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
UNIT OF SERVICE:	One unit per month when any CM activity is provided for a client.

I. Primary Goals

A. The goals of CM are:

1. To delay and/or prevent costly, premature or inappropriate institutionalization of high-risk older adults.

2. To define appropriate levels of care to assist older adults in maintaining independence by utilizing available informal (unpaid) and formal (paid) supports.

3. To provide minimal levels of support necessary to enable caregivers to continue their support for the client

II. Minimum Standards

A. Medical eligibility for care management shall be determined using the MI Choice screen and assessment prior to an individual's enrollment in the CM program.

III. Care Management (CM)

A. CM is the provision of a comprehensive assessment, Service Plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals who are aged 60 and over who are medically complex and at risk of, or in need of, a nursing facility level of care due to functional and/or cognitive limitations.

B. Using a person-centered planning process, services are brokered or directly purchased, according to an agreed-upon service plan, to assist the client in maintaining independence.

C. Care management functions shall be conducted by a multi-disciplinary team. A team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years care manager experience.

IV. Functions of CM

A. Eligibility determination

B. Assessment

C. Service Plan Development

D. Service Arranging

E. Follow-up and Monitoring

F. Supports Coordination

G. Reassessment

H. On-going monitoring

V. Activities

A. Designed to enhance client autonomy

1. Respect client preferences

2. Support caregivers; and

3. Promote efficient use of available resources.

B. Activities shall be conducted in accordance with the established AASA CM Performance Criteria.

VI. Administration and Coordination of CM

A. AAAs are authorized to administer care management as a direct service under the Older Americans Act.

1. If subcontracting the service, AAAs ensure that CM providers are service neutral

a. Agencies that authorize services for CM clients may not provide those services directly or have direct or indirect ownership or controlling interest in, or a direct or indirect affiliation or relationship with an entity that provides services other than care management, except where there is no other viable provider and a waiver is granted by AASA.

B. CM agencies must establish arrangements with direct service providers to define operating parameters and avoid duplication in assessment, reassessment and service arrangement functions.

C. AAAs are responsible for implementing these standards whether CM is provided directly by the AAA or subcontracted.

VII. Eligibility for CM Services

Eligibility for CM is determined through a formal assessment. Eligibility to participate is not based on a person's level of income. AAAs may develop written criteria to further target low-income individuals, however participation may not be denied because individuals do not meet low-income criteria.

A. Age 60 and older.

B. Medically complex with functional and/or cognitive limitations.

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

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

E. At risk of, but not necessarily in need of, a nursing facility level of care.

F. In need of a nursing facility level of care, but not eligible for Medicaid-supported long-term care services.

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

H. A person at risk demonstrates one or more of the following characteristics:

1. Determined medically eligible for nursing facility placement

2. Functionally unable to provide self-care without assistance due to illness or declining health and without sufficient support for meeting care needs.

3. Multiple, complex and diverse service needs.

4. A weak or brittle informal support system.

5. Currently resides in a nursing home, but because of insufficient resources and lack of other supports, is unable to obtain needed community services to return home.

VIII. Standards of CM Performance

A. Program activities shall be conducted in accordance with the values and elements of person-centered planning.

B. Individuals receiving care management services shall have the opportunity to identify and express their goals, choices and needs, and receive services and supports that contribute to realizing goals, honoring choices, and meeting needs.

C. The role of the care manager is to support and facilitate the individual in maintaining the highest level of functioning and independence possible.

D. The client shall sign a consent to participate, which assures their right to accept or refuse services.

1. The consent form shall be signed at assessment and contain the following information:

a. Client's agreement to participate in the program.

b. Acknowledgement that client is fully informed of the information in the consent document.

c. Acknowledgement of the client's right to receive or refuse services.

d. A statement that the consent to participate may be revoked upon request of the client or his/her proxy when the client is determined legally incompetent or physically unable to withdraw consent to participate.

E. The client's right to privacy shall be assured.

1. The law (Privacy Act of 1974, as amended, 5 USC, Subsection 552a and 42 CFR 431.300-.307) treats all communication with the client as confidential, whether oral or written, including records derived from such communications.

2. Information disclosed by the client to the care manager shall be held in strictest confidence and may be released only with prior written consent.

F. The client shall authorize the use or disclosure of health information protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The written authorization should include the following:

1. Permission to use or disclose protected health information (PHI) for purposes beyond treatment, payment or health care operations.

2. A description of the PHI to be disclosed.

3. Purpose for the disclosure.

4. The intended recipient.

5. The date the authorization expires.

G. Qualified staff conduct CM functions. CM functions shall be conducted by a multi-disciplinary team.

1. A team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years CM experience.

H. Each program shall require and thoroughly check references of paid staff that will be entering clients' homes.

1. In addition, each program must conduct a criminal background check through the Michigan State Police for each paid and/or volunteer staff person who will be entering clients' homes.

I. Care managers are provided direct supervision in the conduct of program activities.

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

K. Care managers shall strive to establish and maintain a positive working relationship with clients.

IX. Program Education and Referral

A. In an effort to facilitate appropriate referrals to the program, staff provide education to potential referral sources to raise awareness, describe characteristics of the target population, and explain screening criteria.

1. Potential referral sources include key agencies serving the target population (hospitals, home care agencies, human service agencies, and other community agencies) and family/friends.

B. The AAA shall establish written procedures for managing referrals during periods of time when there is demand for care management services that exceeds program capacity.

X. Person-Centered Planning

A. A person-centered service plan, detailing the services to be arranged or purchased, shall be developed with the active involvement of the client.

1. Others, including family members and caregivers, may be involved as deemed appropriate by the client.

2. Assessment findings shall be incorporated within the service plan.

3. Service plans shall be modified or adjusted based on reassessment findings or other changes in the client's condition.

B. Client preference should be integrated throughout the entire care management process

C. The process will include considering the client preference regarding:

1. Time

2. Date

3. Attendees

4. Service provision

XI. Prescreen

A. Following referral to CM, all applicants are screened to determine their level of need and willingness to receive CM services.

    1. Eligibility for an assessment is determined through a screening process utilizing the MI Choice Intake Guidelines (MIG).

    2. The MIG, instructions, and scoring algorithm can be accessed in the Center for Information Management's (CIM's) COMPASS assessment system.

B. The screen represents a formal request for participation in the program.

    1. The screening process evaluates the applicants' health, social, emotional and environmental needs, and their abilities and needs in performing activities of daily living (ADLs) and instrumental activities of dialing living (IADLs).

    2. It considers the level of caregiving currently provided to the applicant, whether that care will continue, and the amount of additional assistance needed.

C. Referrals are screened through direct questioning of the individual seeking CM service whenever possible.

    1. Direct questioning may occur either by telephone or in person.

    2. Screening may involve a proxy and/or a referral source to confirm the applicant's need and willingness to receive CM and in-home services.

D. Screen questions are to be asked as worded; however, they may be administered flexibly, rather than in the order they appear on the standardized tool.

    1. Additional probative questions are permissible when needed to clarify eligibility.

    2. All sections of the screen must be completed and scored.

E. Applicants who score into Section A are not usually eligible for a CM assessment, and if found not eligible, shall be provided information and referral to a program, agency or community services appropriate to meet their needs.

    1. Applicants who score in sections B and C may be eligible for and offered an assessment.

    2. Applicants who score in sections D, D1 or E are likely eligible for and should be offered a formal assessment.

F. Any time the program is at capacity, a list of individuals screened and awaiting assessment shall be established and maintained.

    1. At a minimum, the waiting list shall include the name, address, telephone number, referral source, date of screen, and total score.

    2. Where program resources are insufficient to meet the demand for services, each CM program shall establish and utilize written procedures for prioritizing clients waiting to receive services, based on social, functional and economic needs.

G. The AAA shall establish written procedures for all staff performing screening functions.

H. Applicants determined not eligible for an assessment shall be provided information and referral to a program, agency or community services appropriate to meet their needs.

I. Referral source and proxies shall be notified of the outcome of the screen.

J. Screen information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

K. All referrals to the CM program will be screened and scored using the MI Choice II Information Guideline (MIG) provided by the Michigan Department of Health and Human Services (MDHHS)

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

M. All referrals must be prescreened within three business days

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

O. Prescreening will determine the order in which the client 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

XII. Assessment

A. The interRAI Home Care Assessment System (IHC) is the basis for the CM Assessment.

1. It is designed to be comparable to the resident assessment instrument congressionally mandated for use in nursing facilities.

2. Care Managers use the IHC to perform a comprehensive evaluation including assessment of the individual's unique preferences: physical, social and emotional functioning; physical environment; natural supports; and financial status.

B. The assessment requires direct questioning of the applicant and the primary caregiver, if available, observation of the applicant in the home environment, and a review of secondary documents

1. Whenever possible, the applicant is the primary source of information and the assessment should be performed face-to-face in the applicant's place of residence.

C. The IHC and Clinical Assessment Protocols (CAPs) can be accessed in CIM's COMPASS assessment system under the Help tab.

