VOLUME 3: Specific Service Requirements

(1) POLICY: Care Management (CM)

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: Aging and Adult Services Agency (AASA) Operating Standards for Service Programs

I. Care Management (CM)

A. CM is the provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are in need of a nursing facility level of care due to the presence of functional limitations.

B. Services are brokered or directly purchased, according to an agreed-upon care plan, to assist the client in maintaining independence.

II. Functions of CM

A. Eligibility determination

B. Assessment

C. Care Plan Development

D. Supports Coordination

E. Reassessment

F. On-going monitoring

III. Eligibility Criteria

A. Age 60 years or older.

B. Have difficulty performing basic activities of daily living such as personal care, bathing and homemaking tasks.

C. Need assistance in linking to and coordination with community resources

D. Need, or a risk of, a nursing facility level of care

E. Persons living in their own homes, the homes of another, or an unlicensed assisted living arrangement

IV. Person-Centered Planning

A. Participant preference should be integrated throughout the entire care management process

B. The process will include considering the participant preference regarding:

1. Time

2. Date

3. Attendees

4. Service provision

V. Prescreen

A. All referrals to the CM program will be screened using the MI Choice Telephone Screen provided by the Michigan Department of Health and Human Services (MDHHS)

B. Referrals refusing to be prescreened are provided with alternate community resources

C. All referrals must be prescreened within three business days

D. All referral sources must be notified of the results of the prescreen process

E. Prescreening will determine the order in which the participant will be assessed based on:

1. Degree of frailty

2. Activities of Daily Living (ADL)

3. Instrumental Activities of Daily Living (IADL)

4. Availability of a care provider

5. Risk of Nursing Home Placement

VI. Assessment

A. MI Choice assessment and reassessment forms and protocols shall be utilized to assess an individual's abilities, health and physical functioning, living situation, informal support potential, and financial status.

B. All assessments must be conducted in person within 30 calendar days of the prescreen

C. All assessments must use a person-centered planning approach

D. The assessment must be a multi-disciplinary team consisting of a licensed social worker and a registered nurse.

E. All assessments must be completed prior to the initiation of services

F. All referral sources will be provided with information as to the results of the assessment

G. Assessment will be used to determine:

1. If any other funding sources for services exist

2. Eligibility for, and access to, program services as appropriate

3. The extent to which services are needed

4. The nature and severity of the individual's disability to assure appropriate service delivery

5. Participant perceived needs and requested services, including discrepancies based on the clinical assessment of need

H. The client's primary medical doctor will be notified that the client has been enrolled in the CM program and will be sent a copy of the medication list

1. The primary medical doctor is asked to verify the medication list

I. A client back-up plan will be developed based on the assessment data

J. A plan of care will be developed detailing the services to be arranged or purchased and established at the time of the assessment

K. Service provider will assure that the client is aware of the complaint resolution procedure.

L. Each client must be notified, in writing, that he or she has the right to comment on service provision.

M. Each client must be notified, in writing, that he or she has the right to appeal termination of services at or prior to the time service is initiated.

1. A copy of the service termination policy must be furnished to the client.

2. Each client must be advised in writing that complaints of discrimination may be filed with the Region VII AAA, MDHHS, Office of Civil Rights, or the Michigan Department of Civil Rights.

N. The client will receive a handbook which includes:

1. Care Management Basics

2. What to expect from the assessment, arrangement of service, and after services are in place

3. Person-Centered Planning

4. Client Rights and Responsibilities

5. Mandated Reporting Requirements of Abuse, Neglect, and Exploitation

6. Critical Incident Reporting

7. Emergency Preparedness

8. Advance Directives

9. Notice of Compliance with Title II of the Americans with Disabilities Act

10. Notice of Privacy Practices

11. Home Safety Checklist

12. Signed Acknowledgement by client that the handbook was received

VII. Case Classification

A. Case status shall be designated for each client. Care managers designate a case status using professional judgement in determining the level of intervention necessary to meet client needs.

B. Open/Active

1. Cases are those with the most difficult, unstable or complex needs which require intensive and/or regular care manager involvement.

2. A case is classified as open/active when the client requires reassessments at least every 90 days

C. Open/Maintenance

1. Cases are more physically stable and less complex than active cases.

2. Maintenance may not be the first status assigned to a case

3. A reason for moving a client from active to maintenance case status must be documented in the case file

4. Maintenance status requires reassessment at least once every 180 days and may be designated for the following reasons

a. The client is stable, but his/her level of frailty or illness may prompt the need to adjust the care plan within the next four to six months, or continued CM assistance is necessary to assure stability in the home

b. The client has refused needed services, but care managers perceive services may be accepted by the client within the next four to six months

c. The client is institutionalized and is expected to return home with CM assistance within the next six months

D. Closed

1. Cases are those that no longer require CM intervention.

2. Closed case status will be designated by case managers for the following reasons

a. The client moves from the service area

b. The client is institutionalized on a permanent basis

c. The client terminates involvement with the program

d. The client's circumstances change which allows for payment from other fund sources

e. Informal support has increased availability

f. Inability to continue to serve the client due to funding or safety concerns

g. The client stabilizes to a point that CM is no longer required

h. Death

VIII. Care Plan Development

A. Service provider will develop, in conjunction with the client, a written person centered, individualized plan of care that assures the maintenance of health, safety, and welfare by addressing all identified client needs.

B. Service provider will link and coordinate the delivery of service to support the needs of the client based on the preferences of the client while considering quality of care and quality of life

C. The plan will be inclusive of those needs as identified by the client, provider staff, and other professionals and will identify specific interventions to be secured and provided while ensuring appropriate and cost-effective utilization of services.

D. The client must approve the plan and all the content contained within the plan.

E. In developing the plan, provider staff will consider each client level of independence or dependence with regard to ADL and IADL, cognitive status, informal support, and other community resources.

F. Service provider will ensure that the participant meets the operating standards and service definitions of requested services prior to authorizing services.

G. Service provider will link and coordinate service delivery outside of CM

H. Formal services will be arranged based on need, the expressed preferences of the client, and available funding.

I. The requested services agency must have an active purchase of service agreement in good standing with Region VII AAA.

J. Service provider will recognize the rights of the client to refuse services as offered or recommended. The risks associated with refusing services will be discussed with the client and documented in the plan.

K. The CAPs and Triggers report will be utilized in the development of the care plan as appropriate and as approved by the client.

L. The client will receive a meaningful and understandable copy of their written, person centered, care plan at the first reassessment, annually, as changes are made, or per request.

M. Each provider must have a written policy and procedure for the development, implementation, and management of the care plans that includes, at the minimum, the following requirements:

1. All services the client receives regardless of the fund source (informal, community, arranged/formal, skilled, etc.)
2. The type of services furnished
3. The amount of service authorized including the projected costs
4. The frequency and duration of each service
5. The type of provider to furnish each service
6. Goals, preferences, and outcomes
7. Participant signature and date, indicating approval
8. Program staff signature(s) and date
9. The fulfillment of service goals and objectives

N. The plan must be evaluated and updated at all reassessments and/or updated based upon changes in the participant's condition, as inadequacies are identified, based upon telephone monitoring findings, and/or as other service needs are identified.

O. The plan is used to assess participant satisfaction with current service delivery, including the amount and quality.

P. Services and supports put into place should lead to positive outcomes. Each participant will be encouraged to identify strategies, support, services, and/or treatments that will achieve their desired outcome(s).

IX. Back Up Plan

A. Service providers must recognize the right of the client to choose CM and to assist in ensuring the client's health, safety and welfare in a less restrictive setting.

B. Service providers cannot guarantee that the client's needs will be met at all times or that the employee of any provider agency will always be available at the times and dates requested.

C. A client choosing to receive CM is expected to have an informal support, emergency, back-up plan that adheres to established standards, inclusive of a priority risk rating that identifies the level of care need required.

1. The risk rating scale was established by the MDHHS and is determined at the assessment, each reassessment, or as significant changes are identified.

D. The service back-up plan provides written alternative arrangements for the delivery of services that are critical to a client's well-being in the event that the provider responsible for furnishing the services fails to or is unable to deliver the service.

E. The back-up plan is developed in collaboration with the client and honors his/her preferences with regard to emergency contacts, persons selected, and service delivery.

F. The back-up plan must be meaningful and understandable to the client.

G. The back-up plan is employed when scheduled providers do not show up as anticipated.

H. The back-up plan includes contact information for all providers furnishing services to the client.

I. The back-up plan includes methods for the client and provider agency to contact provider staff if service is not delivered as planned.

J. Service provider shall follow up with the client following the activation of a back-up plan

K. A copy of the plan is provided to the client in person or will be mailed to the client within 10 days of the date of the initial assessment

L. A copy of the plan will be included in the client's chart and a copy will be given to the purchase of service provider(s) who will be providing care to the client.

