Med-Heart Sample Policies and Procedures

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# Procedure: Acceptance, safeguarding and distributing client mail

**Rationale:** Without a physical address, homeless clients do not have a way to receive important documents through the mail. A procedure was developed to reduce this barrier and allow staff to receive mail on behalf of the client. The mail is stored securely and held intact by the Program Director. Care Coordinators give the mail to clients when they meet for appointments and obtain a “Receipt of Tangible Goods” form.

**Purpose:** To establish a procedure for accepting, safeguarding, and distributing client mail.

It may sometimes be necessary to allow clients to have their important documents sent to PHNTX. This can reduce barriers to care and assist in successful care coordination and is important for clients who are homeless and/or in unstable housing situations and need to receive critical documents. In such cases, clients may arrange with their Community and Client Services care provider to have specific mail sent to PHNTX.

1. **PHNTX will only agree to accept *critical documents* on behalf of the client. These may include:**
* Birth certificates,
* Government issued identification,
* LoneStar assistance cards,
* Section 8 award waitlist notifications, etc.
1. **Community and Client Services staff providing direct services to the client will:**
2. Assess why PHNTX should accept the client’s mail.
3. Inform clients of alternative mail delivery options:
* USPS – general delivery
* UPS – hold for pickup
* The Stewpot
1. Inform clients about the type of mail that will be accepted by the agency.
2. Ensure that the client receives the necessary instructions and signs the requisite form which will be maintained in the client’s chart. **See below.**
3. Inform the client that mail to be accepted by the agency should be addressed as follows:

***Client Name***

***[Organization’s Address]***

1. Inform the Office Support Specialist that mail will be arriving for the client by completing the requisite form.
2. Obtain the mail received by the Office Support Specialist and comply with the requisite process for receipt:

a) Leave mail unopened,

b) Complete a Receipt for Tangible Goods form for the piece(s) of mail in the mail category noting the number of pieces of mail for that date, and photocopy the envelope(s) of the mail and attach to the Receipt for Tangible Goods form.

c) Have client sign the Receipt for Tangible Goods form.

d) File the form in the client’s record.

**IV. The Office Support Specialist will:**

a) Ensure that the list of client names approved to receive mail is maintained in a secure location.

b) Ensure that mail is delivered to the Community and Client Services staff member who signed for the client.

All staff will immediately report problems with accepting client mail to the CPO.

# AGREEMENT TO ACCEPT CLIENT MAIL

|  |  |  |
| --- | --- | --- |
| **Client Initials** | **Terms of Agreement** | **Comments** |
|  | I understand that Prism Health North Texas (PHNTX ) will accept only *critical documents* on behalf of clients. These may include:* Birth certificates,
* Government issued identification,
* LoneStar assistance cards,
* Correspondence from Housing provider
 |  |
|  | I understand that mail must be addressed as follows:*Client name* *[Organization’s Address]* |  |
|  | I understand that I must inform the PHNTX staff with whom I work about possible delivery of a critical document. |  |
|  | I understand that PHNTX retains the right to refuse to accept mail addressed to me but will be responsible for giving me the reason for refusal. |  |
|  | I understand that I must pick up my mail within 10 business days of being informed that the mail was received by PHNTX. |  |

* I understand that PHNTX will keep my mail in a secure space, but will not be responsible in the event that it is damaged in a disaster such as a flood, fire, tornado, etc. or it is stolen.

***\_\_\_\_\_\_\_ (client initial).***

* I understand that I can only get my mail received by PHNTX, at [Organization’s Address] during regular PHNTX business hours (Monday-Friday 8 a.m. to 12 noon and 1 p.m. to 5 p.m.). It will not be available on holidays, weekends or if the Agency is closed for **any** reason, such as weather.

***\_\_\_\_\_\_\_ (client initial)***

**[Client/Staff signatures and date]**

# Procedure: Client complaints

**Rationale:** Clients have the right to file a grievance if they believe that they are not receiving appropriate care and services.

**Purpose:**  To establish procedures for clients to provide feedback and voice their concerns.

The following is provided to every client:

CLIENT COMPLAINT PROCEDURE

PHNTX wants to give you high quality services. If you feel that you were given bad or poor service, PHNTX has a process for you to make a complaint. We hope that you do not have a problem with services you get at PHNTX but if you do please take the steps below, so that we may help solve it quickly.

1. Discuss the problem with your Care Coordinator and try to resolve it together.

2. If the problem remains, call 214-XXX-XXXX and ask to speak to the Health, Hope, and Recovery program director. Explain the problem to him/her. If you leave a message, make sure to give your phone number.

3. If the problem is still not resolved, contact the Chief Program Officer at 214-XXX-XXXX and explain the problem. If you leave a message, make sure to give your phone number.

4. If you are not pleased with the results, state your problem in a letter to:

*Chief Operating Officer*

*Prism Health North Texas*

*[Organization Address]*

Make sure to give your phone number. Our Chief Operating Officer will call you to discuss how the problem may be resolved.

We shall make every effort to address your problem. If you make a complaint, it will not have a bad or negative impact on how we serve you in the future.

# PATH Home Referral and Linkage

**PURPOSE:** To establish a process for identifying, referring and linkage multiply diagnosed HIV positive individuals to the PATH Medical Home Model.