D. Each individual scheduled for assessment shall have been screened for participation in the program.

E. 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.

F. All assessments must be conducted in person with active participation of the applicant within 30 calendar days of the prescreen

1. For individuals assessed in a setting other than their home, such as a hospital or nursing care facility, care managers shall conduct a home visit within 14 days to assess the proposed living environment.

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

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

I. All assessments must be completed prior to the initiation of services according to the IHC Assessment Form and CAPs

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

K. The following activities are conducted as part of the assessment interview:

1. Discuss with the applicant feasible alternatives to receiving long-term care.

2. Secure in writing the applicant's informed consent

3. Secure in writing the applicant's consent to release confidential information.

4. Secure in writing the applicant's consent to disclose protected health information for purposes beyond treatment, payment, or health care operations as applicable.

5. Inform the applicant of the right to appeal actions and decisions.

L. Assessment information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

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

N. 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

O. A Client back-up plan will be developed based on the assessment data

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

Q. Service provider will assure that the Client is aware of the complaint resolution procedure.

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

S. 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.

T. 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

U. Role of the Family and Caregivers in Assessment Process

1. The applicant is the primary focus of the assessment and information is gathered from the applicant whenever possible.

2. In addition, family members and caregivers are an essential part of the applicant's support system.

    a. With the applicant's permission, their input is elicited as part of the assessment whenever possible.

3. At the expressed desire of the applicant, or in instances where the applicant is unable to fully participate in assessment activities, input may be sought and accepted from a proxy source, such as a spouse, adult child, a primary caregiver, or another individual involved in the applicant's care on an on-going basis.

4. In instances where a guardian is assigned to make decisions on behalf of an individual, the guardian must be included in the assessment process to make decisions over which he/she has authority.

V. Role of Other Professionals, Physicians in Assessment Process

1. Due to the medical complexity of individuals enrolled in the program, care managers may receive medical information from a physician or other professionals involved with the client with the client's written permission

    a. Coordination of care with medical providers allows for a comprehensive service plan.

XIII. IHC Clinical Assessment Protocols and Triggers

A. The IHC consists of the IHC Assessment and the CAPs. The IHC Assessment Form is the component that enables a care manager to assess multiple key domains of function, health, social support and service use.

1. Particular items also identify individuals who could benefit from further evaluation of specific problems or risks for functional decline.

2. These items, known as triggers, link the assessment to a series of problem-oriented CAPs.

B. Overview, Purpose/Use

1. The CAPs contain general guidelines for further assessment and individualized care planning for clients who present issues in trigger conditions.

2. There are multiple CAPs that respond to client needs in multiple domains.

3. The focus is not just on simple maintenance services or planning a response to an immediate problem.

4. While these are included, the use of CAPs helps clinicians assess for opportunities to rehabilitate function, prevent decline, and maintain clients' strength.

5. In responding to urgent needs, care priorities can be identified.

6. In looking at chronic problems, comprehensive well-being can be maintained.

C. Role in Service Plan Development

1. An accurate assessment lays the groundwork for all that follows – problem identification, identification of causes and associated conditions, and specification of necessary service goals and related service approaches.

2. The average client will trigger on 10-14 CAPs.

3. Problems will be identified in many areas, prompting further review through an in-depth evaluation of problems.

4. The in-depth evaluation of problems helps care managers to think through why a problem exists or why the client is at risk, providing the necessary foundation on which to base next steps.

XIV. Person-Centered Service Plan Development

A. Person-centered planning is the guiding principle behind service plan development.

1. The Person-Centered Service Plan is a written document detailing the full spectrum of supports and services provided to the client.

2. It is designed to respond to problems and concerns identified through the assessment, as well as a client's expressed choices and needs.

3. The service plan shall maximize the client's strengths, personal control and independent living, while addressing the problems and/or concerns that affect health, safety and quality of life.

4. It takes into consideration the whole person, rather than only those services and supports provided through the care management program.

5. That includes a client's natural support system and what is needed to support those involved in a caregiving role.

6. The service plan prioritizes those services necessary to address basic health and safety issues.

B. Clients have the right to choose who will provide the services indicated in the service plan from among providers under contract with the AAA or enrolled in the direct purchase provider pool.

1. If the client has no preference of provider, the care manager shall select a provider on their behalf based on established selection criteria (quality, availability and cost) for final approval by the client.

XV. Service Arranging

A. Client preference in selection of service provider from among those under contract or enrolled in a direct purchase provider pool with the AAA shall be ensured.

B. Care managers shall serve as agents of the client in negotiating and arranging formal and informal services.

C. Care managers shall serve as the liaison to the client's personal physicians and secure approval for service when service plans specify arranging services that require physician approval.

D. A written service authorization shall be completed and submitted to service providers

1. The service authorization shall delineate each formal service arranged or purchased under the client's service plan and specify the frequency and duration of service delivery.

XVI. Follow-Up / Monitoring

A. Follow-up and monitoring include contact between the care managers, the client and/or service providers to ensure providers deliver services as planned and to the satisfaction of the client.

1. Follow-up and monitoring are the processes used to evaluate the timeliness, appropriateness and quality of services implemented under the client service plan.

2. All services implemented on behalf of clients are monitored by care managers as a function of service planning and reassessment.

B. Follow-up and monitoring is provided to all CM clients.

1. Care managers shall be in contact with clients on at least a monthly basis unless otherwise specified by the client

C. Care managers shall serve as agents of the client in monitoring formal and informal services.

D. Care managers contact newly enrolled clients within fourteen (14) days of the agreed upon service start date to verify that services are provided in the manner arranged and to the satisfaction of the client.

1. Case Managers may contact the service provider in addition to the client to verify service provision and identify any issues identified by the provider.

E. Each follow-up/monitoring contact and date is documented in the client case record.

F. Changes in services negotiated during follow-up/monitoring contacts on behalf of clients are recorded in the case record.

G. Care managers provide oral and/or written feedback to providers regarding services provided according to the service plan when care managers receive client concerns or complaints.

H. When care managers attempt to arrange a service that cannot start within 30 days due to a waiting list for the service, managers must contact the provider agency every 30 days until the service is implemented.

XVII. 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. The following case classifications shall apply to the Care Management Program:

1. AASA/CM = State or Federal Funded Care Management through AASA. The client is enrolled in the AASA Care Management Program.

2. TCM – Targeted Case Management. The client is:

   a. Enrolled in the AASA Care Management Program

   b. Financially eligible for community Medicaid

   c. Meets Nursing Facility Level of Care (NFLOC) criteria

   d. Enrolled in the TCM Program

C. Each client shall be assigned a case classification.

D. A reason for transferring clients from one classification to another shall be clearly documented in the client case record.

E. The client and/or proxy shall be informed of case closure in writing, except when death is the reason for case closure.

F. The client and/or proxy shall be informed of procedures to be followed to re-enter the program if the need for intervention changes.

G. Case classification information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

H. 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

I. 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 Service 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

J. 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 (e.g. refuses service).

    d. The client stabilizes to a point that care management intervention is no longer required.

    e. The Client's circumstances change which allows for payment from other fund sources

    f. Informal support has increased availability

    g. Inability to continue to serve the Client due to funding or safety concerns

    h. The Client stabilizes to a point that CM is no longer required

i. The client dies

XVIII. Service Plan Development

A. Required Service Plan Elements

1. Client identification number
2. Identification of each issue, need, problem, and what it is related to
3. Planned intervention for each issue/need/problem
4. Planned goal and outcome for each issue/need/problem
5. Date intervention is initiated (start date)
6. Date goal is met (stop date)
7. Frequency and duration of service
8. Client approval (verbal or in writing) or other disposition (client will or will not consider)
9. Signatures of assigned care managers

B. 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.

1. The plan shall be developed for each client within 14 days of assessment.

C. Others, including family members and caregivers, may be involved allies as deemed appropriate by client.

1. If the client has a guardian, the guardian must be involved in service planning activities.

D. Each program shall establish linkages with agencies providing long-term care support services within the program area (e.g., in-home service providers, case coordination and support programs, MI Choice Waiver programs).

E. 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

F. 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.

G. The Client must approve the plan and all the content contained within the plan.

H. 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.

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

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

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

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

M. 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.

N. The service plan considers the client's IHC assessment, CAPs and triggers in development of necessary service goals and related service approaches. It shall include all required elements described under Required Service Plan Elements.

O. The CAPs and Triggers report will be utilized in the development of the Service Plan as appropriate and as approved by the Client.

P. The Client will receive a meaningful and understandable copy of their written, person centered, Service Plan at the first reassessment, annually, as changes are made, or per request.

Q. 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. 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. Client signature and date, indicating approval

8. Program staff signature(s) and date

9. The fulfillment of service goals and objectives

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

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

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

U. The client shall approve the service plan prior to implementation of services.

1. Signature on the service plan designates approval.

2. If the care manager is unable to obtain signature, verbal approval may be obtained for purposes of initiating services.

3. The case record shall document the name of staff person obtaining and date of verbal approval.

4. The client's signature must be obtained during the next home visit.

V. Service plan information shall be submitted to the State's data warehouse through the designated data exchange gateway on at least a monthly basis.