M. The back-up plan will reviewed and updated at each reassessment and/or as needed.

N. The client will be provided with an updated copy of the back-up plan as significant changes are identified, as requested, or annually at a minimum.

O. The client will acknowledge and approve, with signature, following each reassessment.

X. Progress Notes

A. Service provider will document all activity (telephone calls, communications) related to the client.

1. This will include:

a. choices offered to clients and their preferences regarding services and service delivery

b. the risks associated with client choice

B. Follow up and monitoring is used to evaluate the timeliness, appropriateness and quality of services implemented under the plan of care.

1. This involves communication with the client (and the provider of service as warranted) to assure services are being delivered in a manner consistent with the client's needs and wishes.

2. Monthly contacts at 30 day intervals will be made with each active client to monitor changes in condition or circumstances.

3. Monthly contacts at 60 day intervals will be made with each maintenance client to monitor changes in condition or circumstances

C. Contact is also made when client changes are reported to program staff. These contacts shall be used to determine:

1. A change in services provided

2. If the client requires more frequent in home staff assessments

3. If the services are being delivered in the manner prescribed in the care plan

4. If clients are receiving the planned interventions as identified.

D. Service provider will contact the client within 14 calendar days following the commencement of any change to the service delivery system to ensure client satisfaction with service provision and to identify and address problems with access to program services, including:

1. New service

2. New provider

3. Change in service (increase or decrease in hours)

4. Termination of services

E. Service provider will take appropriate action when problems with access to program services is identified

XI. Reassessments

A. All reassessment must be conducted in person

B. Reassessment must be completed within 90 days of assessment or previous reassessment for active cases

C. Reassessment must be completed within 180 days of assessment or previous reassessment for maintenance cases

D. All reassessment must use a person-centered planning approach

E. Reassessments are designed to solicit participant feedback and identify changes in participant need, psychosocial/physical status, service delivery, satisfaction, and financial/physical eligibility for the specific service program.

F. The reassessment should incorporate changes in condition and appropriate interventions as changes are identified and implemented based on participant approval

G. Targeted Care Management participants will be seen on, or near, the first day of the month if able to assist in meeting spenddown

XII. Cost share

A. Service providers will complete an evaluation of the participant financial status as part of the assessment process.

B. The evaluation will include:

    1. Income, assets, and monthly expenditures (i.e. house payment, taxes, groceries, etc.).

C. The information received during the assessment will determine the quarterly cost share status of the participant.

D. Service provider will use the total income from all sources of the participant receiving the service and will be used to determine the participants share in the cost of the services provided.

E. Total income shall be determined by confidential self-declaration of each eligible individual client.

F. The client will not be asked for income verification.

G. If the client does not wish to disclose the income, the cost share amount will be set at the highest cost share value.

H. Assets, savings, or other property owned by the client is exempt in the calculation of total income.

I. Clients with identified income of 185% or less of the poverty income guidelines shall not be required to cost share and will be encouraged to contribute toward the cost of the services received

J. Clients receiving service whose self-declaration of total income is at or above 185% of the poverty income guidelines will be required to cost share following a fee scale based on an annual income level.

    1. Service provider must develop a fee scale base including an amount for clients refusing to disclose income amounts

K. All program clients will be provided the opportunity to voluntarily contribute to the cost of services received.

L. Any client may volunteer to share in the cost of service in an amount above that required by the approved sliding fee scale.

XIII. Client Record Requirements

A. Service providers shall establish and maintain a confidential record for each client served

B. The record shall include, at a minimum,

1. Completed telephone screen
2. Completed assessment
3. Client approved plan of care
4. Documentation of service orders, linkage forms
5. Progress notes which serve as a log for documenting pertinent contacts with client, providers, and others involved in caring for the client
6. Monthly contact forms
7. Two week check forms
8. Completed reassessments
9. Correspondence pertaining to client's care, including physician letter
10. National Aging Program Information System (NAPIS) form
11. Person-centered planning
12. Record of all releases of information about the client and signed and dated releases of information forms
    a. Copies of signed release of information forms that are time-limited not to exceed one year, service/agency specific, and specific as to the information being released
13. Back up plans
14. Acknowledgement of the receipt of the HIPAA Notice of Privacy Practices
15. Accident reports
16. Termination reports

17. Cost share letters

XIV. Waiting List

A. An eligible referral to the CM program will be placed on a waiting list when the program is at capacity serving participants or if eligible referrals exceed the program's capacity to conduct assessments.

B. When care management resources are insufficient to meet the demand for services, individuals on the waiting list will be prioritized according to indicators of isolation and dependence with ADLs and IADLs.

C. Individuals scoring higher on the priority scale will be served before other individuals on the waiting list with a lesser score.

D. The wait list will be inclusive of the following:

1. Client name

2. Date service is first sought

3. The service being sought

4. The county of residence

E. The referral source will be informed that a waiting list exists and the probable time an individual will be on the list.

F. All referrals placed on the waiting list will be linked with the Case Coordination and Support Program to ensure that immediate needs are met.

G. The need for care management may be negated should the person's needs be met through other community based care options.

H. When the program is able to serve a participant from the waiting list, the referral source will be contacted to confirm the need for care management services.

XV. Disaster List

A. Service providers are required to keep a current and accessible listing of those isolated older persons, with active or maintenance case files, that may be in potential need should a disaster strike.

B. The disaster list shall be kept current and placed on file with the local emergency services agency.

C. The disaster list should be updated monthly, at a minimum.

XVI. Staff Requirements

A. Service providers must employ qualified case managers as defined by:

1. A registered nursed licensed to practice in the State of Michigan

2. A licensed social worker, as described with the Michigan Public Health Code)

a. An individual with a minimum of two years care manager experience may also be accepted

B. Care Managers shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and clients, and to improve their skills in completion of job tasks

XVII. Targeted Case Management (TCM)

A. TCM is a Medicaid State Plan service approved for a specific client population

1. The target group consists of persons who are:

a. At least 60 years old and disabled, or at least 65 years old; and

b. Seeking admission to, or at risk of entering a nursing care facility

c. Eligible and enrolled in the CM program

d. Documented as having multiple, complex and diverse service needs and a lack of capacity and support systems to address those needs without case management

e. Living in their own homes, the homes of another, or an unlicensed assisted living arrangement

f. Meet Medicaid financial eligibility

2. TCM providers are only reimbursed for the annually-adjusted federal percentage portion of each approved in-person encounter

3. Visits for the purpose of assessment and reassessment must be conducted by a licensed registered nurse in order to be considered an eligible encounter

4. Face-to-face visits conducted by the social worker for the purpose of arranging services or monitoring/follow-up are acceptable for billing as long as the registered nurse signs off on case notes and other documentation

5. TCM billing will be disallowed for any period of time that a program operates without a registered nurse on staff

6. TCM reimbursement is available for in-person encounters during which one or more of the following billable activities occurs:

    a. Assessment

    b. Care Planning

    c. Service arranging

    d. Follow-up and monitoring

    e. Reassessment

    f. Only visits with documented nurse involvement are eligible

7. Each billable encounter with a TCM client shall be recorded on a Medicaid Service Log and maintained in the case record

    a. The log shall indicate:

        1. The date

        2. Length of contact

        3. Description of service provided

        4. Location of service provided

        5. Must be initialed by the individual making the contact

8. A corresponding description of the contact must be documented in the progress notes

9. All encounters must be submitted for payment within 12 months of the date of the service

VOLUME 3: Specific Service Requirements

(2) POLICY: Case Coordination and Support (CCS)

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: AASA Operating Standards for Service Programs

XVIII. Case Coordination and Support (CCS)

A. CCS provides a comprehensive assessment of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible.

B. Components of the CCS Function

1. Intake

2. Assessment and reassessment of individual needs

3. Development and monitoring of a service plan

4. Identification of and communication with appropriate community agencies to arrange for services

5. Evaluation of the effectiveness and benefit of services provided

6. An assignment of a single individual as the caseworker for each client

C. Related services provision

1. Up to twenty percent (20 percent) of the total CCS units reported to Region VII AAA during the contract year may be comprised of "Other Acceptable" activities

2. Actual time spent performing "Other Acceptable" activities must be recorded on case coordinators daily activity logs in a column that is separate from the column used to record time spent performing the listed components of CCS Functions.