**POLICY:** Through this 5 year SPNS/HRSA Demonstration Project, “Building a Medical Home for Multiply Diagnosed HIV+ Homeless Populations”, UF CARES in collaboration with River Region will develop a Medical Home Model for patients who are homeless or unstably housed.

Patients will be identified, referred and linked into comprehensive medical care and provided assistance with housing and other services through intensive case management and referral to an on-site clinic within a housing complex.

As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

# PROCEDURE: Clinic Flow

1. PATH staffing occurs on the 1st and 3rd Thursday of each month from 0830-0930 at UF CARES.

2. PATH clinic occurs the 2nd and 4th Thursday of each month from 1300-1700 at RRHS.

3. PATH schedule is finalized and the MCM (Medical Case Manager) distributes it to clinic staff members at staffing.

4. UF CARES MA (Medical Assistant) pre-processes all scheduled clients for multi-disciplinary staffing.

5. PCP (Primary Care Physician) and Mental Health referrals/appointments are identified.

6. Rooms for clinic are designated based on number of services being provided to ensure clinic flow by RRHS Director of Nursing.

7. Medical Case Manager faxes a copy of the medication list, labs and problem list to RRHS Medical Department for any new PC (Primary Care) clients prior to clinic.

8. Within 24 – 48 hours prior to clinic, clients will be contacted by the Peer Navigators for appointment reminders and to facilitate transportation to and from clinic.

9. The day of clinic all clients check in 15 minutes before their appointment at the main entrance of RRHS and are seen by the Director of Intakes and Admissions.

10. RRHS staff escort PATH clients to the UF Cares Patient Navigator and they are checked in for the clinic. They are then seated in the PC waiting room.

11. Clients check in with the Medical Assistants and have their vital signs, laboratory work and HAM-D (Hamilton Depression Rating Scale) completed. Clients remain in the PC waiting room after their MA triage.

12. MA’s place completed charts in the appropriate rack for PCP or Specialty appointments.

13. MA’s room the clients for PCP or Specialty appointments ensuring that both exam rooms are occupied.

14. While clients are waiting to be seen by PCP or Specialty appointments, the clients meet with other disciplines. The other disciplines notify the MA’s and sign the log sheet if they take the client out of the PC waiting room. Clients are also offered lunch and hygiene items while they wait.

15. Following PCP and or Specialty appointments, clients meet with the Medical Case Manager and Comprehensive Case Manager.

16. Clients receive follow-up PC appointments from RRHS staff members.

17. Clients are checked out from their appointments and clients receive follow-up Specialty appointments from the Medical Case Manager.

# Multnomah County HIV Clinic Staff Debrief Guidelines

Last updated: 3/21/17

**Purpose**

The purpose of this framework is to provide guidance and considerations for HSC staff when initiating, participating in, or following-up on a formal debrief. The intention of a formal debrief is to provide a safe space to process a crisis or traumatic event and create a plan for the future for support as well as to learn and develop best practices from these type of occurrences.

**Framework**

According to SAMHSA’s concept of a trauma-informed approach,

“A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread impact of trauma and understands potential paths for recovery;
2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

In the interest of creating a trauma-informed framework, this definition will be used as the framework for this procedure.

**Realize** the widespread impact of trauma and understands potential paths for recovery

* Staff training
	+ HSC will maintain commitment to ongoing training for staff (both all staff and for specific role groups as appropriate)
	+ HSC will conduct a regular staff survey to track staff perceptions about trauma, trauma-informed care, and healing as well as to identify training needs and clinic progress
* HSC Trauma Informed Care committee (TIC Talk)- The clinic’s internal trauma-informed care committee will continue meeting monthly to identify and implement trauma informed practices to improve patient care and support HSC staff.

**Recognize**

* Shared language related to trauma and healing
	+ Assist staff in becoming familiar with trauma-informed terminology (see Trauma & Healing Workgroup Definitions 11-9-15)
	+ Have shared terminology for identifying need/desire for a debrief
* Identifying possible signs of a traumatic response

|  |  |
| --- | --- |
| * + Eating disturbances (more or less than usual)
	+ Sleep disturbances (more or less than usual)
	+ Low energy
	+ Depression, spontaneous crying, despair and hopelessness
	+ Anxiety
	+ Fearfulness
	+ Irritability, anger and resentment
	+ Emotional numbness
 | * + Guilt feelings
	+ Grief reactions
	+ Memory lapses, especially about the trauma
	+ Difficulty making decisions
	+ Decreased ability to concentrate
	+ Feeling distracted
	+ Intrusive thoughts
	+ Withdrawal from normal routine and relationships
 |