W. Developing Goals and Interventions

1. The service plan shall clearly identify each issue, need, or problem identified during the assessment, reassessment or regular contact with the client regardless of whether the resulting intervention is on a formal (paid) or informal (arranged) basis.

2. Goals shall be established for each recommended intervention.

    a. The service plan shall clearly identify the intended goal of each intervention.

    b. Goals shall be outcome based and measurable through ongoing review during subsequent contact with the client.

3. A recommended intervention shall be developed to alleviate identified problem need or condition.

    a. The service plan shall identify recommended frequency of intervention.

X. Resource Utilization/Allocation Strategies

1. Exploration of the potential resources for supports and services to be included in the client's service plan shall be considered in this order:

    a. The client

    b. Family, friends, guardian and significant others

    c. Resources in the neighborhood and community

    d. Publicly-funded supports and services

2. Planning shall address client's needs with the focus on providing the minimum level of formal services necessary to support the informal caregiver(s) to continue involvement in the provision of care.

    a. Services shall not be used to supplement existing informal care except in situations where the provision of services is expected to extend the ability of caregivers to provide continuing support to the client.

3. To the greatest extent possible, services from informal caregivers (family, neighbors, and friends) and/or community agencies who provide services at no charge are maximized prior to purchasing services.

4. Clients may provide financial support toward the cost of the services in accordance with locally established cost sharing practices

    a. Under no circumstances shall services be denied for failure to contribute toward the cost of care.

5. The program shall pursue and secure all available third party funding. Effort shall be made to maximize the coordination of skilled and home health benefits funded through Medicare.

    a. The programs shall also maximize use of regular Medicaid state plan benefits, veteran's benefits, insurance benefits, and other sources of long-term care available to the client, including patient pay in instances where unused monthly income may result in excess assets if allowed to accumulate over time.

XIX. 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.

XX. 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. Ongoing monitoring and follow-up shall be conducted to ensure the client's health and safety, quality of care, and satisfaction with services.

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 Service 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

XXI. Reassessment and/or Person-Centered Service Plan Redevelopment

A. Reassessment provides a scheduled, periodic in-person reexamination of client functioning for the purpose of identifying changes that may have occurred since the previous assessment and to measure progress toward meeting specific goals outlined in the client service plan.

1. It provides a basis upon which care managers make recommendations for service plan adjustments.

B. The IHC is used for reassessments and completed according to the assessment guidelines found above.

C. Person-Centered Service Plan redevelopment is a process whereby the care manager, client and allies meet between the previous and next scheduled assessment to review, refine and improve the last person-centered service plan.

    1. The focus is specifically on providing more time for the care manager to support and coordinate a better plan as defined by the client and their chosen support system.

D. All reassessment must be conducted in person

E. An in-person reassessment is conducted 90 days after the initial assessment and/or previous reassessment for active cases

F. An in-person reassessment (or an in-person, person-centered planning meeting with a redeveloped service plan) is conducted 180 days after the first/previous reassessment

G. An in-person reassessment is conducted 180 days after the previous reassessment or person-centered planning meeting with a redeveloped service plan.

H. Repeat the 180-day cycle as listed in G and H above.

I. A reassessment is conducted sooner when there are significant changes in the individual's health or functional status, or significant changes in the individual's network of allies (i.e. death of a primary caregiver)

J. All reassessments must use a person-centered planning approach

K. Reassessment information is collected on a standardized form and included in the client case record.

L. Either a multi-disciplinary CM team or an individual care manager can perform reassessments. A team is not required to perform reassessments.

M. Reassessment findings are reviewed with the client and others as deemed appropriate by the client.

    1. The service plan may be updated, based on mutually agreed upon changes.

N. Reassessment/redeveloped service plan information shall be submitted to the state's data warehouse through the designated data exchange gateway on at least a monthly basis.

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

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

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

XXII. Cost Sharing

A. If the CM Program bills for and receives reimbursement through the Medicaid TCM program, it must have a cost sharing process in place for the state funded AASA/CM service for non-Medicaid eligible individuals (Reference AASA TL #393).

1. Cost sharing for in-home services arranged or purchased on behalf of care management clients are treated separately and not included under this requirement

B. It is the responsibility of the care manager or other designated staff to explain cost sharing to the client and determine the cost share amount.

1. This activity is most often accomplished during the assessment visit.

2. On a locally determined schedule, a statement shall be sent to the client requesting payment of the predetermined cost share amount.

3. Subsequent cost sharing shall be conducted on at least a quarterly basis. Funds generated as a result of CM cost sharing shall be used to support the program.

C. Programs that participate in the Medicaid TCM Program shall have a cost sharing process in place for non-Medicaid eligible individuals.

D. Service providers will complete an evaluation of the client's financial status as part of the assessment process.

E. The evaluation will include:

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

F. Programs shall establish written policies and procedures to guide administration of cost sharing

G. The information received during the assessment will determine the quarterly cost share status of the client.

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

I. Total income shall be determined by confidential self-declaration of each eligible individual Client.

J. The Client will not be asked for income verification.

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

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

M. 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

N. 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. Programs must establish sliding fee schedules based on reasonable gradations of income consistent with the standard of living in the service area to be applied to all individuals enrolled in the program.

        a. Cost share amount for clients whose incomes are at or below 100% of the federal poverty level shall be zero.

O. All program Clients will be provided the opportunity to voluntarily contribute to the cost of services received.

P. Individuals may not be denied participation in the program for failure to contribute cost share.

1. Client records shall reflect that an attempt was made to collect the cost share.

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

XXIII. Conflict Resolution

A. Conflicts between clients and care managers shall be resolved through direct negotiation.

1. If negotiation fails, client/care manager conflicts shall be referred to the care management supervisor for discussion and resolution.

2. All conflicts not immediately resolved through negotiation shall be documented in the case record.

B. Programs shall have written client grievance procedures.

1. Clients shall be provided a copy of the client grievance procedure at the time of assessment at a minimum.

2. A copy shall also be provided upon client request.

3. In situations where professional judgment indicates that a change in services is appropriate and the client does not agree to the change, the client shall be provided with written information on how to appeal decisions.

C. When conflicts between clients and service providers arise, care managers shall negotiate resolution to ensure implementation of the service plan to the client's satisfaction.

1. Resolution may include obtaining services from an alternate provider.

D. Conflict of professional judgment may arise during the development, implementation and monitoring of the client service plan.

1. Conflicts between care managers and service providers shall be resolved to promote the implementation of the service plan to the client's satisfaction.

2. If a conflict between care managers and service providers cannot be readily resolved through direct negotiation, the issue shall be referred to the care management supervisor and service provider supervisor for resolution.

XXIV. Client Record Requirements

A. Records shall be maintained in a detailed and comprehensive manner that conforms to good professional practice, permits effective professional review and audit, and facilitates an adequate system for follow-up

B. Programs shall have written policies and procedures in place for maintenance of records to ensure that records are documented accurately and promptly, are readily accessible, and permit prompt and systematic retrieval of information.

C. Each program shall utilize the Center for Information Management's (CIM's) COMPASS or AASA-approved data systems to track clients, services and billing data.

D. Care managers shall establish and maintain a confidential record for each Client served

E. The record shall include, but not be limited to, the following information:

1. Completed ~~telephone~~ eligibility screen

2. Completed assessment and reassessment

3. Consent to release confidential information.

4. Client-approved person-centered service plan.

5. Service orders and instructions to providers.

6. Progress notes for documenting client progress/status, contacts with client, providers, and others involved in caring for the client.

7. Monthly contact forms

8. Two week check forms

9. Reassessment~~s~~

10. Correspondence pertaining to Client's care, including physician letter

11. National Aging Program Information System (NAPIS) form

12. Person-centered planning

13. 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

14. Back up plans

15. Acknowledgement of the receipt of the HIPAA Notice of Privacy Practices

16. Accident reports

17. Termination reports

18. Cost share letters

19. Other documentation and correspondence sufficient to fully disclose the quantity, quality, appropriateness and timeliness of services provided.

F. Case record entries shall be signed or initialed by each care manager making the case record entry.

    1. When initials are used, a signature log shall be maintained with employee name, initials and position/title.

    2. Case records may be on paper or electronically via date, time, case manager identification or certification (such as in COMPASS).

G. CM programs shall establish local procedures to ensure documentation is completed in a timely manner

H. Records shall be retained for a minimum of ten (10) years following case closure.

XXV. Waiting List

A. An eligible referral to the CM program will be placed on a waiting list when the program is at capacity serving clients 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 client from the waiting list, the referral source will be contacted to confirm the need for care management services.

XXVI. Disaster List

A. Programs shall ensure staff is available to assist in disaster management activities coordinated by the local emergency operations center as necessary to protect the health and safety of CM clients.

B. 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.

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

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

XXVII. Quality Assurance/Quality Improvement

A. Quality assurance activities are undertaken to determine client satisfaction with both care management and the services that result from service plan implementation, and to ensure program compliance with established performance criteria.

    1. Quality improvement is undertaken to address identified program deficiencies

B. Client Satisfaction

    1. Programs shall establish specific client-oriented methods to measure and assure quality, and the frequency with which the methods will be applied.