3. Other Acceptable Functions

a. Information and referral

b. Outreach

c. Assistance with completion of tax forms and energy assistance forms

d. Food baskets and commodity distribution

e. Meetings or discussions with groups of seniors to inform/discuss needs and problems

D. Unit of service

1. A unit of service is the provision of one (1) hour of a component of the CCS Function.

E. Client

1. A client is one person age 60 or older who receives services

2. A recipient of service may be counted only once during the contract year.

3. An individual may be counted as a CCS client under the Region VII AAA contract when the following minimum requirements are met.

a. A case file has been established for the client that, at the minimum, contains a completed and dated intake form with the required basic information and progress notes.

b. The client must have received at least 1/2 unit of service, the provision of which is documented both in the individual's progress notes and in the case coordinator's activity log.

XIX. Prioritizing CCS Service

A. Priority must be given to clients with multiple needs.

1. A multiple needs client is defined as a frail older person who is at risk of institutionalization due to illness, disability, or declining health.

2. Such individuals will require assistance from informal supports such as family, neighbors, formal community services, or a combination of both informal and formal support in order to live independently in their own home.

B. A multiple needs client does not necessarily require or need to receive more than one service from a community agency.

C. A multiple needs client must require assistance in more than one of the following areas.

1. Mobility
2. Shopping
3. Housekeeping
4. Preparation of meals
5. Bathing/grooming
6. Dressing
7. Eating
8. Toileting

D. The service provider shall be able to verify that priority is given to multiple needs clients through the client files.

1. A review or sampling of client files must indicate that the vast majority of clients demonstrate multiple needs, as indicated in the assessment and documented in the service plan.

E. Service providers shall assure that not more than twenty percent (20 percent) of the CCS units provided under the Region VII AAA contract are comprised of "Other Acceptable" functions.

XX. Client Intake Record

A. Intake

1. Each CCS service provider must have uniform intake procedures and maintain consistent records.
2. Intake may be conducted over the telephone
3. Intake records for each potential client must include at a minimum

a. Individual's name, address, and telephone number

b. Individual's age or birth date

c. Physician's name, address, and telephone number

d. Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency

e. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems

f. Perceived supportive service needs as expressed by individual or his/her representatives

g. Race (optional)

h. Gender (optional)

i. An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes. At or below 125% of poverty for referral purposes

j. Date of intake and client's signature, if possible

k. Brief statement of needs or problems

B. Service providers will perform a standardized prescreening process to determine if the client demonstrates multiple needs.

C. When an intake indicates a single service need on a one-time or infrequent basis, the individual should be provided with information and assistance services.

D. When intake suggests ongoing and/or multiple service needs, a comprehensive individual assessment of need must be performed within ten working days of intake.

E. Intake information may be obtained through a referral from an outside agency.

F. When intake suggests ongoing or multiple complex service needs at a level beyond the scope of the CCS program, a referral shall be made to the Care Management program.

XXI. Assessment

A. Assessment Information Requirements

1. All assessments and reassessments must be conducted in person.

2. A standardized written assessment form must be utilized.

3. Caseworkers must attempt to acquire each item of information listed below, but must also recognize and accept the client's right to refuse to provide requested items.

4. At a minimum a standardized written assessment must include the following:

a. Basic Information:

1. Individual's name, address, and telephone number

2. Age, date, and place of birth

3. Gender

4. Marital status

5. Race and/or ethnicity

6. Living arrangements

7. Condition of environment

8. Income and other financial resources, by source, including Social Security Income and general assistance

9. Expenses

10. Previous occupation, special interests, and hobbies

11. Religious affiliation, if applicable

b. Functional Status Information

12. Vision

13. Hearing

14. Speech

15. Oral status (condition of teeth, gums, mouth, and tongue)

16. Prosthesis

17. Psychosocial functioning

18. Limitations in activities of daily living

19. History of chronic and acute illnesses

20. Eating patterns and diet history

21. Prescriptions, medications, and other physician orders

c. Supporting Resources Information

1. Physician's name, address, and telephone number

2. Pharmacist's name, address, and telephone number

3. Services currently receiving or received in past, including identification of those funded through Medicaid

4. Extent of family and/or informal support network

5. Hospitalization history

6. Medical/health insurance available

7. Clergy name, address, and telephone number, if applicable

d. Need Identification Information

1. Client or family perceived need

2. Assessor perceived or identified need from referral source or professional community

5. In situations in which the item of information is not applicable to the client, an "N/A" must be indicated on the form

B. Determining Potential eligibility for MDHHS

1. When the client appears to be in need of and eligible for MDHHS funded benefits and services, a referral to the MDHHS field offices should be made

    a. The client must first consent to a referral for MDHHS funded benefits and services

C. Assessment of Client Satisfaction Information

1. The client's satisfaction with services received

2. The client's satisfaction with program staff performance

3. The client’s satisfaction with the consistency of services provided

D. Assessment includes Signatures and Client Consent Information

1. Dated signature of the client and/or his/her representative indicating consent to receive services for which they are determined eligible

2. Dated signatures of assessors

3. Each client must be notified, in writing, that he or she has the right to comment on service provision.

4. Each client must be notified, in writing, that he or she has the right to appeal termination of services at or prior to the time service is initiated.

    a. A copy of the service termination policy must be furnished to the client.

5. Each client must be advised in writing that complaints of discrimination may be filed with the Region VII AAA, MDHHS, Office of Civil Rights, or the Michigan Department of Civil Rights.

6. When it is determined at the time of initial assessment that referral to another agency may be necessary or appropriate, a Release of Information form must be signed by the client or the client's guardian or designated representative.

    a. The release must be time-limited, not to exceed one year from the signature date, and be service specific and specific as to information for release.

E. Reassessment

1. Reassessments are to determine changes in client status, client satisfaction and the results of implementing the service plan.

2. Reassessments must be conducted in person.

3. Clients must be reassessed at least every 180 days, unless circumstances require more frequent visits.

    a. A determination of when the next reassessment is to take place must be noted on the assessment form.

    b. When the initial assessment indicates that the client should be reassessed before six months, a determination of when reassessments should take place must be noted.

4. Reassessments must include a review of all required initial assessment items.

5. When a reassessment determines the client's identified needs have been adequately addressed, the case should be closed.

XXII. Telephone Monitoring

A. Case managers will ensure that a telephone contact is made to the client at least once every two months to monitor changes in the client’s condition or circumstances and the continued need for service.

1. Telephone monitoring contact and outcome must be documented in the client's file.

2. Telephone monitoring contacts and in-home personnel reports shall be used to determine if the reassessment must be conducted prior to the scheduled date.

B. A telephone monitoring contact must be made whenever in-home volunteers or personnel report client changes.

XXIII. Client Service Plan

A. A service plan must be developed for each person determined eligible and in need of CCS.

B. The service plan must be developed in cooperation with and be approved by the client or the client's guardian or designated representative.

C. The service plan must contain at a minimum the following:

1. A statement of the client's problems, needs, strengths, and resources

2. Statement of the goals and objectives for meeting identified needs

3. Description of methods and/or approaches to be used in addressing needs

4. Identification of services and the frequency at which they are to be provided

5. Treatment orders of qualified health professionals, when applicable, such as a physician order for special diets.

6. Dates that the service plan was reviewed with the client or guardian.

D. Each provider must have a written policy and procedure for the development, implementation, and management of the service plans that includes, at the minimum, the following requirements:

1. Service plans for clients must be update and evaluated at all client reassessments.

2. The plan must include notations of all changes in the scope of service activities and the frequency or duration of services determined based on the reassessment.

a. Written notations of such changes must be dated.

3. When the reassessment indicates that no changes are needed in the scope of service tasks or the frequency or duration of services, a dated, written notation of "no change" must be entered into the service plan.

4. When the reassessment indicates that additional services may be needed, a dated, written notation of the needed referral or arrangements shall be entered in the service plan.

5. When the reassessment indicates that the service goals and objectives have been fulfilled, the client should be terminated in accordance with the required procedures and a dated notation of termination entered in the service plan.

XXIV. Client Records

A. CCS programs must maintain comprehensive and complete individual client records.

B. All client files must be kept confidential in controlled access files.

C. The individual client record must contain, at a minimum, the following information:

1. Details of client's referral to CCS program
2. Completed intake and assessment forms
3. Completed reassessment forms
4. Service plan with updates and notations of any revisions
5. Listing of all chronological and cumulative case notes
6. Record of all releases of information about the client and signed and dated releases of information forms
    a. Copies of signed release of information forms that are time-limited, service/agency specific, and specific as to the information being released
7. Physician's orders for special modified diets

D. Service providers must maintain chronological and cumulative case notes for each client that includes the following requirements:

1. Dated, written entries
2. A column for the number of service units for each contact
3. Details of the client's referral to the program
4. Service plan reviews with the client and/or guardian
5. Documentation of assessment and reassessment visits
6. Documentation of any unusual circumstances or significant changes
7. Improvements or regression reported by delivery volunteers or other direct service personnel visiting the home.
8. Dated entry for other contacts such as telephone or correspondence with the client, the family, another agency, and/or the outcome of the contact

9. Notation of the purpose of the contact and an indication of units

10. Comments verifying client's receipt of services from other providers and whether service adequately addressed client need

E. Each client file must be assigned status in one of the following categories.

1. Open Status

a. Initial referral

b. Reassessment of inactive case

c. Current activity in implementing a service plan

2. Closed Status

a. Client decides to discontinue service.

b. Client needs have been met.

c. Another program or agency has assumed responsibility for client.

d. Client is unable to be served and referral of case is not possible.

e. Client has died.