**Respond**

* Immediate planning
	+ When a supervisor recognizes or is notified by staff about a possible traumatic response or event, they will assist in determining best short-term plan to ensure staff and client(s) impacted by crisis have adequate and necessary support and resources. Each plan developed by supervisor and staff will be specific to the unique situation and staff/client(s) impacted. Plans could include but are not limited to:
		- Taking a “breather” break in a quiet/calm space or going on a short walk around the building
		- Connecting with another support person
		- Arranging for transportation
		- Having another staff work with the involved patient
		- Taking time off
		- Informal check-in or case consultation to discuss incident and follow-up plan
	+ Supervisor and staff will determine if formal debrief needs to occur.
	+ Supervisor will determine who else needs to know about crisis and plan and communicate with minimal staff necessary.
* Initiating a formal debrief
	+ What is a formal debrief?
		- A specific time/space set aside to discuss what happened, how staff/clients were impacted, what worked/didn’t work during event, what follow-up is needed
		- A formal debrief typically includes the supervisor and staff who have been impacted by crisis or traumatic event
	+ Any staff person can initiate a formal debrief by informing supervisor that debrief is needed
	+ Goal is to have the debrief as soon after the event as is possible. This will depend on situation and how many staff are impacted. Supervisors will work with staff to identify appropriate time and assist with coverage plan to support staff to attend.
	+ Supervisor will find space to hold debrief that maintains confidentiality and avoids including staff not aware/impacted by event
* Holding a formal debrief meeting
	+ Identify someone to gently facilitate debrief (ideally not someone impacted by traumatic event)
	+ Identify someone to take notes of any action/follow-up items
	+ Potential questions to consider/discuss during debrief. This will depend on who/how many people participating in debrief.
		- What happened? Brief facts
		- What were your first thoughts?
		- What is the worst thing about this event for you?
		- What symptoms are you experiencing?
		- What can we do to help you feel whole?
		- What went well?
		- What could have been improved or done differently?
* Documentation
	+ Use debrief notes template
	+ Debrief notetaker will be sure to record the following:
		- Brief description of event (date, staff involved, MRN of any clients involved)
		- What worked and what could have been done differently during event
		- Follow-up plan and who will be responsible for ensuring these action item(s) happen and when
	+ Supervisor will determine if Incident Report form needs to be completed
	+ As appropriate depending on situation, supervisor will notify All Staff via email to acknowledge that an event occurred (without details) and that debrief did/will occur and that follow-up communication will happen with anything all staff needs to know as well as any lessons learned
	+ Following formal debrief, supervisor will send email to those involved in debrief that includes follow-up plan

**Resist Re-Traumatization**

* Formal debrief follow-up
	+ Debrief follow-up plan- Each debrief will have a follow-up plan of any action items identified that includes who will be responsible for ensuring these things happen and by when (ex: supervisor will check-in with staff member tomorrow to ensure they contacted EAP)
	+ Documentation- All debrief notes will be collected and retained by clinic manager for later review and to note any patterns and/or lessons learned
	+ Clinic manager (and clinic management team as appropriate) will review debrief notes to identify if any systemic issues and/or policies contributed to situation and determine next steps to address these issues.
* Resources
	+ Benefits offered by Multnomah County
		- Employee Assistance Program- offered through Reliant Behavioral Health and includes 6 free counseling visits per issue per year and a 24/7 Crisis Line (866-750-1327). More info can be found at: <https://commons.multco.us/employee-benefits/news/new-employee-assistance-program-eap>
		- Massage- Most County health plans offer massage benefits and weekly onsite massage is available in the McCoy building.
		- Fitness- The Multnomah County Wellness Program operates two large employee Wellness Fitness Centers and offer a range of high to low impact worksite fitness classes.
		- Mindfulness- Soon to be offered onsite at McCoy are regular mindfulness practice sessions by Hun Taing, the Health Department’s Trauma and Healing Coordinator
		- Trainings- The County offers several workshops that staff can register for using the Online Training Calendar. This includes Practicing Mindfulness in the Workplace, Compassionate Communication, and an annual Trauma-Informed Learning Series.
	+ Other Resources
		- Trauma Informed Oregon- a statewide collaborative aimed, in part, at promoting and sustaining trauma informed practices to support wellness and resilience. Includes resources for individuals here: <http://traumainformedoregon.org/resources/resources-individuals-families/>
		- JBS International Trauma-Informed Resources- over 20 self-care resources and mobile apps that provide self-help, education, and support for those who have experienced trauma and for those who work with traumatized individuals at <http://trauma.jbsinternational.com/traumatool/Module3Resources.html#Self-Care>
	+ TIC Talk will continue development of a resource binder for staff that can be used during debrief or any needed time

# Debrief Meeting Form

Debrief meeting date:

Debrief recorder:

Debrief attendees:

Event Details

|  |  |
| --- | --- |
| Date of event |  |
| Brief description of event |  |
| MRNs of any clients involved during event |  |
| Staff impacted by event |  |
| Supervisor(s) involved during event |  |
| What worked well during event? |  |
| What could have been done better during event? |  |
| Follow-up Plan & Action Items | Who is Responsible? | When will this happen? |
|  |  |  |
|  |  |  |
|  |  |  |

Incident Report Completed? Y N

# Crisis Intervention Plan

Early Warning signs that I may need assistance:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When I have any of these early warning signs I will:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Things that support person can do to help:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resources available to help (Names and contact numbers):

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In case of Emergency call 911

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
|  **Family Health Centers of San Diego**  **Mental Health Services** LOGAN HEIGHTS FAMILY COUNSELING CENTER  LOGAN HEIGHTS FAMILY HEALTH CENTER **** NORTH PARK FAMILY HEALTH CENTER **** EAST COUNTY FAMILY COUNSELING CENTER CITY HEIGHTS FAMILY HEALTH CENTER**** BEACH AREA FAMILY HEALTH CENTER**** SPRING VALLEY ELEMENTARY COUNSELING CENTER**** DIAMOND FAMILY HEALTH CENTER**** CHULA VISTA FAMILY HEALTH CENTER | **Patient Identification** |