    2. Client satisfaction should be determined through direct questioning as part of routine activity as well as through written surveys that seek general and/or specific feedback.

    3. At a minimum, surveys should address all aspects of care management service delivery, including the degree to which the principles and elements of person-centered planning are utilized in identifying and addressing a client's needs and desires.

    4. Information obtained through client surveys shall be used to guide both internal and external quality improvement initiatives.

C. State-Level Performance Review

    1. The CM Program will be evaluated by the assigned AASA field representative as part of the Annual AAA Assessment process.

        a. The AAA completes the AASA Care Management Program Assessment Section of the Area Agency on Aging Assessment Guide prior to the assessment visit

        b. The assigned field representative reviews the AAA responses in the Care Management Assessment Section, addresses issues that may come up and reviews documentation of CM protocols and practices as needed during the AAA Assessment visit.

D. Program level performance reviews shall be conducted a minimum of annually.

    1. The care manager responsible for the case may not conduct a review of his/her own cases.

2. The number of cases reviewed shall be equal to 10% of the active caseload.

3. Programs are responsible for establishing methodology for selection of cases.

4. AAAs who subcontract all or part of the care management program are required to review programmatic, financial and contractual data of subcontracted providers on an annual basis.

5. Utilizing a locally determined procedure, the AAA shall review subcontractor performance against established standards, policies and procedures related specifically to care management, as well as review for compliance with contractual requirements.

6. The AAA will provide a written report of findings and recommendations to the subcontracted provider.

XXVIII. 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

XXIX. Targeted Care Management (TCM)

A. The purpose of Targeted Care Management (TCM) is to provide AAAs with resources for managing the community-based care needs of Medicaid eligible persons age 60 and older who are not enrolled in the MI Choice waiver program.

B. Qualifications of TCM Provider Agencies

1. TCM provider agencies must be certified as meeting the following criteria:

a. Demonstrated capacity to provide all core elements of case management services including the following:

    1. Client assessment and reassessment

    2. Service plan development

    3. Service arranging (linking/coordination of services)

    4. Monitoring and follow up of service

b. Demonstrated experience in coordinating and linking community resources required by the target population.

c. Demonstrated experience with the target population.

d. Sufficient staff to meet the CM service needs of the target population.

e. An administrative capacity to insure quality of services.

f. Financial management capacity and system that provides documentation of services and costs.

g. Capacity to document and maintain individual case records.

C. Qualifications of TCM Case Managers

1. TCM Case Managers shall be:

    a. A registered nurse (RN) licensed to practice in the state of Michigan.

    b. A social worker licensed to practice in the State of Michigan.

    c. An individual with a minimum of two years case management experience.

2. TCM billing will be disallowed for any period of time that a program operates without an RN on staff.

3. Provided under auspices of the AASA CM program, TCM is both a program type and a funding source.

4. It is a Medicaid State Plan service (Revision HCFA-PM-87-4, March 1987) approved for a specific client population (see Target Group C / Eligibility below).

5. TCM Providers must meet federal-approved criteria to qualify for TCM participation.

6. AASA is responsible for certifying that providers meet criteria on an annual basis.

7. The certification is conducted as part of the AASA Annual AAA Assessment process.

D. Medicaid is a federal/state jointly funded program.

1. TCM providers are reimbursed only for the annually adjusted federal percentage portion (FMAP) of approved in-person encounters when billable activities occur.

2. The annual AASA CM allocation is considered the state share contribution.

3. The target group consists of persons who are:

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

   b. Determined to meet Nursing Facility Level of Care (NFLOC) criteria

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

   d. Eligible and enrolled in the AASA Care Management Program

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

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

   g. Meet Medicaid financial eligibility

4. CM clients who fall into this target group and also meet community Medicaid financial eligibility shall be assigned a case classification of TCM.

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

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

7. 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

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

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

    a. Assessment

    b. Service Planning

    c. Service arranging

    d. Follow-up and monitoring

    e. Reassessment

    f. Only visits with documented nurse involvement are eligible

10. Prescreening is not a billable activity. Do not bill in-person screening activities or any other CM activity not specifically identified above.

11. 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

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

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

E. Case Manager Credentials for Billable Activity that is TCM Reimbursement Eligible

1. Only in-person billable activities are eligible for reimbursement.

2. When an RN or social worker conducts; an assessment, reassessment, service planning, service arranging or follow up/monitoring, it is considered TCM reimbursement eligible.

3. If an individual with a minimum of two years case management experience conducts a reassessment separate from an RN or social worker, either the RN or social worker must review and sign off on the reassessment to be considered TCM eligible.

4. If an individual with a minimum of two years case manager experience conducts service planning, service arranging, or follow up/monitoring it is consider TCM reimbursement eligible.

    a. The TCM billing guidelines above replace Transmittal Letter #2018-169 TCM Billing and Reimbursement Guidelines.

F. Case Record Documentation

1. Case records must clearly document the purpose of the encounter and the individual conducting the visit.

2. Acceptable documentation includes either a Medicaid service log or completed assessment and/or reassessment documents and signed progress notes, whether on paper or electronically via date, time, case manager identification or certification (such as in COMPASS)

G. Claims Submission

1. Per Medicaid policy, encounters must be submitted for payment within 12 months of the date of service.

a. AAAs are encouraged to submit claims on at least a quarterly basis.

b. An exception to the 12-month rule is implemented for claims submitted at fiscal year-end.

c. Such claims must be submitted for processing within 45 days following the end of the fiscal year.

H. Medicaid Identification numbers and eligibility dates should be verified prior to completing and submitting invoices.

1. This information can be verified online by contacting MDHHS Eligibility Verification at: http://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_5100-57088--,00.html

2. Providers without internet access should contact Provider Inquiry at 1-800-292-2550 to verify eligibility.

3. Claims shall be prepared and submitted under the professional billing format described in the MDHHS Medicaid Provider Manual Billing and Reimbursement for Professionals available on the MDHHS website at: http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

4. Claims for services rendered must contain the name and individual national provider identifier (NPI) of the provider

a. As explained in the manual, all claims are submitted and processed through CHAMPS. MDHHS encourages claims to be submitted electronically.

b. Once claims have been submitted and processed through CHAMPS, a remittance advice (RA) is produced to inform providers about the status of claims.

c. Electronic CHAMPS RAs are sent for those choosing an electronic RA.

d. The CHAMPS RA is also available to providers online or is sent via paper if requested through the Provider Enrollment Subsystem.

e. Electronic Funds Transfer (EFT) is the method of direct deposit of State of Michigan payments.

f. All claims, electronic or otherwise, must be formatted to HIPPA compliant MDHHS standards, and the files must be submitted to MDHHS for processing.

g. MDHHS requires that NPI number be reported in any applicable provider loop or field on the claim.

5. MDHHS processes claims and issues payments by check or EFT.

   a. An RA is issued with each payment to explain the payment made for the claim.

   b. If no payment is due or if claims have been rejected, an RA is also issued.

   c. If a claim does not appear on an RA within 60 days of submission, a new claim should be submitted.

   d. The electronic RA is produced in the HIPAA-compliant format.

   e. When a claim is initially processed, the claim adjustment reason/remark column on the RA identifies which service lines have been paid or rejected and edits which apply.

6. If a service line is rejected, a claim adjustment reason/remark code prints in the claim adjustment reason/remark column of the RA.

   a. The provider should review the definition of the codes to determine the reason for the rejection and verify that the provider NPI number and beneficiary identification number are correct.

I. Cash Receipt / Accounting

1. The Federal Medical Assistance Percentage (FMAP) rate is applied to the quarterly amount claim detail.

   a. The billing/reimbursement is for one monthly amount.

   b. The Federal Medical Assistance Percentages (FMAPs) are used in determining the amount of Federal matching funds for State expenditures for assistance payments for certain social services, the Social Security Act requires the Secretary of Health and Human Services to calculate and publish the FMAPs each year.

c. The FMAP is computed from a formula that takes into account the average per capita income for each state relative to the national average.

d. The multiplier is based on the FMAP.

e. For every dollar the state spends on Medicaid, the federal government matches at a rate that varies year to year.

f. The correct calculation for the federal match rate for FY 2017 is based on $498.24 ($519 minus the 4% fee)

2. MDHHS centralized budget office distributes to AASA quarterly claim detail for each AAA in a Warrant Suspend report.

   a. AASA then applies the FMAP rate (Rate of FMAP changes from year to year) and sends a notification to each individual AAA of the availability and amount of each fund transfer (see Example A).

   b. To receive funds, the AAA must have an approved budget and submit a Cash Request to AASA through the online Aging Information System FIRST module.

Example A

Subject: AAA Targeted Care Management (TCM) Reimbursement – 1st Quarter FY 2017

Dear AAA Director,

Based on reporting and authorization from the DHHS Budget Office, your agency is now eligible to submit a cash request for the following amount related to Targeted Care Management (TCM). The Medicaid Reimbursement Rate for this period is .6515 for TCM.