XXV. Disaster List

A. Service providers are required to keep a current and accessible listing of those isolated older persons, with active case files that may be in potential need should a disaster strike.

B. The disaster list shall be kept current and placed on file with the local emergency services agency. The list should be updated monthly.

XXVI. Activity Log

A. CCS direct service staff must maintain a daily activity log.

1. Service staff time must be recorded and categorized as either:

a. CCS Functions

b. Other acceptable activities

c. Other administrative activities

B. CCS Functions

1. Intake
2. Assessments
3. Reassessments
4. Development of service plan
5. Monitoring of service plan through telephone contacts with client provider agency or meetings with provider agencies to discuss a client's visit
6. Arranging for service for a client through identification of and communication with agencies and informal supports such as family, church, or neighbors
7. Evaluation of a service to a client or a particular arrangement
8. Transportation to or from client in conjunction with the above activities

C. Other Acceptable Activities

1. Group presentations that are intended to locate or inform seniors of available services and opportunities
2. Identifying and contacting isolated elderly
3. Assistance with completion of forms
4. Distribution of food commodities
5. Information and referral

D. Other Administrative Activities

1. Vacation and sick leave
2. Paid holidays

3. Breaks

4. Staff meetings

5. Training, in-services not client-specific, seminars, or workshops

6. Time spent preparing reports that are not client-related such as fiscal, board reports, time, or travel sheets

7. Time spent supervising the staff or volunteers

8. Time spent performing non-CCS activities for another service program.

9. Travel time in conjunction with the above.

E. Activity Log Minimum Entry

1. Activities completed in less than 15 minutes should be grouped together so that a single entry on the log represents no less than 1/4 hour (unit).

2. To facilitate unit tallying each entry should be made in multiples of 1/4 hour (unit), such as 1/4, 1/2, 3/4, 1, 1 1/4.

F. Use of Activity Log for Reporting

1. For any given month, the total CCS units reported to the Region VII AAA shall be comprised of the sum of direct service staff hours recorded on the activity log as Support Component Functions and Other Acceptable Activities.

2. Time recorded in the Other Administrative column must not be included in the tally of CCS units report.

3. Not more than twenty percent (20 percent) of the total CCS units reported to the Region VII AAA during the contract year may be comprised of Other Acceptable Activities.

4. During the assessment, the Region VII AAA will verify reported CCS units through a review of the Activity Logs.

XXVII. Staff Requirements

A. Service providers shall employ case managers who have a minimum of a bachelor's degree in a human service field.

1. Service providers can employ case managers who by training or experience have the ability to effectively determine an older person's needs and match those needs with appropriate services.

2. If the program does not employ an individual with an appropriate bachelor's degree, the provider must provide access to a registered nurse or social work professional that can arrange for technical support or consultation.

B. CCS staff must receive in-service training at least twice each fiscal year.

1. Training must be specifically designed to increase staff knowledge and understanding of the program and clients and to improve their skills at tasks performed in the provision of service.

2. An individualized in-service training plan should be developed for a staff person when performance evaluations indicate a need.

C. Only one case coordinator may be currently assigned to each individual case.

XXVIII. Coordination

A. Service providers must develop a cooperative working arrangement with other human service agencies, other Older Americans' Act programs, churches, and other service provider organizations in the community.

B. Service providers must refer clients with identified unmet health needs, physical or mental, to an appropriate health care agency.

C. Service providers are responsible for post-referral follow-up and monitoring to determine the referred client's status and to ensure that needed services are being provided.

D. Service providers are responsible for maintaining updated information on eligibility criteria and other application requirements for persons age 60 and older.

VOLUME III: Specific Service Requirements

(3) POLICY NAME: Outreach Services

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: AASA Operating Standards for Service Programs

I. Outreach Services

A. Outreach services will identify and contact isolated older persons and/or older persons in greatest social and economic need, who may have service needs, and assisting them in gaining access to appropriate services.

1. Emphasis is on low-income minority and disabled elderly.

B. Outreach includes search and find efforts that includes the following.

1. Door-to-door or request basis, which seek out isolated living alone, withdrawn, immobile, minority or low income individuals in the community who may have need for services.

2. Outreach includes informing individuals of the services available in the community and assisting them in gaining needed services.

C. Activities related to Outreach

1. Service providers will specify annually how it intends to satisfy the service to low-income minority individuals in its service area.

2. Activities include, but are not limited to canvassing efforts to reach older individuals, intake and prescreening to determine an individual's needs, mobilization of community resources to respond to the needs of older persons, advocacy, and referral.

3. Service providers will make every effort to inform older individuals, and the caregivers of such individuals, of the availability of assistance.

4. Link to information and assistance (I&A) services and follow-up to ensure that needs have been met

5. Outreach does not include comprehensive assessment of need, development of a service plan, or arranging for service provision.

D. Unit of Service

1. One hour of outreach service including identification and contact of isolated older persons, assistance in their gaining access to needed services, and follow-up.

E. Outreach Client

1. One person age 60 or older who receives an initial, individual, in-person contact

2. Persons who participate in a group contact shall not be counted as a client, unless an individual in-person contact is also made.

3. A client receiving Outreach service may only be counted once during the contract period.

4. Unduplicated count of clients is reported to Region VII AAA.

5. An individual age 60 or older may be counted as an Outreach client under the Region VII AAA contract only if the following minimum requirements are met:

a. A case file has been established for the client, which, at the minimum, contains a completed and dated intake form with the required basic information, and progress notes.

b. The client shall have received at least one initial, in-person Outreach visit, and the provision of which is documented both in the individual's progress notes and in the Outreach Worker's activity log.

II. Targeting Requirements

A. Service providers must develop a plan outlining how persons age 60 and over will be located.

1. Efforts shall include the entire service area, but emphasis shall be given to:

a. Elderly persons in greatest economic with particular attention to low-income, minority elderly

b. Elderly persons with greatest social need with particular attention to low-income, minority elderly

c. Elderly residing in rural areas

d. Elderly with severe disabilities

e. Elderly who are Native American

f. Elderly with limited English speaking ability

g. Elderly with Alzheimer's disease or related disorders with neurological and organic brain dysfunctions and the caregivers of such individuals

III. Client Intake

A. Intake Form

1. Each service provider must have a written intake form and procedure, which identifies and documents client needs.

2. Service providers shall complete an intake form for each person who receives an individual, in-person outreach visit.

B. The intake form must include at a minimum the following:

1. Intake Date

2. Individual's name, address, and telephone number

3. Individual's age and birth date

4. Physician's name, address, and telephone number

5. Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency

6. Diagnosed medical problems.

7. Assistance needs or service needs as expressed by individual or his/her representatives.

8. Race (optional)

9. Gender (optional)

10. An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes and at or below 185 percent of poverty level for referral purposes

11. Listing of services that individual is currently receiving or received in the past

12. Client's signature

C. Intake Requirements

1. Outreach staff must attempt to acquire each item of information on the intake form and must recognize and accept the client's right to refuse to provide requested items of information.

2. When the initial Outreach visit and the intake data indicate that, an individual has multiple or complex needs and inadequate assistance from the family members or other informal supports, the service provider shall refer the individual to the CCS program in the service area.

3. When a referral to another agency on behalf of the client is necessary or appropriate, the client, the client's guardian, or other representative must sign a release of information form.

    a. The release must be time-limited not to exceed one year from the signature date and be service specific and specific as to information for release.

IV. Client Follow-up

A. A follow-up contact must be made with at least 50 percent of annual clients to determine if needed services have been received.

B. Follow-up contacts may be made by telephone or through an in-person visit.

C. A follow-up contact must be made of all clients on whose behalf a referral for service was made to another agency or program

D. Referrals and follow-up must be made within 30 calendar days from the date of the initial visit or request for additional help.

E. A follow-up contact need not be made for clients who during the initial visit state that they neither need nor are interested in obtaining services or assistance or participating in community programs.

V. Record Keeping Requirements

A. Activity Log

1. Outreach direct service staff must maintain a daily activity log for the purpose of verifying units reported to the Region VII AAA.

2. The format shall include, at the minimum:

a. A column client name, a column for describing the specific Outreach activity, a column for recording all group contact units, a column for recording all individual in-person contact units, and a column for recording all follow-up contacts.

