cultural Discovery
 - b. The family vision statement
 - c. The safety plan and/or crisis plan if applicable
 - d. The care plan
 - e. All releases of information that were executed
 - f. Signed HIPAA forms
 - g. All necessary consent forms
 - h. Team member sign in
 - i. Satisfaction surveys
 - j. Wraparound Observation Form, if applicable
9. There should be evidence of contact with families, at a minimum, every 30 days and Family Team Conferences held based on family acuity but no less frequent than every 30 days/more frequently based on case track and monthly evidence of contact with team members to ensure the plan is progressing and tasks assigned are being fulfilled. Contact with families should also be received via weekly or monthly progress reports received from the informal or formal service providers working with the family.
10. Any persons who knowingly falsifies, alters, destroys, defaces, overwrites, removes, or discards an official record relating to an individual in the care and custody of a state agency, which act has the potential to detrimentally affect the health, safety, or welfare of that individual, commits a felony of the third degree as defined by laws in the state of Florida.

BY DIRECTION OF THE PRESIDENT AND
CHIEF EXECUTIVE OFFICER:



PHILIP J. SCARPELLI
President and Chief Executive Officer
Family Partnerships of Central Florida

APPROVAL DATE: March 26, 2026