$7,971.84 x 0.6515 = $5,194.00 (rounded)

You are eligible to submit a cash request for this amount.

Provider Name	Appropriation Number	Amount	Rate	Reimbursement
Region Area Agency on Aging	46511	$7,971.84	0.6515	$5,194.00

Please be advised: Federal OMB Circular A-133, Subpart B, Section .201(i) indicates that

J. TCM Reimbursement Guidelines

1. MDHHS and AASA, which reimburse for TCM expenses on a cost-reimbursement basis, require that TCM funds be treated as federal awards.

2. Please be advised that the federal Office of Management and Budget's Circular A-133, Subpart B, Section .205(i) indicates: "Medicaid payments to a sub-recipient for providing patient care services to Medicaid eligible individuals are not considered Federal awards expended under this part unless a State requires the funds to be treated as Federal awards expended because reimbursement is on a cost-reimbursement basis." (Reference Transmittal Letter #2013-264).

3. The federal Health Care Financing Administration (HCFA)-TCM program, the Catalog of Federal Domestic Assistance (CFDA) number is 93.778.

K. Guidelines for Expenditure of TCM Reimbursement (Refer to Transmittal Letter #2008-166)

1. Approved reimbursements from medical service billing claims made for case management activities under the approved Medicaid State plan amendment, as allowed by P.L. 99-272, shall be returned to the AAA region and CM site that generated the revenue.

2. TCM reimbursement shall be used to directly support the care management program.

a. Earned reimbursements shall be expended for allowable costs in accordance with the approved budget.

1. Allowable costs include: wages/salaries, fringe benefits, travel, supplies, occupancy, communications, administration, other, and purchase of services for program clients.

b. Non-allowable costs include equipment items defined as tangible items with a value of $5,000 or more, with a life expectancy greater than one year with the exception of computer hardware and/or software necessary to support the care management program and the MI Choice Information System (MICIS)

3. TCM revenues shall be reported and expended on an accrual basis.

   a. TCM revenues shall be accounted for and expended during the fiscal year in which the original date of service occurred.

   b. The care management grant provided by AASA serves as match for TCM reimbursement.

      1. That grant shall be reduced at fiscal year-end by the amount of unspent TCM revenues.

   c. Actual Medicaid claims approved during the first three fiscal year quarters shall be reported on the AASA Financial Status Report (FSR).

      1. The fourth quarter FSR shall reflect actual and estimated claims for the fiscal year.

      2. The AAA shall submit a cash request for payment of TCM funds.

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

XXX. 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.

XXXI. 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.

XXXII. 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.

XXXIII. 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.

XXXIV. 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.

XXXV. 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.

XXXVI.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.

XXXVII. 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.

XXXVIII. 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 Older Adults
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.

XXXIX. 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.

XL. 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 Older Adults.

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. Older Adults persons in greatest economic with particular attention to low-income, minority Older Adults

b. Older Adults persons with greatest social need with particular attention to low-income, minority Older Adults

c. Older Adults residing in rural areas

d. Older Adults with severe disabilities

e. Older Adults who are Native American

f. Older Adults with limited English speaking ability

g. Older Adults 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 information 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 Older Adults.

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 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 Service 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 conjunction 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 clients in taking medications, which includes at a minimum the following:

a. Who is authorized to assist clients 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 Older Adults.

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, as available, 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. The program shall establish a limit on the amount to be spent on any one house in a 12-month period.

G. 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.

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

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

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

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

L. 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 ~~Older Adults~~ 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 is to be provided

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.

VOLUME III: Specific Service Requirements

(10) POLICY NAME: General Requirements for Nutrition Service Programs

PURPOSE: The Michigan Department of Health and Human Services, Aging Adult Services Agency (AASA) encourages nutrition providers to operate nutrition programs for older adults that allow for choice and flexibility, while maintaining federal and state standards and requirements. The meals should include key nutrients and follow dietary recommendations that relate to lessening chronic disease and improving the health of older Michiganders. Diabetes, hypertension, and obesity are three of the most prevalent chronic conditions among all adults in Michigan. Special attention should be paid to nutritional factors that can help prevent and manage these and other chronic conditions.

AUTHORITY: AASA Operating Standards for Service Programs

UNIT OF SERVICE: A unit of service is one completed meal served to an eligible client.

I. Business Practices

a. Nutrition providers must be able to produce a nutrient analysis for a meal

i. Nutrition analysis does not have to be listed on the menu.

ii. All nutrition providers should purchase, or have access to, an electronic nutritional analysis program.

iii. Providers may use up to $1,000 in state or federal nutrition funds to purchase or maintain such a program.

iv. Local funds may be used if the costs exceed $1,000.

v. A record of the menu actually served each day shall be maintained for each fiscal year's operation.

b. Each program shall use an adequate food cost and inventory system at each food preparation site facility.

i. The inventory control shall be based on the first-in/first-out method and conform to generally accepted accounting principles.

ii. The system shall be able to provide food costs, inventory control records, and other cumulative reports on food and meal costs as requested.

c. For programs operating under annual cost-reimbursement contracts, the value of the inventory on hand at the end of the fiscal year shall be deducted from the total amount expended during that year.

d. For programs operating under a unit-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year does not have to be considered.

e. Each program shall be able to calculate the component cost of each meal provided according to the following categories:

i. Raw food: All costs of acquiring foodstuff to be used in the program.

ii. Labor: All expenditures for salaries and wages, including valuation of volunteer hours, for personnel involved in food preparation, cooking, delivery, serving, and cleaning of meal sites, equipment and kitchens; all expenses for salary and wages for persons involved in project management.

iii. Equipment: All expenditures for purchase and maintenance of items with a useful life of more than one year or with an acquisition cost of greater than $5,000

iv. Supplies: All expenditures for items with a useful life of less than one year and an acquisition cost of less than $5,000

v. Utilities: All expenditures for gas, electricity, water, sewer, waste disposal, etc.

vi. Other: Expenditures for all other items that do not belong in any of the above categories (e.g. rent, insurance, fuel, etc.) are to be identified and itemized.

vii. Where a provider operates more than one meal/feeding program (congregate, home-delivered meal (HDM), waiver, catering, etc.), costs shall be accurately distributed among the respective meal programs.

1. Only costs directly related to a specific program shall be charged to that program.

f. Each program shall provide or arrange for monthly nutrition education sessions at each meal site and to HDM clients.

i. Emphasis should focus on giving the client the information and tools to make food choices in relation to health and wellness, and to any chronic diseases they may have, including making choices at the meal site, at home, and when they eat out.

ii. Educational sessions should be encouraging and informative, as well as encourage clients to take responsibility for the food choices they make throughout the day.

iii. Topics shall include, but not be limited to, food, nutrition, and wellness issues.

iv. Nutrition education materials must come from reputable sources.

v. Questions pertaining to appropriateness of materials and presenters are to be directed to the regional dietitian.

vi. Program materials distributed must take into consideration the level of literacy, living alone status, caregiver support and translation of materials as appropriate for older adults with limited English proficiency.

vii. At least once per year, the following topics must be covered:

1. How food choices affect chronic illnesses

2. Food safety at home and when dining out

3. Food choices at home

4. Emergency preparedness- what to have on hand

g. Staff and volunteers of each program shall receive in-service training of at least six (6) hours each fiscal year, which is specifically designed to increase their knowledge and understanding of the program, and to improve their skills and tasks performed in the provision of service.

i. Records shall be maintained which identify the dates of training, topics covered, and persons attending.

h. All staff and volunteers must undergo a background check.

i. This includes persons who are delivering meals at a special event, or fund-raiser, or any other occasion whereas they would only be delivering a few times.

ii. If a group of volunteers from a business or agency participates in the meal delivery representing that business or agency, arrangements may be made for the business or agency to certify that background checks have been completed for their employees, and only no/low risk employees have been cleared to participate.

i. Nutrition providers may waive the background check requirement for volunteers who are under the age of 18 and/or those who are packing meals or doing other activities that do not involve direct contact with a meal program client and are under the supervision of nutrition provider staff and/or adult leaders.