3. Activities reported on the log that are specific to an individual client must be transferred into the case notes section of the individual client's file.

B. Outreach Units

1. For any given month, the total Outreach units reported to the Region VII AAA shall be comprised of the sum of all group contacts, all individual contacts, and all follow-up contacts recorded on the activity logs.

2. Only units provided by direct service staff listed in the Region VII AAA contract/budget shall be reported.

3. During assessment, the Region VII AAA will verify reported Outreach units through a review of the activity logs.

VI. Client Files

A. Files

1. Outreach service providers must establish and maintain a client file in order to count an individual as a Region VII AAA client.

2. All client files must be kept confidential in controlled access files.

B. Individual client file information.

1. The individual client file information must contain the following:

a. Completed intake form

b. Copies of signed and dated release of onformation forms

c. Case notes

C. Case notes must document each contact with or activity carried out on behalf of a client.

1. Each written entry must have a date and worker's initials after it.

2. Case notes must be chronological and cumulative.

3. Case notes should include the following types of entries:

a. Date of individual's referral to the Outreach program, source of the referral, and reasons for the referral

b. Date of the initial in-person contact or visit and a synopsis of significant needs or problems identified during the visit

c. Date of all referrals made to other agencies or programs on behalf of the client and the disposition or outcome

d. Date of all follow-up contacts and the outcome

D. Client File Status

1. Client files must be assigned status as "open" or "closed."

2. At the end of the fiscal year, all files must be reviewed.

3. A client file must be closed if there is no need for further referral or follow-up.

a. Generally, clients contacted for an initial visit before September 1 should be closed.

E. Under no circumstances will the service provider count a client under the Region VII AAA contract if the client received neither an initial visit nor a follow-up contact as documented in the file during the contract year.

F. Disaster List

1. Service providers are required to keep a current and accessible listing of those isolated older persons identified through Outreach who may be in potential need should a disaster strike.

2. The disaster list shall be kept current and placed on file with the local emergency management services agency.

3. The disaster list will be updated monthly.

VII. Coordination

A. Service providers must establish linkage with CCS and I&A programs in the service area and be able to assist clients in gaining access to available services, as needed.

1. Service providers must be able to demonstrate or document that such linkages exist through interagency agreements, referrals documented in client files, and documentation of participation in joint meetings.

B. Service providers must develop a cooperative working arrangement with other human service agencies, other Older Americans Act (OAA) programs, churches, and other service providing organizations in the community.

C. Service providers are responsible for maintaining updated information on eligibility criteria, application requirements and other information for income, health, energy, and other programs and services for persons age 60 and older.

D. Service Providers are responsible for contacting and informing other health and human service agencies in the service area about the availability of Outreach services and the nature and scope of activities provided.

VIII. Bilingual Outreach Services

A. Bilingual Outreach Services must meet the following additional requirements:

1. All positions funded with Region VII AAA funds, except the Director or fiscal staff, must be able to communicate verbally and in written form in the native language of the target community.

B. The service provider must provide the translation services necessary to link Outreach clients with existing community services.

1. Translation services to non-Outreach clients cannot be provided through this program.

C. Region VII AAA will consider requests to utilize a portion of supply funds for the translation of printed materials.

VOLUME III: Specific Service Requirements

(4) POLICY NAME: Transportation Services

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: AASA Operating Standards for Service Programs

I. Transportation Service

A. Centrally organized services for transportation of older persons to and from community facilities in order to receive support services, reduce isolation, or otherwise promote independent living.

1. Emphasis is on door-to-door services.

B. Unit of service

1. A unit of service is a one, one-way trip per person.

C. A client receiving transportation services may only be counted once during the contract period.

1. Only the unduplicated count of clients served is reported to the Region VII AAA.

II. Fundable Service Operations

A. Region VII AAA funds may be used to fund all or part of the operational costs of transportation programs based on the following:

1. Demand/Response: characterized by flexible routing and/or scheduling of small vehicles to provide door-to-door service on demand

a. Route Deviation Variation: where a normally fixed route vehicle leaves scheduled route upon request to pick up client.

b. Flexible Routing Variation: where routes are constantly modified to accommodate service requests.

2. Volunteer Reimbursement: characterized by reimbursement of out-of-pocket expenses for individuals who transport older persons in their private vehicles.

3. Public Transit Reimbursement characterized by partial or full payment of the cost for an older person to use an available public transit system.

B. Purchase or Lease of Vehicles

1. OAA funds may not be used for the purchase or lease of vehicles for providing transportation services, unless the service provider receives prior written approval from the Region VII AAA and AASA.

C. Allowable Expenses

1. Funds for transportation shall be used primarily for vehicle maintenance, oil, gas, insurance, and volunteer mileage reimbursement and secondarily for wages for drivers and dispatchers.

III. Transportation Client Intake

A. General Procedures

1. Service providers must complete an intake form for each eligible individual served.

B. Other Funding Source

1. During the intake process, service providers must determine whether clients are eligible for other private or publicly funded transportation services.

2. Third-party payment for services rendered to eligible individuals must be sought, as appropriate and available.

a. Examples include American Cancer Society, Veterans Administration, MDHHS, United Way, and Michigan Department of Transportation programs.

IV. Priority Statement

A. Transportation service providers must develop and utilize a written priority statement for services delivery.

1. The statement must be used to prioritize requests for transportation for scheduling purposes.

2. Service providers shall give the highest priority to medically related transportation requests within the limits of available resources.

V. Staff Requirements

A. Personnel Policy

1. Service providers will have written policies that directly relate to personnel management within the organization.

B. Personnel & Volunteer Requirements

1. All paid drivers for transportation programs supported with Region VII AAA funds must be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles.

    a. Such assistance must be provided unless expressly prohibited by either a labor contract or insurance policy.

2. All paid drivers must be trained to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

3. The training is to be provided before the end of the first fiscal quarter during which the services are provided.

4. Volunteer drivers need not obtain this training, although such training is advised.

5. All paid drivers must possess a valid State of Michigan Chauffeur's License. Volunteers must possess a valid Michigan Driver's license.

6. All drivers, paid and volunteer, who transport passengers in agency-owned buses or vans with the capacity to transport ten or more persons must possess a valid State of Michigan Chauffeur's License.

7. All paid staff shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and clients, and to improve their skills in completion of job tasks

    a. Volunteer drivers must be offered in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and clients

VI. Vehicle ~~Safety~~

A. Safety Inspections

1. All service provider owned vehicles must undergo an annual safety inspection recognized by the National Safety Council and in compliance with the requirements of the Secretary of State.

2. Vehicles not meeting minimal safety standards are to be removed from service by the provider agency.

B. Insurance

1. All vehicles used must be covered by liability insurance.

C. Each program must operate in compliance with seat belt usage.

CHAPTER 1: Specific Service Requirements

(5) POLICY NAME: General Requirements for In-Home Service Programs

PURPOSE: General procedures and policy position for in-home service categories.

AUTHORITY: AASA Operating Standards for Service Programs

I. Allowable Services

A. Homemaker, In-Home Respite Care, Personal Care, and Home Health Aide

B. Region VII AAA funds only those specific services that are designated under the Multi-Year Plan and the Annual Implementation Plan.

C. Specific service definitions and additional requirements for each Region VII AAA funded service program are provided under the individual service policy in this manual.

II. Client Eligibility

A. Generally, persons 60 years of age or older shall be eligible for services supported in whole or in part by state and federal funds awarded by the Region VII AAA.

B. Service programs that have additional eligibility criteria are included in individual service program policy sections.

C. Priority shall be given to meeting the needs of persons with the greatest economic and social needs with preference to serving low-income, minority elderly.

III. Initiating Service

A. Prior to initiating service, each in-home service provider must determine if a potential client is eligible to receive a requested service or any component support service through a program supported by other funding sources, particularly programs funded through the Social Security Act.

1. If it appears that an individual can be served through an outside program or through other resources, an appropriate referral should be made or third-party reimbursement sought.

B. Each service provider must establish coordination with the appropriate local MDHHS to ensure that funds received from the AASA are not used to provide in-home services that can be paid for or provided through programs administered by MDHHS.

C. For instances where a client enters a hospice care program while receiving in-home services, the in-home services are not required to be withdrawn.

    1. A revised service plan must be developed, with consultation from all services providers involved including the hospice care provider.

        a. The service plan must be developed based on the client's needs, preferences and the availability of resources from each provider.

D. OAA funding may not be used to supplant other federal, state, or local funding that was being used to fund services, prior to the availability of OAA funds.