Client Signature Date Provider Signature Date

# Disruptive Behavior Client Agreement

Disruptive behavior is defined as any behavior which is inconsistent with PHNTX, policies that may compromise the integrity of the program or the safety of staff, clients and others. Such behavior may include but is not limited to the following:

* Verbal abuse including profanity, aggression, threats, and disrespect.
* Physical abuse including harm or intent to harm.
* Emotional abuse including name calling and belittling.
* Sexual abuse including elicitation or solicitation of a sexual nature or sexual overture/innuendo.
* Possession of illegal substances and/or drug paraphernalia, as well as presenting under the influence and/or in an altered state.
* Possession of an unlawful/unauthorized handgun or other lethal weapons.
* Exhibiting behaviors that promote a negative atmosphere including unnecessary or excessive phone calls, email and other forms of communication.

PHNTX has a zero tolerance policy with regard to disruptive behavior. If staff observes or experiences any of the above behaviors, the following actions will be taken:

1. Verbal warning by the staff that is present and the staff’s supervisor.
2. Written warning by the staff member and the staff’s supervisor.
3. Possible temporary/permanent suspension/dismissal from PHNTXPHNTX services with a referral/referrals to another agency. This action will involve communication and guidance from the Chief Program Officer.

The following will result in non-negotiable immediate and permanent dismissal from PHNTX’s services as follows:

1. Physical abuse including but not limited to punching, pushing, slapping, beating, and/or physically touching any PHNTX staff member in an abusive and aggressive manner.
2. Sexual abuse including but not limited to sexually suggestive touching, groping, fondling or exposing one’s self.

By signing, you agree to the above procedures and indicate a clear understanding of PHNTX zero tolerance policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHNTX Staff Signature Date

# Procedure: Distribution of Pre-Paid Cell Phones and Minutes

**Rationale:**  Homeless clients do not have a way for their providers to contact them. To address this concern, prepaid cell phones are given to clients when necessary so that they may be contacted more reliably and thus improve communication and attendance at appointments.

Purpose: To provide guidance regarding the distribution of Pre-Paid Cell Phones and Minutes

* Pre-paid cell phones will be provided to Health, Hope, and Recovery clients who are not eligible for Federal Lifeline Assistance.
* Pre-paid cell phones will be provided with a SIM card and a $20 pre-paid top-up card.
* Clients will be required to sign an Acknowledgement of Receipt form for each pre-paid cell phone and $20 pre-paid top up card.
* Clients are eligible to receive a $20 pre-paid top-up card every 30 days. For extenuating circumstances, such as client hospitalization, job interviews etc., Care Coordinators may advocate for additional minutes with Program Director. Client may only receive additional minutes per 30 day period once every year.
* If a client is out of contact during the 30 days following receipt of a pre-paid cell phone and/ or $20 pre-paid top-up card client will not be eligible for additional minutes until client meets with Care Coordinator.
* In the event that a pre-paid cell phone is lost or stolen, a client is eligible to receive one replacement pre-paid cell phone during enrollment in the Health, Hope, and Recovery program.
* Provision of pre-paid cell phones and $20 pre-paid top up cards to each client will be tracked for outcome measures by the Health, Hope, and Recovery Program Director.

# Procedure: Documentation Replacement Assistance

**Rationale:** Homeless clients often present without the requisite documentation to enroll them in critical services which is a significant barrier to care. In addition they do not have the financial resources to pay the fees to obtain documents such as state IDs , driver’s license, or birth certificates have costs. To overcome this barrier, Care Coordinators work with the clients to obtain the documents.

**Purpose:** To provide guidance regarding providing Documentation Replacement Assistance.

* Documentation replacement assistance will be provided for up to two documents per year.
* Documentation replacement assistance will be provided for clients who do not qualify for assistance from The Stewpot.
* Clients will be required to sign a Documentation Assistance Request form.
* Care Coordinators will provide a receipt to the Program Director which will be filed with the Documentation Assistance Request form.
* Expedited requests require a justification from the Care Coordinator which will be staffed with the Program Director. Expedited requests will be considered on a case by case basis and are not guaranteed.
* Provision of Documentation Replacement Assistance to each client will be tracked by the Program Director of Health, Hope and Recovery.

# Procedure: Financial Assistance for Emergency Housing

**Rationale:** PHNTXrecognizes that some clients are shelter resistant due to personal safety or medical conditions and has developed a process to provide emergency housing for up 6 weeks in local motels for those with a valid basis for being shelter resistant, those needing medical respite, and most commonly, those whose housing is imminent and need to learn how to be housed.

**Purpose:** To provide guidance regarding providing financial assistance for emergency housing.

Initial Client eligibility requirements for Financial Assistance for Emergency Housing:

* All clients must be on a housing waitlist prior to receiving Financial Assistance for Emergency Housing or have an identified income source that will sustain permanent housing.
* Clients must provide a copy of a birth certificate, social security card, Texas Driver’s License or Texas State ID Card to their Care Coordinator to facilitate placement in permanent housing.
* Care Coordinators must complete an Emergency Housing Financial Request form detailing the need for the assistance as well as the plan of action during and after the period that the client receives Financial Assistance for Emergency Housing. The Emergency Financial Request form must explain why the client cannot utilize local emergency shelters.