II. Menu Development

a. Meals may be presented hot, cold, frozen or shelf-stable and shall conform to the most current edition of the *USDA Dietary Guidelines for Americans* (DGA) and the AASA Nutrition Standards.

b. Each program shall utilize a menu development process, which places priority on healthy choices and creativity, and includes, at a minimum:

i. Use of written or electronic standardized recipes;

ii. Provision for review and approval of all menus by a registered dietitian (R.D.).

iii. Posting of menu to be served in a conspicuous place at each meal site, and at each place food is prepared. The program must be able to provide information on the nutrition content of menus upon request; and

iv. Modified diet menus may be provided, where feasible and appropriate, which take into consideration client choice, health, religious and ethnic diet preferences.

c. The nutrition program must operate according to current provisions of the Michigan Food Code.

i. Minimum food safety standards are established by the respective local Health Department.

ii. Each program must have a copy of the most recent Michigan Food Code and all updates available for reference.

iii. Programs are encouraged to monitor food safety alerts pertaining to older adults.

d. Each program, which operates a kitchen for food production, shall have at least one key staff person (manager, cook or lead food handler) complete a Food Service Manager Certification Training Program that has been approved by the Michigan Department of Agriculture and Rural Development (MDARD).

i. A trained and certified staff member may be required at satellite serving and packing sites.

ii. Please refer to your local Health Department for local regulations on this issue.

e. The time period between preparation of food and the beginning of serving shall be as minimal as feasible.

i. Food shall be prepared, held and served at safe temperatures.

ii. Documentation requirements for food safety procedures shall be developed in conjunction with, and be acceptable to, the respective local Health Department.

f. The safety of food after it has been served to a client and when it has been removed from the meal site or left in the control of a HDM client, is the responsibility of that client.

g. Purchased Foodstuffs- The program must purchase foodstuff from commercial sources which comply with the Michigan Food Code.

i. Unacceptable items include: home canned or preserved foods; foods cooked or prepared in an individual's home kitchen (this includes those covered under the Cottage Food Law); meat or wild game NOT processed by a licensed facility; fresh or frozen fish donated by sport fishers; raw seafood or eggs; and any un-pasteurized products (i.e., dairy, juices and honey).

ii. Acceptable contributed foodstuff include: fresh fruits and vegetables and wild game from a licensed processor. A list of licensed processors can be found on the Michigan Department of Agriculture and Rural Development website (http://www.michigan.gov/MDARD).

h. Acceptable donated products must be handled and prepared just like products that are purchased from commercial sources.

i. Each program shall use standardized portion control procedures to ensure that each meal served is uniform.

    i. At the request of a client, standard portions may be altered or less may be served than the standard serving size.

    ii. A client may refuse one or more items.

    iii. Less than standard portions shall not be served to 'stretch' available food to serve additional persons.

j. Each program shall implement procedures designed to minimize waste of food (leftovers/uneaten meals).

k. Each meal program is encouraged to use volunteers, as feasible, in program operations.

l. Each program shall develop and utilize a system for documenting meals served for purposes of the National Aging Program Information System (NAPIS).

    i. Meals eligible to be included in NAPIS meal counts reported to the respective AAA are those served to eligible individuals (as described under respective program eligibility criteria) and which meet the specified meal requirements.

    ii. The most acceptable method of documenting meals is by obtaining signatures daily from clients receiving meals.

    iii. Other acceptable methods may include, but not limited to, HDMs maintaining a daily or weekly route sheet signed by the driver which identifies the client's name, address, and number of meals served to them each day.

m. Each program shall use a uniform intake process and maintain a NAPIS registration for each program client.

    i. The intake process shall be initiated within one week after an individual becomes active in the program.

ii. Completion of NAPIS registration is not a prerequisite to eligibility and may not be presented to potential clients as a requirement.

n. Nutrition Services Incentive Program (NSIP)

i. The purpose of the NSIP is to provide incentives to encourage and reward effective performance in the efficient delivery of nutritious meals to older individuals.

ii. The NSIP provides an allotment of cash to the state for their nutrition programs based on the number of ***eligible*** Title IIIC meals served by the state that year, as reported in NAPIS.

iii. The State of Michigan has elected to receive cash in lieu of commodities. NSIP cash is allocated to AAAs based on the number of NSIP-eligible meals served by all AAAs as reported through NAPIS.

iv. NSIP cash may only be used for meals served to individuals through the congregate meal program or HDM program.

v. The program must make a reasonable attempt to purchase foods of U.S. origin with NSIP funding.

vi. Meals counted for purposes of NSIP reporting are those served that meet the Title IIIC Requirements and are served at a congregate or HDM setting.

vii. Meals that <u>do not</u> count toward NSIP funding include:

1. Medicaid (MI-CHOICE Waiver) adult day care meals;

2. Adult day care meals for which Child and Adult Care Food Program (7 CFR Part 226) funds have been claimed

3. Meals funded by Title IIIE served to caregivers under the age of 60; and

4. Meals served to individuals under age 60 who pay the full price for the meal.

viii. Each AAA that has NSIP-only (non-AAA funded) sites must have:

1. A signed contract or Memorandum of Agreement in place detailing the nutrition requirements for the meal;

2. The mechanism for distributing NSIP only funds; e.g. per meal rate, percentage of total; and

3. Written plan for assessment of site based on Title IIIC requirements.

o. Each nutrition program shall carry product liability insurance sufficient to cover its operation.

p. Each program, with input from program clients, shall establish a suggested donation amount that is to be posted at each meal site and provided to HDM clients.

i. The program may establish a suggested donation scale based on income ranges, if approved by the respective AAA.

ii. Volunteers under the age of 60 who receive meals shall be afforded the opportunity to donate toward the costs of the meal received.

q. Program income from client donations must be used in accordance with the additive alternative, as described in the Code of Federal Regulations (CFR).

i. Under this alternative, the income is used in addition to the grant funds awarded to the provider and used for the purposes and under the conditions of the contract.

ii. Use of program income is approved by the respective AAA as part of the budget process.

r. Each program shall be allowed to accept donations for the program as long as the following apply

i. The method of solicitation for the donations is non-coercive;

ii. No qualified person is turned away for not contributing;

iii. The privacy of each person with respect to donations is protected;

iv. There are written procedures in place for handling all donations which includes the following at a minimum;

1. Daily counting and recording of all receipts by two individuals;

2. Provisions for sealing, written acknowledgement and transporting of daily receipts to either deposit in a financial institution or secure storage until a deposit can be arranged; and

3. Reconciliation of deposit receipts and daily collection records by someone other than the depositor or counter.

s. Each program shall take steps to inform clients about local, State and Federal food assistance programs and provide information and referral to assist the individual with obtaining benefits.

   i. When requested, programs shall assist clients in utilizing Supplemental Nutrition Assistance Program (SNAP) benefits, formerly known as "food stamps," as client donations to the program.

t. Programs shall not use funds from AASA (federal and state) to purchase vitamins or other dietary supplements.

u. Complaints from clients should be referred to the nutrition provider that hosts the site or manages the HDMs.

   i. Each nutrition provider shall have a written procedure for handling complaints.

   ii. The nutrition provider and AAA nutrition staff shall develop a plan for what type of complaints need to be referred to the AAA.

v. Nutrition providers must develop a written emergency plan. The emergency plan shall address, but not be limited to:

   i. Uninterrupted delivery of meals to HDM clients, including, but not limited to use of families and friends, volunteers, shelf-stable meals and informal support systems;

   ii. Provision of at least five, and preferably more, shelf-stable meals and instructions on how to use for HDM clients. Every effort should be made to assure that the emergency shelf-stable meals meet the nutrition guidelines. If it is not possible, shelf-stable meals will not be required to adhere to the guidelines.

      1. MI-CHOICE clients may receive two emergency meals that are billed to MI-CHOICE. Additional emergency meals may be billed to Title III-C2

iii. Back-up plan for food preparation if usual kitchen facility is unavailable;

iv. Agreements in place with volunteer agencies, individual volunteers, hospitals, long-term care facilities, other nutrition providers, or other agencies/groups that could be on standby to assist with food acquisition, meal preparation, and delivery;

v. Communications system to alert congregate and HDM clients of changes in meal site/delivery;

vi. The plan shall cover all the sites and HDM clients for each nutrition provider; and

vii. The plan shall be reviewed and approved by the respective AAA and then submitted electronically to AASA for review.

III. MEAL COMPONENTS

a. Salad and Soup Bar Option

i. Congregate meal sites may include a salad bar as part, ***or all*** of their meal service. (See chart for information as to how to add it in)

Soup/Salad bar as main meal	Must meet all nutrition standard requirements
Soup/Salad bar as a part of a meal, e.g. vegetable or carb. (pasta choices)	Must meet nutrition requirement for the element it is used for
Soup/Salad bar is an addition to, or add on, to a regular meal	Does not have to meet nutrition standards or criteria

b. Beverages: Milk and water must be offered with every meal. Coffee and/or tea, or other beverages, are optional.

i. Milk may be skim, 1%, 2%, full-fat or chocolate. It should be available to clients but is not required.

ii. Water can be available as self-serve, in a pitcher, or at a drinking fountain that has a special attachment for filling cups. The provider does not need to purchase water in bottles, or pre-fill cups with water.

iii. If the provider chooses to offer coffee and/or tea, this may also be self-serve. The provider may provide hot water for instant coffee and tea, or may brew coffee. Individuals may also bring in their own tea bags and instant coffee if they choose to.

iv. The provider may use state and federal congregate meal funds to purchase these products, as well as to keep equipment such as coffee makers, in good repair.

IV. Meal Planning

a. Menu standards are developed to sustain and improve a client's health through the provision of safe and nutritious meals using specific guidelines.

i. These guidelines should be incorporated into all requests for proposals/bids, contracts and open solicitations for meals.

b. The Older Americans Act requires that meal components meeting the 33 1/3 percent of the DRI must be offered if one meal is served per day.

i. If two meals are served, meal components with 66 2/3 percent of the DRI must be offered.

c. Nutrition providers must use person-centered planning principles when doing menu planning.

i. Food should be offered, not served.

ii. Choices should be offered as often as possible.

iii. This is for both congregate and HDM clients.

iv. If possible, this should include offering alternatives for food allergies, digestive issues and chewing issues.

d. Follow the five guidelines from the most current edition of the *USDA Dietary Guidelines for Americans.*

i. Follow a healthy eating pattern across the lifespan.