E. OAA programs do not qualify as third party payers for Medicaid programs.

F. Information Requirements

    1. The following information must be gathered and retained on file for each client:

        a. That the client appears to be eligible for MDHHS funded In-Home services and other benefits

        b. That the potentially eligible client consents to a referral for MDHHS funded in-home services and benefits

        c. That a referral to MDHHS or a request for third-party reimbursement through MDHHS has been initiated and the date on which this was made

        d. The information must be completed for all clients. In situations in which the item of information is not applicable to the client a "N/A" must be indicated on the form.

        e. The information may be included on the standard intake form or MDHHS Coordination of Services form.

G. In order to assure continuity of care to the client who is referred to MDHHS, the service provider may initiate needed services to the client until such time MDHHS initiates the service or third-party reimbursement is approved.

H. All third-party reimbursements for eligible in-home services made to the service provider on behalf of the client must be reported to the Region VII AAA as program income.

IV. Prioritizing Clients

A. Each service provider must establish and utilize standardized, written procedures for applying the following criteria to prioritize clients who will receive service:

1. Factors Indicating Social Need: isolated, living alone, age 75 and over, minority group member, non-English speaking, and other relevant factors.

2. Factors Indicating Functional Needs: handicapped as defined by the Rehabilitation Act of 1973, limitations in activities of daily living, mentally unable to perform specific tasks or services required, acute and chronic health conditions, and other relevant factors.

3. Factors Indicating Economic Need: source of income, actual income at or below 185 percent of the poverty threshold

4. Such procedures are to be utilized to determine priority among persons waiting to receive services.

V. Services

A. Upon death, institutionalization or foster home placement of an eligible recipient of in-home services, the service provider shall not automatically continue the provision of service(s) for the surviving or remaining spouse or other household member.

B. A separate determination of eligibility that meets the general requirements for all Region VII AAA funded services, the general requirements for in-home services and the specific service eligibility requirements must be made for each individual.

C. All appropriate intake, assessment, and service plan procedures must be followed prior to the authorization of service(s) for the surviving or remaining individual in the household.

VI. Client Assessment

A. General Intake/Assessment Requirements

1. Each service provider must conduct a comprehensive assessment of individual need for each client. The assessments are to be used to determine eligibility for the specific service(s) and the extent to which services are needed.

2. Basic intake information must be obtained for each individual at the time the request or referral for assistance is made. Basic intake information may be obtained by telephone.

    a. comprehensive assessment must be completed no later than ~~ten~~ fourteen (14) calendar days from the date of the intake.

3. The assessment must be conducted prior to the initiation of service.

4. All programs must have access to, and utilize, a Registered Nurse (RN) for assistance in reviewing assessments and maintaining linkages with appropriate health care programs.

5. Each program with required assessments should avoid duplicating assessments of individual clients to the maximum extent possible.

6. In-home service providers may accept assessments and reassessments conducted by an appropriate referring program and initiate services without having to conduct a separate assessment.

    a. The assessment must contain the required information to meet the minimum standards.

    b. The assessment must have been completed within ~~30~~ 180 calendar days prior to the referral for service.

    c. Appropriate referring programs include CCS, Care Management, home and community based Medicaid programs, other aging network home care programs, and Medicare certified home health providers.

    d. A copy of the assessment completed by the appropriate referring agency must be on file with the provider prior to the initiation of service.

7. Assessments are to be used to verify need, eligibility, and the extent to which services are to be provided.

8. Each service provider must verify that each individual to be served has either functional, physical, or mental characteristics that prevent him or her from providing the service-specific tasks and activities for himself or herself.

9. The service provider must also verify that informal support (family, friends, neighbors, etc.) is unavailable or insufficient to meet the needs identified and

to perform the specific tasks and activities authorized in the client's service plan.

10. If an individual is found to be ineligible, the reason(s) are to be clearly stated.

11. Each assessment and reassessment must be conducted face to face and provide as much of the information specified as possible to determine.

12. Periodic reassessment must be conducted according to the chart below.

In-Home Services Requiring Assessments	Minimum Reassessment Frequency (unless circumstances require more frequent reassessment)
Homemaking	180 days
Home Care Assistance	180 days
Home Delivered Meals	180 days
Medication Management	90 days
Personal Care	180 days
Respite Care	180 days
Home Health Aide	90 days

13. Each assessment and reassessment should include a determination of when reassessment should take place.

B. Minimum Assessment Form Requirements

1. In-home service providers must utilize a standardized, written assessment form.

2. At the minimum, the assessment form must include the following items of information:

    a. Basic Information

        i. Individual's name, address, and telephone number

        ii. Source of referral

        iii. The name, address, and phone number of a person to contact in case of an emergency

        iv. The name, address, and phone number of caregiver(s)

        v. Gender

vi. Age and date of birth

vii. Race and/or ethnicity

viii. Living arrangements

ix. Condition of residential environment

x. Whether or not the individual's income is below the poverty level and/or sources of income (particularly SSI)

b. Functional Status

i. Vision

ii. Hearing

iii. Speech

iv. Oral status (condition of teeth, gums, mouth, and tongue)

v. Prostheses

vi. limitations in activities of daily living

vii. Eating patterns (diet history), special dietary needs, source of all meals, and nutrition risk

viii. History of chronic and acute illnesses

ix. Prescriptions, medications, and other physician orders

c. Support Resources

i. Physician's name, address, and phone number (for all physicians)

ii. Pharmacist's name, address, and phone number (for all pharmacies utilized)

iii. Services currently receiving or received in past (including identification of those funded through Medicaid)

iv. Extent of family and/or informal support network

v. Hospitalization history

vi. Medical/health insurance available

vii. Clergy name, address, and phone number, if applicable

d. Client Satisfaction (at reassessment)

i. Client's satisfaction with services received

ii. Client's satisfaction with program staff performance

iii. Consistency of services provided

e. Signatures and Client Consent

i. Dated signature of client or his/her representative indicating consent to receive services for which he or she is determined eligible

ii. Dated signature(s) of assessor(s)

C. Assessors must attempt to acquire each item of information identified on the assessment form, but must also recognize and accept, the client's right to refuse to provide requested items of information.

D. Changes in any item should be specifically noted during reassessments.

E. Each in-home service provider must notify, in writing, each client of their right to comment about service provision or right to appeal termination of services at, or prior to, the time service is initiated.

1. Notice must advise that complaints of discrimination may be filed with the Region VII AAA, with the Michigan Department of Health and Human Services, Office of Civil Rights, or the Michigan Department of Civil Rights.

2. A copy of the Service Termination Policy must also be furnished to the client at that time.

F. At the time of the initial assessment, a release of information form must be signed by the client, or the client's guardian or designated representative.

1. The release must be time limited, not to exceed one year from the signature date and specific as to information for release.

VII. Client Follow-Up and Reassessment

A. Reassessments are to determine changes in client status, client satisfaction and continued eligibility for the specific service program. Reassessments must be conducted in face-to-face.

B. Each in-home care program must have a RN available to review and sign off on all care plans developed from assessments and reassessments.

C. Each in-home care provider must ensure that a follow-up telephone contact is made to the client at least once every two months to monitor changes in the client's condition or circumstances.

1. A telephone monitoring contact must be made whenever direct service personnel, aides, or workers report changes to program supervisory personnel.

2. Telephone monitoring contacts and outcome must be documented in the client's file.

3. Telephone monitoring contacts and direct service personnel reports shall be used to determine if the reassessment must be conducted prior to the scheduled date.

4. Telephone monitoring may be conducted by CCS program staff or by other trained provider staff or volunteers.

5. Telephone monitoring contacts shall not be counted in the reporting of in-home care service units.

VIII. Client Service Place

A. Each in-home service provider must establish a written service plan for each client based on the assessment of need, within 14 calendar days of the date the assessment was completed.

B. The service plan must be developed prior to providing service and in cooperation with the client, client's guardian, or designated representative.

C. The service plan must contain at a minimum:

1. A statement or the client's problems, needs, strengths, and resources

2. A statement of the goals and objectives for meeting identified needs

3. Description of methods and/or approaches to be used in addressing needs

4. Identification of services and the frequency at which they are to be provided

5. Treatment orders of qualified health professionals, when applicable

6. Documentation of referrals and follow-up actions

D. When the service plans for in-home care programs are not developed by a RN, the programs must have access to a RN.

1. The service plan must be reviewed and signed by the RN

2. The RN does not have to be an employee of the program

E. Service plans for all programs must be evaluated at all client reassessments and updates.

F. The plan must include notations of all changes in the scope of service activities and/or frequency or duration of service determination based on the reassessment.

1. Written notations of such changes must be dated.

2. When the reassessment indicated that no changes are needed in the scope of service tasks or the frequency or duration of services, a dated, written notation of “no change” must be entered into the service plan.

3. When the reassessment indicates that additional services may be needed, a referral to CCS services should be initiated and a dated, written notification of the referral entered in the service plan.