Continued Client Eligibility requirements for Financial Assistance for Emergency Housing:

* Clients must meet with their Care Coordinator on a weekly basis in order to receive continued assistance.
* In order to verify funds are used appropriately, clients will abstain from allowing friends and/or family members to move into their motel room. If client has a spouse/partner, client and Care Coordinator will discuss appropriate provisions.

Management of Financial Assistance for Emergency Housing:

Care Coordinators will complete an initial Emergency Housing Financial Request form to document client’s current status, progress and barriers. The Program Director and Care Coordinator will review the Emergency Housing Financial Request weekly to complete ongoing assessments required to determine need for continued assistance.

* Clients will be able to receive financial assistance for emergency housing for a maximum of **six weeks.**
* Emergency housing payments will be processed weekly.
* Emergency housing assistance is to be paid directly to the motel or facility, ***not the client***.
* Clients will be eligible for Emergency Housing Assistance a maximum of twice per year.

# Home Visit Protocols

***General Description***

**Purpose**

The purpose of this policy is to meet the needs of community members who seek medical Case Management and find it difficult to attend a session at the coordinated services center or nearest FHCSD clinic.

**Policy**

Counseling sessions are held during regular clinic hours. There are times when home visits are preferred or necessary. A home visit is made for one of the following reasons:

A. Case Management interventions when the client is unable to come to the clinic.

B. Clinically necessary home visit to complete and assist medical Case Management services

C. Crisis intervention.

D. Individual is chronically disabled

E. Individual and or family have definite lack of transportation.

F. Facilitate an intake.

G. Special assistance requested by medical provider, program supervisor, and/or the client himself.

H. Home visit requests are determined on a case by case basis.

**Procedure**

Prior to any home visits, the location is researched, mapped out, and the program supervisor(s) is consulted in regards to the knowledge of the home situation, home location, any possible dangers, and to verify there are no other means for the client to complete the intervention.

The following rules are adhered to for home visits:

A. Staff utilizes common sense as to the safety of the visits.

B. Identification (badges) are worn at all times - no visits are to be made without them.

C. Staff, at all times, uphold the legal, ethical and moral standards of their professional role and adhere to all agency confidentiality/HIPAA guidelines.

D. For safety purposes home visits requires 2 FHCSD staff present at all times

E. Both FHCSD staffs are required to have a working cell phone in the case of an emergency.

F. All efforts are made to conduct the Medical Case Management session in a “community” room such as a living room, dining room, kitchen, etc.

G. If home visit take longer than 1(one) hour, Staff is required to check in with immediate supervisor**.**

# Housing : Process for Linking Clients to Home Model

**PURPOSE:** To establish a process for identifying, referring and linkage multiply diagnosed HIV positive individuals to the PATH Medical Home Model.

**POLICY:** Through this 5 year SPNS/HRSA Demonstration Project, “Building a Medical Home for Multiply Diagnosed HIV+ Homeless Populations”, UF CARES in collaboration with River Region will develop a Medical Home Model for patients who are homeless or unstably housed.

Patients will be identified, referred and linked into comprehensive medical care and provided assistance with housing and other services through intensive case management and referral to an on-site clinic within a housing complex.

As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

**PROCEDURE:**

1. Housing receives referral from UF Cares.
2. Initial attempt to contact client made within 72 hours by Comprehensive Case Manager. After two attempts, if unable to contact client, Medical Case Manager with be called for assistance. This will be within 5 business days of initial contact attempt.
3. When client is reached, appointment for intake with Comprehensive Case Manager will take place within 72 hours. Housing needs will be addressed at the time of intake.
	* 1. CCM will determine what programs client may be eligible for.
		2. CCM will immediately begin gathering copy of id/social security card, proof of homelessness, verification of disability, proof of income, and criminal history check.
		3. Literally homeless individuals are priority over unstably housed individuals.
4. If client chooses to look for housing on their own, they will be given two weeks to locate housing and make a decision.
5. If client would like assistance in locating housing, Comprehensive Case Manager will provide 3 options for housing and client will have 2 weeks to make a decision from these 3 options.
	* 1. CCM will refer and assist client to Coordinated Intake for housing assessment.
		2. CCM will follow up with client regarding suggestions from Coordinated Intake.
		3. CCM will refer client to RRHS HOPWA funded housing programs when appropriate, i.e., client is recommended for ALF, shared living, or is part of a family with children.
		4. CCM will assist client in looking for an unsubsidized apartment in the community if client does not qualify for subsidized housing.
6. If client is non-compliant with the timeframe given, Medical Case Manager will be contacted and advised letter is going out re: non-compliance.
7. Letter will give client two weeks from date of letter to contact CM.
8. If no contact from client in two weeks, client will be closed out.

# Procedure: Maintaining boundaries with clients and other external parties

**Purpose:** To clarify boundaries related to working with clients and community members. Boundaries refer to the lines that you must ***not*** cross when working with community members and/or clients as a representative of PHNTX. *All such individuals will be referred to as 'clients' for purposes of this Procedure.*

Solicitation of clients in any manner for services, goods or other business not related to PHNTX’ programs is grounds for immediate dismissal from employment. Any behavior that is exploitative, coercive or manipulative towards a client will not be tolerated and is cause for immediate disciplinary action or dismissal.