1. All food and beverage choices matter.

2. Choose a healthy eating pattern at an appropriate calorie level to help achieve and maintain a healthy body weight, support nutrient adequacy, and reduce the risk of chronic disease.

ii. Focus on variety, nutrient density, and amount.

1. To meet nutrient needs with calorie limits, choose a variety of nutrient-dense foods across and within all food groups in recommended amounts.

iii. Limit calories from added sugars and saturated fats and reduce sodium intake.

1. Consume an eating pattern low in added sugars, saturated fats, and sodium.

2. Cut back on foods and beverages higher in these components to amounts that fit within healthy eating patterns.

iv. Shift to healthier food and beverage choices.

1. Choose nutrient-dense foods and beverages across and within all food groups in place of less healthy choices.

2. Consider cultural and personal preferences to make these shifts easier to accomplish and maintain.

v. Support healthy eating patterns for all.

1. Everyone has a role in helping to create and support healthy eating patterns in multiple settings nationwide from home, to school to work to communities.

e. Key recommendations from the DGA to consider when planning meals.

i. Consume a healthy eating pattern that accounts for all foods and beverages within an appropriate calorie level.

1. A variety of vegetables from all of the sub-groups- dark green, red and orange, legumes (beans and peas), starchy, and other

2. Fruits, especially whole fruits

3. Grains, at least half of which are whole grains

4. Fat-free, or low-fat dairy, including milk, yogurt, and cheese

5. A variety of protein foods, including seafood, lean meats and poultry, eggs, legumes, nuts and seeds

6. Oils

ii. Nutrient-dense meals shall be planned using preparation and delivery methods that preserve the nutritional value of foods.

1. Consume less than 10% of calories per day from added sugars

2. Consume less than 10% of calories per day from saturated fats.

3. Consume less than 2300 grams of sodium per day (this may be averaged in your meal plans).

iii. The target for carbohydrate per meal is 75 grams. If the nutrition provider is following one of the suggested meal patterns from the Dietary Guidelines for Americans, listed below, the CHO grams should follow that pattern

iv. See "Suggested Meal Patterns" below for more information.

f. Other Considerations:

i. Desserts: Serving of dessert is optional.

1. Suggested, but not limited to, desserts are: fruit, fruit crisps with whole grain toppings, pudding with double milk, gelatin with fruit, low-fat frozen yogurt, Italian ices.

2. Use of baked, commercial desserts should be limited to once per week.

ii. Beverages:

1. Congregate: Milk and water must be offered with every meal.

    a. Coffee and/or tea, or other beverages, are optional.

2. Home Delivered: Milk, or a milk substitute, must be offered with every meal. If requested, water shall be provided.

    a. Milk may be skim, 1%, 2%, full-fat or chocolate.

g. Special occasion or celebratory meals are allowed on a periodic basis.

    i. These meals do not have to follow the 1/3 DRI rule.

    ii. The registered dietician must have knowledge of the meal and grant approval of it.

h. Breakfast may include any combination of foods that meet the AASA Meal Planning Guidelines.

i. Special Menus. To the extent practicable, adjust meals to meet any special dietary needs of program clients for health reasons, ethnic and religious preference and provide flexibility in designing meals that are appealing to program clients.

V. Suggested Meal Patterns

a. The Plate Method (http://www.choosemyplate.gov) may be used as the meal pattern.

b. The Healthy U.S.-Style Eating Pattern may be used as the meal pattern (Dietary Guidelines for Americans, 2015-2020, Appendix 3, Table A3-1, page 80).

c. The Healthy Mediterranean-Style eating pattern may be used as the meal pattern (Dietary Guidelines for Americans, 2015-2020, Appendix 4, Table A4-1, page 84).

d. Vegetarian meals can be served as part of the menu cycle or as an optional meal choice based on client choice, cultural and/or religious needs and should follow the MDHHS Aging and Adult Services Agency Meal Planning Guidelines to include a variety of flavors, textures, seasonings, colors, and food groups at the same meal. (Dietary Guidelines for Americans, 2015-2020, Appendix 5, Table A5-1, page 87).

i. Vegetarian meals are a good opportunity to provide variety to menus, feature Michigan produce and highlight the many ethnic, cultural, or religious food traditions that use vegetables and grains in greater amounts at the center of the plate and in different combinations with fruits, vegetables, grains, herbs and spices for added flavor, calories and key nutrients.

VOLUME III:	Specific Service Requirements
(10) POLICY NAME:	Nutrition Services – Home Delivered Meals
PURPOSE:	This section outlines procedures that must be followed by Home Delivered Meals nutrition programs funded by the Region VII AAA.
AUTHORITY:	AASA Operating Standards for Service Programs
UNIT OF SERVICE:	A unit of service is one completed meal served to an eligible Client.

I. Home Delivered Meals

A. The Home Delivered Meals (HDM) service is the provision of nutritious meals to homebound older persons.

B. Clients must be determined through assessment.

C. Client Counts

1. A Client may only be counted once during the reporting period.

2. Only the unduplicated count of Clients served is reported to Region VII AAA.

II. Home Delivered Meals Eligibility

A. Each program shall have written eligibility criteria which places emphasis on serving older persons in greatest need and includes the following, at a minimum:

1. Persons 60 years of age or older, or if indicated in the HDM assessment, that it is in the best interest of the eligible person, the following persons may also receive a meal:

a. The spouse or partner of an HDM-eligible person, regardless of age

b. The unpaid caregiver of an HDM-eligible person, including a family member under the age of 60 who provides full time care for an eligible person.

c. An individual living with a disability who resides in a non-institutional household with a person who is eligible to receive home-delivered meals

2. Individuals who are homebound, i.e. normally is unable to leave the home unassisted, and for whom leaving home takes considerable and taxing effort

    a. A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services.

3. Individuals who are unable to participate in the congregate nutrition program because of physical, mental or emotional difficulties, such as:

    a. A disabling condition, such as limited physical mobility, cognitive or psychological impairment;

    b. Lack of knowledge or skill to select and prepare nourishing and well-balanced meals.

    c. Lack of means to obtain or prepare nourishing meals;

    d. Lack of incentive to prepare and eat a meal alone;

4. Lack of an informal support system: has no family, friends neighbors or others who are both willing and able to perform the service(s) needed, or the informal support system needs to be supplemented.

5. Individual's special dietary needs can be met by the program, as defined by the most current edition of the *USDA Dietary Guidelines for Americans*.

6. The individual is able to feed himself or herself

7. The individual agrees to be home when meals are delivered or contact the Service Provider when absence is unavoidable, and to work with the program staff if participating in both HDM and congregate programs.

B. Extended Eligibility

1. The nutrition provider will work with the AAA to determine if it would benefit the client to provide a meal to another person in the home that does not meet the criteria above. These include the following.

a. The spouse, or other individual 18 or older, living full-time in the home may receive a meal if the HDM assessment finds that it is in the best interest of the HDM-eligible person

b. Unpaid caregiver 18 or older may receive a meal if the HDM assessment finds that it is in the best interest of the HDM-eligible person

c. An individual, between the ages of 18-59, living with a disability who resides in a non-institutional household with a person who is an HDM client may receive a meal

a. Documentation of the disability status must be on the individual's assessment or a Declaration of Disability Statement must be in the Client's file.

b. This category of eligibility may be at the Service Provider's discretion.

2. At the provider's discretion, persons not otherwise eligible may be provided meals if they pay the full cost of the meal.

a. The full cost of the meal includes raw food, preparation costs, and administrative and/or supporting service costs.

b. Documentation that full payment has been made shall be maintained.

c. Eligibility criteria shall be distributed to all potential referring agencies or organizations and be available to the general public upon request.

d. Nutrition Services Initiative Program (NSIP) reimbursements cannot be obtained for the meals served to those persons.

C. The eligibility criteria must be disseminated to potential referral agencies and be available to the public upon request.

1. Emphasis should be placed on distribution of the criteria to new referral sources or those who make the least amount of referrals.

2. Eligibility criteria must be available to the public upon request.

3. Service providers must make a concerted effort to serve clients in all parts of the target area on an equal basis.

4. Service design should consider not only demand, but also census and other demographic data that indicates pockets of age 60 or older, low income, and minority older adults.

D. Upon death, institutionalization, or foster home placement of an eligible recipient, the service provider shall not automatically continue the provision of meals to the eligible surviving or remaining spouse or other household member.

1. A separate determination of eligibility that meets the general requirements for all Region VII AAA funded services and the specific HDM eligibility requirements must be made for such individuals.

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

III. Waiting List

A. Each program must complete a prioritizing pre-screen for each individual placed on a waiting list for HDMs.

B. Each program must be able to document their criteria for prioritizing individuals being placed on a waiting list

IV. Client Intake and Assessment

A. General Intake/Assessment Requirements

1. Basic intake information must be obtained for each individual at the time the request or referral for assistance is made.