4. When the reassessment indicates that the service goals and objectives have been fulfilled, the client should be terminated in accord with the required procedures and a dated notation of termination be entered in the service plan.

IX. Client Records

A. Each in-home care provider must maintain comprehensive and complete individual client records.

1. All client files must be kept confidential in controlled access files.

B. The individual client record must contain, at a minimum, the following:

1. Details of referral to program
2. Assessment of individual need or a copy of the assessment from the referring program
3. Completed reassessment forms
4. Service plan with updates and notations of any revisions
5. Notes in response to client, family, and agency contacts (including notation of all referrals made)
6. Programs with multiple sources of funding must specifically identify clients served with funds from Region VII AAA
    a. Records must contain a listing of all contacts paid for with funds from Region VII AAA and the extent of services provided
7. Record of release of any personal information about the client and a copy of signed release of information form
8. Service start and stop dates
9. Service termination documentation, if applicable
10. Signatures and dates on client documents, as appropriate

C. Service Providers must maintain chronological, cumulative case notes for each client.

1. Each written entry must be dated.
2. Case notes must document the following:
    a. Dated entry of all contact along with a notation of the number of units of service rendered and any unusual circumstances or changes such as improvement or regression
    b. Emergency, accident or sudden illness reports occurring during the provision of service, including date, time, conditions under which the incident occurred, and action taken

X. Termination Policy

A. Each in-home care service provider must establish a written service termination policy, which addresses the following:

1. Formal written notification to client which includes the following:

a. The reason for the termination

b. The effective date of the termination

c. The rights to appeal termination

B. Reasons for termination may include but are not limited to the following:

1. Client's decision to stop receiving services

2. Reassessment that determines a client to be ineligible

3. Improvement in the client's condition so that he or she no longer is in need of services

4. Change in the client's circumstances which makes him or her eligible for in-home services from other sources

5. Increase in the availability of support from friends and/or family

6. Institutionalization of client in either acute care or long term care facility. If temporary, services need not be terminated

7. The program becomes unable to continue to serve the client and referral to another provider is not possible

8. Death of client

C. The termination policy must be approved by the service provider's governing body

XI. Staffing

A. Staff and volunteers must receive an orientation which includes:

1. Introduction to the program, assessment and observation skills, maintaining records, basic first aid, community resources, aging process, ethics, emergency procedures, and safety and sanitation.

2. Staff must be qualified by training or experience to competently provide clients with in-home services.

3. The service provider is responsible for providing instruction and training on specific assigned tasks for those workers who lack training or experience in the completion of such tasks.

B. Each program must thoroughly check references on all paid staff.

C. Each program must perform a criminal background check on all staff and volunteers.

D. In-home care staff must receive in-service training at least twice each fiscal year which is specifically designed to increase knowledge and understanding of the program and clients to improve skills at tasks performed in the provision of service.

1. Comprehensive records identifying dates of training, persons attending, and topics covered are to be maintained.

2. An individualized in-service training plan should be developed for each staff person when performance evaluations indicate a need.

E. Each in-home care provider must conduct in-home supervision of program staff at least once each fiscal year.

1. Supervision for all programs must be conducted by qualified staff.

2. Program supervisors must be available to program staff via telephone at all times they are in the client's home.

F. Direct service staff must be required to immediately report changes in a client's condition or circumstances to the supervisor.

1. The service provider must establish and instruct staff on formal written procedures to ensure timely reporting of client changes, emergencies, and incident reports.

XII. Coordination of Service

A. Each in-home care service provider must establish linkage with CCS and CM programs operating in the area.

B. Each in-home care service provider must demonstrate working relationships with other agencies providing in-home services for referrals and resource coordination to

ensure that clients in need of services available from other agencies have access to such services.

XIII. Sanitation

A. Each in-home care program shall have written policies and procedures on safety and sanitation practices in a client's home.

B. Safety and sanitation policies and procedures must establish precautionary measures necessary to minimize risks to both the worker and/or the client in the presence of communicable diseases or conditions that may be transmitted through direct contact.

C. Safety and sanitation procedures shall be a required component of service staff orientation.

VOLUME III:	Specific Service Requirements
(6) POLICY NAME:	Personal Care
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	AASA Operating Standards for Service Programs
UNIT OF SERVICE:	A unit of service is one hour spent performing personal care activities

I. Service Definition

A. Personal Care is the provision of in-home assistance with activities of daily living (ADL) for an individual including assistance with bathing, dressing, grooming, toileting, transferring, eating and ambulating.

B. This service does not include health-oriented services as specified for Home Health Aide Service.

C. A client is one person age 60 or older who receives Personal Care.

II. Restrictions and Limitations

A. Unallowable activities include, but are not limited to the following:

1. Assisting with a prescribed exercise regimen
2. Supervising the client's adherence to prescribed and/or special diets
3. Changing non-sterile dressing
4. Taking blood pressure
5. Administering enemas
6. Administering or supervising tube feedings
7. Other health monitoring activities

B. Direct service staff shall not dispense or administer prescription medications, nonprescription medications, or dietary supplements to the client.

C. Personal care funds may use up to twenty percent of the personal care service budget to support the provision of related homemaker services.

1. This shall correspond to twenty percent of the contracted service units.

III. Staffing Requirements

A. Personal Care workers must be directly supervised by a professionally qualified person

B. Each worker must be trained for each task to be performed.

1. The supervisor must approve tasks to be performed by each worker.

2. Completion of a recognized nurse aide or home health aide training course by each worker is recommended

VOLUME III:	Specific Service Requirements
(7) POLICY NAME:	Homemaking
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	AASA Operating Standards for Service Programs
UNIT OF SERVICE:	A unit of service is one hour spent performing homemaking activities

I. Service Definition

A. Homemaking is the performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations.

1. Homemaking does not include the provision of chore or personal care tasks.

2. Allowable homemaking tasks are limited to the following:

a. Laundry

b. Ironing

c. Meal preparation

d. Shopping for necessities, including groceries and errand running

e. Light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds)

f. Maintaining a safe environment

g. Observing, reporting, and recording any change in client's condition and home environment

h. Social/emotional support of client may be offered in conjuction with other allowable tasks

II. Client Requirements

A. Each program must have written eligibility criteria

B. Statement of eligibility criteria shall be given to all clients prior to the initiation of service.

C. A client is one person age 60 or older who receives homemaking.

III. Staffing Requirements

A. Background

1. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, meal preparation, good health practices, observation, reporting and recording information.

B. In-Service Training

1. Required in-service training topics include safety, sanitation, household management, nutrition and meal preparation.

VOLUME III: Specific Service Requirements

(8) POLICY NAME: In-Home Respite Care

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: AASA Operating Standards for Service Programs

UNIT OF SERVICE: A unit of service is one hour of respite care provided

I. Service Definition

A. In-Home Respite Care is the provision of companionship, supervision, and/or assistance with activities of daily living for persons with mental or physical disabilities and frail older persons in the absence of the primary care giver(s).

B. Each program must establish written eligibility criteria which include at a minimum:

1. That clients must require continual supervision in order to live in their own homes or the home of a primary care giver, or

2. Require a substitute caregiver while their primary caregiver is in need of relief or otherwise unavailable; and/or

3. That clients may have difficulty performing or be unable to perform activities of daily living (ADLs) without assistance as a result of physical or cognitive impairment.

C. In-home respite care services include:

1. Attendant Care: Provides companionship, supervision, and/or assistance with toileting, eating, and ambulating for clients who are not bed-bound.

2. Basic Care: Provides assistance to clients, who may or may not be bed-bound, with ADLs, routine exercise regimen, and assistance with self-medication.

3. Respite Care may also include chore, homemaking, home care assistance, home health aide, meal preparation, and personal care services.

a. When provided as a form of respite care, these services must also meet the requirements of that respective service category.

D. A client is the caregiver of one person age 60 or over who receives respite care.

II. Program Policies and Procedures

A. Coordination of Service

1. Each In-home respite care service provider must be able to demonstrate working relationships with a hospital and/or other health care facility for the provision of emergency health care services.

B. Medications

1. Each respite care service provider must develop a written policy and procedure to govern the assistance given to participants in taking medications, which includes at a minimum the following:

a. Who is authorized to assist participants in taking either prescription or over-the-counter medications and under what conditions such assistance may take place.

b. A review of the type of medication to be taken and its impact upon the client

c. Verification of prescription and dosages

d. Medications shall be maintained in their original labeled containers

e. Instructions for entering medications information in client files including times and frequency of assistance

f. A clear statement of the client's and client's family responsibility regarding medications to be taken by the client while participating in the program.

g. Provision for informing the client and client's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

2. Each service provider must furnish a copy of the medication policy to the client or caregiver prior to the initiation of service or be able to demonstrate that the client and the caregiver have been familiarized with and understand the policy.