The following provides specific recommendations regarding maintaining clear boundaries when working with clients. In some instances you may need to use your judgment in making a decision; however it is imperative that you keep your supervisor apprised of the situation and obtain approval when necessary. ***Always discuss any questions that you have with your supervisor or the Chief Program Officer.***

Services

* Do ***not*** pick up food, bus passes, or any tangible item for clients unless the client is physically disabled, incapacitated, hospitalized or has no access to transportation. If this is required to fulfill programmatic needs, you will be given permission and specific guidance by your supervisor.
* In the event that you pick up tangible items, you must have the client sign a Tangible Items.

 Receipt Form (see attached).

* Never give a client food that is a ‘left-over’ or unpackaged.
* Never provide clients with cigarettes, alcohol, and/or any illegal substances.
* Do not allow clients to send items other than letters through the mail to the agency.
* Do not offer to hold items for client at the agency. If this is required to fulfill programmatic needs, you will be given permission and specific guidance by your supervisor.
* Discuss extenuating circumstances in advance with your supervisor.
* All items that are given to clients must be approved and should fall within Community and Client Services guidelines.

Transportation of clients

* Never transport a client ***under any*** circumstances

Relationships

* Do not date or engage in any sexual activities with clients.
* Do not provide services to a person you know personally. This might include, but is not limited to, current partners, ex-partners, relatives, friends, neighbors or co-workers. Whereas, there are situations in which a personal relationship may exist with a current client of the agency, it is imperative that you discuss this with your supervisor. It may be necessary to transfer the client's care to another staff person or supervisor.
* Always be discreet in social situations outside of the agency with any client currently receiving services from the agency. ***Never*** discuss any client issues or personal information with clients in a social gathering.
* Do not discuss client information in areas that are accessible to those who should not have access to the information such as in the lobby, elevators, parking lot, or any public area.
* Never accept services from a client.
* Use discretion with regard to eating/sharing meals with clients unless it is part of an approved activity. If it is imperative to do so, make sure that you attend to the professional task at hand.
* Never share cigarettes, alcohol or illicit substances with a client.
* Use extreme discretion when sharing personal information about yourself with the client.

Communication

* Do not give clients your ***personal*** cell phone or home number for any reason. If you are in a dangerous situation or lost while on a home visit, you may contact the client from your cell phone by using \*67 to block your number or you may set up a Google Voice phone number. If using Google Voice, you must follow program guidelines in regards to availability to answer Google Voice messages.
* Do not communicate with clients through social networking websites (i.e. Instagram, Facebook, Twitter, etc.). If this is required to fulfill programmatic needs, you will be given explicit permission and specific guidance by your supervisor after consulting with, and obtaining permission from the Chief Program Officer.

Gifts/Contractual Work

* Do not accept ***any*** gifts or gratuities from clients. A food item that is within reason (not extravagant), such as a small baked good, may be acceptable.
* Do not give gifts to clients unless they are endorsed by PHNTX; this includes tangible gifts including gift cards. If this is an approved programmatic activity, you must follow specific procedures defined by the program.
* Do not engage in contractual agreements (verbal or written) with clients that may include selling to clients, buying from clients, and/or accepting or giving a monetary loan. A contractual agreement may include but is not limited to the following:

 - Hiring a client or being hired to perform a service

 - Renting a room

 - Selling or purchasing goods such as vehicles or other items

 - Money exchange of any sort

There will always be circumstances outside these guidelines, please seek guidance from your supervisor regarding specific guidelines. Failure to follow this procedure may lead to disciplinary action up to termination.

# Procedure: Managing Situations in which Clients are Disruptive/Inappropriate

**Purpose:** To ensure safety of staff, clients and others in the vicinity

***Disruptive behavior*** is defined as any behavior which may compromise the integrity of the services we provide or the safety of staff, clients and others. Such behavior may include but is not limited to the following:

1. Verbal abuse including use of profanity or aggressive words, making threats, and being disrespectful.
2. Physical abuse including inflicting harm or intent to harm.
3. Emotional abuse including name calling and belittling.
4. Sexual abuse including elicitation or solicitation of a sexual nature or making sexual overtures/innuendos.
5. Possession of illegal substances and/or drug paraphernalia, presenting under the influence and/or in an altered state.
6. Possession of an unlawful/unauthorized handgun or other lethal weapons.
7. Behaviors that promote a negative atmosphere including unnecessary or excessive phone calls, emails and other forms of negative communication.

The following processes provide guidance regarding how you should manage client disruptive behavior:

Phone Calls:

When a client exhibits disruptive/inappropriate behavior over the phone follow these steps:

1. State to the client that the specific behavior is inappropriate and ask the client to stop the behavior. Example: “Your use of profanity and the tone of your voice is not appropriate and I ask that you stop.”
2. If the behavior continues, state to the client, “If you continue to speak to me in this way, I will need to end this conversation and we will talk again when we are able to communicate in a more productive manner.”
3. Should the phone call need to be ended because the behavior continues, state to the client, “I am going to end this phone call now and we will talk again when we are able to communicate in a more productive manner ***or*** when you are more calm. You may contact me but please wait for 24 hours.”
4. If the client continues to call during the ’24-hour period’, have the calls routed to your immediate supervisor or an available supervisor. (See front desk procedure)
5. Do not contact the client during the 24 hour cooling down period unless there is a true emergency.
6. After a phone incident set up an appointment with your immediate supervisor to debrief regarding what occurred and procedures to be followed in the future related to home visits/offsite visits and other relevant topics.