3. All service workers must receive instructions on the medications policy during orientation.

C. An emergency notification plan shall be developed for each client in conjunction with the client's primary caregiver.

1. Emergency information must be included in the client file and may be a part of the assessment or plan of care.

2. Emergency information must be accessible to the assigned respite care worker and on hand while providing respite care services.

3. At a minimum, the emergency notification plan must include:

a. The name, address, phone number, and relationship to client of at least two persons to contact in an emergency

b. Physician's name and phone numbers

c. Identification of preferred hospitals

d. Consent for ambulance transportation

e. Authorizing signature, if separate from plan of care

D. Each program shall ensure that the skills and training of the respite care worker to be assigned coincides with the service plan of the client, client needs, and client preferences.

1. Client needs may include, and are not limited to, cultural sensitivity, cognitive impairment, mental illness, and physical limitation.

VOLUME III:	Specific Service Requirements
(9) POLICY NAME:	Chore Service
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	AASA Operating Standards for Service Programs
UNIT OF SERVICE:	A unit of service is one hour spent performing allowable chore tasks

I. Service Definition

A. Chore Services are those non-continuous household maintenance tasks intended to increase the safety of the individual living at the residence.

1. Allowable tasks are limited to the following:

a. Replacing fuses, light bulbs, electric plugs, and frayed cords

b. Replacing door locks and window catches

c. Replacing or repairing pipes

d. Replacing faucet washers or faucets

e. Installing safety equipment

f. Installing screens and storm windows

g. Installing weather stripping around doors

h. Caulking windows

i. Repairing furniture

j. Installing window shades and curtain rods

k. Cleaning appliances

l. Cleaning and securing carpets and rugs

m. Washing walls and windows and scrubbing floors

n. Cleaning attics and basements to remove fire and health hazards

o. Pest control

p. Grass cutting and leaf raking

q. Clearing walkways of ice, snow, and leaves

r. Trimming overhanging tree branches

B. A unit of service is one hour spent performing allowable chore tasks.

C. A client receiving chore services may only be counted once during the contract period.

1. Only the unduplicated count of clients served is reported to the Region VII AAA.

II. Client Eligibility and Priority Requirements

A. Persons 60 years of age or older shall be eligible for services supported in whole or in part by State and Federal funds awarded by the Region VII AAA.

B. Priority shall be given to meeting the needs of persons with the greatest economic and social needs with preference to serving low-income, minority elderly.

C. Before beginning services the service provider must determine whether a client is eligible for chore services provided through other funding sources, including programs funded through Title XVIII and XIX of the Social Security Act.

1. The service provider shall develop a written agreement to secure third party payment for services rendered to eligible clients or refer eligible clients to Service Providers administering the funding sources listed above.

D. In order to maximize the number of clients who may be served services provided to an individual should not exceed eight manpower hours in one calendar week.

E. Service providers shall outline the parameters of the program, including the circumstances in which the program will complete potentially high demand activities, such as lawn mowing and snow removal.

III. Client Intake

A. Service providers must complete an intake for each individual served by the program.

B. The intake process must document the client's unmet need for chore services.

1. A list of the Chore tasks to be performed must be included.

C. The intake form must be completed once per fiscal year per client at the time services are initially requested.

1. Every additional time the client requests services, the service provider must reestablish the unmet need for chore services.

2. The list of tasks to be performed must be updated and a new work order prepared.

IV. Staff Requirements

A. Service providers must provide on-site supervision in a client's home for each employee at least once per year.

V. Restrictions and Limitations in the Scope of Service

A. Funds awarded for chore service programs may be used to purchase materials and disposable supplies used to complete the chore tasks that increase the safety of the individual.

1. No more than $200 may be spent on materials for any one household per year.

B. Equipment or tools used to perform chore tasks may be purchased or rented with funds awarded up to an amount equal to 10 percent of total grant funds.

C. Only appropriately licensed suppliers may provide Pest control services.

D. Each program must develop working relationships with the home repair and weatherization service providers, as available, in the project area to ensure effective coordination of efforts.

VOLUME III: Specific Service Requirements

(10) POLICY NAME: Home Repair Services

PURPOSE: The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.

AUTHORITY: AASA Operating Standards for Service Programs

UNIT OF SERVICE: A unit of service is one hour spent performing allowable home repair tasks

I. Service Definition

A. Home repair services are defined as permanent improvements to an older person's home to prevent or remedy a sub-standard condition or safety hazard.

B. Home repair service offers permanent restoration and/or renovation to extend the life of the home and may involve structural changes.

C. Home repair does not involve making aesthetic improvements to a home, temporary repairs, chore or home maintenance that must be repeated.

D. Allowable home repair tasks include:

1. Roof repair or replacement
2. Siding repair or replacement
3. Door and window repair or replacement
4. Foundation repair or replacement
5. Floor repair or replacement
6. Interior wall repair
7. Plumbing and drain repair or replacement
8. Insulating/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers, and door sweeps)
9. Stair and exterior step repair or replacement, including converting stairs or steps to wheelchair ramps

10. Heating system repair or replacement

11. Ensuring safe and adequate water supply

12. Electrical wiring repair or replacement

13. Obtaining building permits

14. Painting to prevent deterioration and in conjunction with repairs.

E. A client receiving home repair services may only be counted once during the contract period.

1. Only the unduplicated count of clients served is reported to the Region VII AAA.

II. Client Eligibility

A. Each home repair service provider must establish and utilize written criteria for prioritizing homes to be repaired which address the following:

1. The condition of the home

2. Client need and appropriateness of requested repairs

3. Owner of the home

a. An older person with a life lease or life estate agreement is considered the owner of the home for purposes of Region VII AAA funded Home Repair programs.

b. If an agreement specifies that another party is responsible for paying for repairs to the structure, the program must either refer the client to that party or arrange for payment from that party for repairs.

c. If the agreement does not address repair of the home or specify responsibility of a third party for paying the costs of repair, the older person should be treated as the homeowner for the program.

d. All minimum standards for the Home Repair service apply to potential clients with life lease or life estate agreements on their homes.

4. Each home repair service provider, prior to initiating service, must determine whether a potential client is eligible to receive services through a program

supported by other funding sources, particularly programs funded through the Social Security Act.

a. When an individual can be served through other resources, an appropriate referral must be made.

III. Requirements

A. Each service provider must develop working relationships with available weatherization, chore, and housing assistance service providers in the project area to ensure effective coordination of efforts.

B. Service providers must assure that they will not weatherize a home for any individual who is eligible to receive home weatherization through a federal or state funded weatherization program.

C. If service providers can document that assistance from the existing home weatherization program is not available, they may provide home weatherization to older persons who have requested such assistance.

D. No more than $2,400 may be expended per home during a contract year regardless of the activities undertaken.

E. Funds awarded for home repair service may be used for labor costs and to purchase materials used to complete the home repair tasks that prevent or remedy a sub-standard condition or safety hazard.

F. Equipment or tools needed to perform home repair tasks may be purchased or rented with funds from the Region VII AAA up to an amount equal to 10 percent of total grant funds.

G. Each program must maintain a record of homes repaired including dates, tasks performed, materials used, and cost.

H. Service providers shall be required to adhere to all applicable laws, ordinances, and regulations relative to home construction, repair, or modification.

I. The service provider must assure that each home repaired complies with local building codes.

J. No repairs shall be made to a condemned structure.

K. Home repair services may not be provided on rental property.

IV. Client Procedures

A. Service providers must complete an intake form for each individual served.

1. The intake process must document the client's unmet need for home repair services.

2. A list of the home repairs to be completed or a work order must be included.

B. The service provider must utilize a written agreement with the ~~elderly~~ owner of each home to be repaired that includes at a minimum the following:

1. A statement that the home is occupied and is the permanent residence of the owner

2. A statement that in the event the home is sold within two years of completion of work by the program, the owner will reimburse the program the full cost of repairs made to the home

3. Specification of the repairs to be made by the program

C. Each program must utilize a job completion procedure that includes the following:

1. Verification that work is completed and correct

2. Verification by local building inspector that work satisfies building codes

3. Acknowledgement by homeowner that work is acceptable within ten (10) days of completion

V. Staff Requirements

A. Service Providers must provide on-site supervision in a client's home for each employee at least once per year.

B. Workers performing repairs must have experience or training in construction or repair.

C. Service providers may expend no more than 25 percent of the approved budget for contract labor such as plumbers, electricians, etc~~.~~

D. The service provider shall assure that when contractors are used, a minimum of two competitive bids shall be obtained and kept on file.

1. If the repair to be provided is an emergency situation, only one bid is necessary

2. The bid and the final invoice shall itemize labor and material costs separately.