Home Visits/Offsite Visits - General:

When conducting a home visit/offsite visit, use the following procedure:

1. Always sit closest to an exit door and visualize a path between you and the exit.
2. Be aware of your surroundings.
3. Carry with you only a few items such as your case file and a pen, car keys, and cell phone; use one bag that allows you to carry all your items leaving your hands free.
4. Avoid parking in places that do not allow you to exit quickly. Pay close attention to prohibited parking.
5. Do not accept food or beverages from a client. There are instances when you may feel that it will offend the client if you refuse - use your best judgment and discretion.

Home Visits/Offsite Visits – Client Disruptive Behavior

If a client exhibits disruptive/inappropriate behavior during a home visit, follow these steps:

1. Attempt to redirect the behavior.
2. If the behavior continues, end the visit. Consider saying:
	1. “We are not making progress so I shall leave now; I’ll call to set up another appointment.”
	2. “We are having difficulty staying on track so I am going to end our visit and I will contact you soon to discuss the plan of care.”
3. After you end a home visit/offsite visit due to disruptive/inappropriate behavior, schedule an appointment with your supervisor to debrief regarding what occurred and procedures to be followed in the future related to home visits/offsite visits, and other relevant topics.
4. When you next make contact with your client, discuss the reason why you needed to end the home visit/offsite visit. Depending on the decision that was made regarding future home/offsite visits, tell the client that: a) if (s)he continues to be disruptive or inappropriate, you will not be able to see the client in the home or offsite but just in the office, ***or*** b) You will not be able to conduct home/off site visits and only see the client in the office.

Office Visits – Client Disruptive Behavior

If a client exhibits disruptive/inappropriate behavior during an office visit, follow these steps:

1. Attempt to redirect the behavior.
2. If the behavior continues, end the visit. Consider saying:
	1. “We are not making progress so I shall end our visit now.”
	2. “We are having difficulty staying on track so I am going to end our visit and I will contact you soon to discuss the plan of care.”

3) After you end an office visit due to disruptive/inappropriate behavior, schedule an appointment with your supervisor to debrief regarding what occurred and procedures to be followed in the future related to office visits, and other relevant topics.

4) When you next make contact with your client, discuss the reason why you needed to end the office visit. Make it clear that you will not tolerate the behavior in the future.

Front Desk Procedure

If a client is being verbally aggressive and/or harassing you or the front desk, take the following steps:

1. Inform the client that the employee asked for is unavailable at this time; (s)he may

a) leave a voice mail and wait for a return call, or

b) speak with the employee’s immediate supervisor.

For example, “I can tell that you need to talk to someone urgently; however, at this time, Ms. X- *name of employee* is not available. I can give you two options right now to help meet your immediate needs. You can leave a voicemail for Ms. X and I will also let her know you need to speak with her urgently, ***or*** you may speak with her supervisor and I shall locate her/him for you.”

1. If the client continues to call excessively and/or is verbally abusive, and the immediate supervisor is not available, ask client to hold so that you may find another supervisor or the Chief Program Officer.

Cell Phone Procedure

1. When calling a client from your cell phone, ***you must always*** utilize the \*67 function prior to dialing the number. This will block your cell phone number. For example, you would dial \*67-XXX-XXX-XXXX.
2. If the client gains access to your cell phone number and calls, at the very first encounter tell the client that agency policy prevents you from using your cell phone to talk to clients and that (s)he must only call the main PHNTX phone number to contact you.
3. Personal cell phone numbers/email addresses should ***not*** be given out to clients under any circumstances. Clients may use the PHNTX business line for professional communication.
4. If the client continues to contact you via your personal cell phone after you have told the client not to, inform your supervisor immediately. The supervisor will provide guidance regarding next steps.

# Co-Occurring Outpatient PATH Home Procedure

**PURPOSE:** To establish a process for identifying, referring and linkage multiply diagnosed HIV positive individuals to the PATH Medical Home Model.

**POLICY:** Through this 5 year SPNS/HRSA Demonstration Project, “Building a Medical Home for Multiply Diagnosed HIV+ Homeless Populations”, UF CARES in collaboration with River Region will develop a Medical Home Model for patients who are homeless or unstably housed.

Patients will be identified, referred and linked into comprehensive medical care and provided assistance with housing and other services through intensive case management and referral to an on-site clinic within a housing complex.

As part of the demonstration project, eligible patients may also participate in a multi-site evaluation study to evaluate models of care across nine other demonstration sites.

**PROCEDURE:**

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1. Counselor is contacted by PATH Housing Case Manager via telephone to schedule an assessment. Client is scheduled for the earliest available assessment slot for PATH clients (Monday and Thursday at 12 p.m.).
2. An email notification of an upcoming assessment, counseling appointment, and medication management appointment for all PATH clients is sent to PATH’s housing case manager and peer navigator one week prior to the appointment. This is completed weekly by the end of the week.
3. When an assessment is completed, a consultation request is forwarded to the Administrative Assistant for the Director of Medical Services to schedule a psychiatric evaluation within 24 hours of assessment completion.
4. The Administrative Assistant for the Director of Medical Services sends an email to counselor of upcoming scheduled psychiatric evaluations, which counselor forwards to PATH housing case manager. This is completed weekly by the end of the week.
5. A follow-up session is completed two weeks after assessment. Individual counseling is on a monthly basis (or more frequently based on clinical need).
6. Counselor attends PATH staffing on the first and third Thursday of the month and any PATH-related meetings as needed.
7. Counselor meets with clients who have missed appointments or have overdue items (e.g., treatment plan reviews) at PATH clinic, which occurs on the second and fourth Thursday of the month.
8. Counselor forwards clinical information (e.g., treatment plans, psychiatric diagnosis, and psychotropic medications) to PATH housing and medical case managers upon completion of the psychiatric evaluation or at completion of the treatment plan (usually when the assessment is completed) if psychiatric services are not clinically necessary.

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Director VP of Medical or AVP**

# Sample policies and procedures

Health Hope and Recovery staff follows procedures and protocols relevant for all staff providing similar services. However specific procedures were developed to support the unique needs of the priority population.

#### Procedure: Program Outline and Protocol

**Purpose:** To provide a program outline and guidance for referrals, assignment, contact, waiting lists, and termination and closure.

1. **Eligibility**

Clients must be homeless or at risk of homelessness as defined below:

1. People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.
2. People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled up situation, within 30 days and lack resources or support networks to remain in housing.
3. Families with children who are unstably housed and likely to continue in that state.
4. People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing.

**In ADDITION to meeting homeless eligibility, clients must have active mental health and/or substance abuse disorders that impact success in medical care.**

1. Client must be HIV+
2. Clients must be receiving or enrolling in HIV medical care at PHNTX clinic.
3. **Referral**
4. Clients who are screened eligible at intake will be staffed with program director.
5. Current PHNTX clients identified as eligible through their medical providers, case managers or other PHNTX service providers are referred to Program Director HHR.
6. Outside agencies may refer clients however if the client is not currently with PHNTX they will need to first go through intake and plan to enroll in medical services at a PHNTX clinic. A care coordinator will be assigned to follow this client through the intake process as needed.
7. **Assignment**
8. The Program Director HHR will assign new client screenings to care coordinators based on care coordinator's caseload, special skill sets, and prior relationship with client.
9. During screenings, care coordinators will assess client’s level of acuity.
10. Care coordinators will present client screening information to program director to review client assessment as well as to assign client to care coordinator.
11. If possible, the client will be assigned to care coordinator that completed initial screening to reflect the trauma formed care model.
12. However, the program director will make every effort to ensure that care coordinators will have no more than (5) level 4 clients on their caseload at a time.
13. **Contact**
14. All clients will be contacted by their care coordinator within 48 hours.
15. Minimum contact is determined by acuity level.
16. It should be noted that all care coordinators must attempt to meet “minimum” guidelines, however many clients will require more frequent contact.
17. Plans of contact must be determined at initial appointment and clearly documented by care coordinator. Client will be provided with written reminders and/or telephone reminders if client has a telephone.
18. Missed meetings, appointments and failed contact attempts must be clearly and accurately documented. All missed appointments require follow up and documentation by the care coordinator. Reasons for missed appointments will be immediately addressed.
19. **Maintenance Mode**
20. After 16-18 months of intensive care coordination clients will be offered an option of transitioning into maintenance mode.
21. If during a reassessment a client screens as acuity level one they will be offered to transition into maintenance mode.
22. Upon reaching acuity level one; clients will be transferred to the HHR case manager to ensure a “warm transfer” into case management.
23. **On Hold**
24. If a client is missing for 90+ days s/he will be placed “on hold.”
25. During the 90 days the care coordinator must be making consistent attempts to contact and re-engage the client. All attempts must be accurately documented.
26. If a client goes to jail or another closed institution and is expected to stay longer than 90 days s/he will be placed “on hold.”
27. If a client wishes to reinstate services while “on hold” s/he will be directed to the program director for reassessment of acuity and reassignment. The program director will assign the client to the previous care coordinator unless that care coordinator does not have capacity, in which case s/he will be assigned to another care coordinator.
28. In the event of a waiting list clients who wish to reinstate services will be placed on the waiting list and assigned according to acuity.
29. Clients who are “on hold” are not included in outcome assessment.
30. If a client is not participating in the treatment plan the care coordinator will staff with the program director who may decide that the client will be placed “on hold.” The client will have the opportunity to return at any time in the event that s/he completes requirements outlined by care coordinator.
31. Clients “on hold” are not eligible to receive services until they meet with program director and are reassigned to a care coordinator.
32. **Waiting List**
33. In the event that care coordinators reach capacity the program director will place new or reinstated clients on a waiting list.
34. As openings come available clients will be assigned based on acuity, preference given to highest acuity levels.
35. **Termination and Closure**
36. Clients may decide to terminate services at any time.
37. After a period of stability the care coordinator and client will collaboratively make a transition plan based on the assessment. Transition options are: maintenance mode, general case management, and referral case management.
38. Services may be suspended or terminated for disruptive behavior according to PHNTX Disruptive Behavior policy.
39. In the event of client death appropriate parties will be notified and Procedure for Closure of Client File of Deceased will be followed.