2. Basic intake information may be obtained by telephone.

3. Service Providers must verify that each individual to be served has either functional, physical, or mental characteristics that prevent them from preparing and/or providing nutritious meals for him/herself.

4. The Service Provider must also verify that informal supports such as family, friends, or neighbors are unavailable or insufficient to meet the nutritional needs identified and to provide the necessary meals.

B. Each Service Provider must establish and utilize standardized written procedures for applying the following criteria for prioritizing Clients.

1. Factors Indicating Social Need

    a. Those isolated, living alone, age 75 and over, minority group member non-English speaking, etc.

2. Factors Indicating Functional Need

    a. Handicapped as defined by the Rehabilitation Act of 1973

    b. Limitations in activities of daily living

    c. Physically or mentally unable to perform specific tasks or services required

    d. Acute and chronic health conditions

3. Factors Indicating Economic Need

    a. Source of income such as Social Security Income, General Assistance, and actual income at or below 185 percent of the poverty level

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

C. Prior to initiating service, it must be determined if a potential Client is eligible to receive the requested services or any component support services through a program supported by other funding sources, particularly programs funded Through the Social Security Act.

V. Other Funding Sources

A. When it appears that the 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 appropriate Michigan Department of Health and Human Services offices to ensure that funds received from the Aging and Adult Services Agency are not used to provide in-home services that can be paid for or provided through programs administered by the Department of Health and Human Services.

C. The following information must be gathered and retained on file for each Client.

1. Whether the Client appears to be eligible for funded in-home services/benefits

2. Whether the potentially eligible Client consents to a referral for Department of Health and Human Services funded in-home services and benefits.

3. When a referral to the Department of Health and Human Services or a request for third-party reimbursement through the Department of Health and Human Services has been initiated and the date on which this was made.

4. The information must be completed for all Clients.

    a. Situations in which the item of information is not applicable to the Client an "N/A" must be indicated in the form.

5. This information may be included on the standard intake form.

VI. Program Requirements

A. Each program shall conduct an assessment of need for each client within fourteen (14) days of initiating service.

    1. At a minimum, each client shall receive two assessments per year (in-person), a yearly assessment and a six-month reassessment, conducting them at 6 months and 12 months

B. Service Providers may initiate needed services to the clients who are referred to the Department of Health and Human Services until MDHHS can complete the service.

C. When HDMs are provided for 10 days or less, a comprehensive assessment need not be conducted by the Service Provider.

    1. The Service Provider must determine the client's service eligibility and gather necessary intake information.

    2. When two daily meals, such as a hot meal and a cold sack meal are to be provided, the intake form must document and explain the need for the second daily meal.

D. When HDMs are to be provided for more than 10 days, the Service Provider must conduct a comprehensive assessment of individual need within 14 calendar days following the initiation of service.

1. The assessment is to be used to verify eligibility for the service or continuation of the meals beyond 14 days, and to determine the frequency and duration of services and any special meal requirements.

2. The assessment process must determine the following:

    a. The scope of the meal service to be provided

    b. The quantity and type of meals

    c. Whether or not the Client has the physical capacity and appropriate equipment to store and heat frozen meals

    d. Additional services which the Client may need from the Service Provider or other resources in the community.

3. It is the responsibility of the assessor to make such referrals and follow up to make sure services are provided.

E. The program should avoid duplicating assessments of individual clients when to the extent possible.

F. HDM programs may accept assessments and reassessments of the clients conducted by case coordination and support programs, care management programs, other in-home service providers, home and community-based Medicaid programs, other aging network home care programs, and Medicare certified home health providers.

G. Clients with multiple needs should be referred to case management programs as may be appropriate.

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

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

3. Referring program includes CCS, personal care, home health aide, care management, and the MI Choice waiver.

4. A copy of the comprehensive assessment completed by the referring agency must be on file with the HDM Service Provider within 10 days following the initiation of service.

VII. Assessment Form Requirements

A. HDM Service providers must utilize a standardized, written assessment form.

B. If the HDM program is the only program the client will be currently enrolled in, the assessments and reassessments must, at a minimum, include the following:

1. Basic Information

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

b. Source of referral

c. Name, address, and telephone number of person to contact in case of an emergency

d. Names and phone numbers of caregivers

e. Gender

f. Age and date of birth

g. Race and/or ethnicity

h. Living arrangements

i. Condition of environment

j. Whether or not the individual's income is below the poverty level and/or sources of income articulately Social Services income and general assistance, 185 percent of poverty is used for intake, reporting purposes, and is used for referral purposes.

2. Functional Status

a. Vision

b. Hearing

c. Speech

d. Oral status, condition of teeth, gums, mouth, and tongue

e. Prostheses

f. Limitations in activities of daily living

g. Eating patterns, diet history, and special dietary needs

h. Current chronic illnesses or recent (within the past six months) hospitalizations.

i. Prescriptions, medications, and other physician orders

3. Support Resources

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

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

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

d. Extent of family and/or informal support network

e. Hospitalization history

f. Medical/health insurance available

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

4. Eligibility Determination

a. Assessors must indicate on the assessment form whether a person is eligible with respect to the specific service program eligibility criteria.

b. Reasons for ineligibility must be clearly stated.

c. Assessors must indicate and refer to the Department of Health and Human Services individuals thought to be eligible for Medicaid and home help services.

d. The re-assessment date must be noted on the assessment form.

e. If the initial assessment indicates that the Client should be reassessed before six months, a determination of when reassessments should take place must be noted.

5. Client's Satisfaction Reassessment

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

b. Client's satisfaction with services received (Reassessment only)

c. Client's satisfaction with program staff performance (Reassessment only)

d. Dated signature of assessor

C. Assessors must attempt to acquire each item of information identified on the assessment form.

1. Clients have the right to refuse to provide requested items of information.

2. When service is initiated, Service Providers must notify each Client in writing of their right to comment about service provision or appeal termination of services.

3. Written notice of a Client's rights must advise that complaints of discrimination may be filed with the Region VII AAA, the Department of Health and Human Services, Office of Civil Rights, or the Michigan Department of Civil rights.

4. When service is initiated, Service Providers must provide a copy of the Service Termination Policy to the Client.

D. Assessors must attempt to acquire a release of information before disseminating information.

1. The release must be time-limited, not to exceed one year from the signature date.

2. The release must be service specific and specific as to information for release.

E. Client Follow-up and Reassessment

1. Reassessments are to determine changes in Client status, Client satisfaction, and continued eligibility for the specific service program.

2. Reassessments must be conducted in person.

3. Each Client must be reassessed at least every six (6) months unless circumstances require more frequent assessments.

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

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

    a. Changes in Client status such as circumstances and conditions must be transferred onto the original assessment tool if a separate reassessment form is used.

5. Service Providers will ensure that a follow-up telephone contact is made to the Client.

    a. At least once every two months, service providers will monitor changes in the Clients' condition or circumstances and the continued need or interest in receiving meals.

    b. A telephone monitoring contact must be made whenever delivery volunteers or personnel report changes to the program supervisory personnel

    c. Telephone monitoring contact and outcome must be documented in the Client's file.

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

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

VIII. Client Service Plan

A. HDM program must establish a written service plan for each Client receiving meals for more than 10 days based on the assessment of need.

B. The service plan must be developed prior to the continuation of service beyond 10 days and in cooperation with the Client, Client's guardian, or designated representative.

C. The service plan must contain at a minimum:

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 that they are to be provided

5. Treatment orders of qualified health professional, when applicable, such as physicians' orders for special diets

6. When Clients are authorized to receive two (2) meals per day, hot or cold, justification of the need for the additional meal must be written into the service plan.

D. Service plans for HDM Clients must be evaluated at all Client reassessments and updated.

E. The plan must include a notation of all changes in the scope of service activities and/or frequency or duration of service determined based on the reassessment.

1. Written notations of such changes must be dated.

F. 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.

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

H. 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 program 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, at a minimum, contain the following:

1. Completed intake and assessment form or a copy of the assessment form from an appropriate referring program

2. Completed reassessment forms

3. Service plan with updates and notations of any revisions

4. Case notes

D. The Service Provider must maintain chronological and cumulative case notes for each Client.

1. Each written entry must be dated.

2. Case notes must be documented.

3. Details of the Client's referral to the program

4. Documentation of Client or program initiated cancellations of meals for five or more consecutive days

5. Documentation of assessment and reassessment visits

6. Documentation of any unusual circumstances or significant changes, improvements, or regression reported by delivery volunteers or other direct service personnel visiting the home

7. A dated entry for all other contacts such as telephone or correspondence with the Client or with the family or another agency, along with a notation of the purpose and outcome of the contact

8. Emergency, accident, or sudden illness reports occurring during the delivery of meals, including date, time, conditions under which the incident occurred, and action taken

9. Copies of signed release of information forms that are time-limited and service/agency specific

10. Physician's order for special modified diets

E. Service Providers serving eligible persons with disabilities under age 60 must include a declaration of disability Statement in Client's record or document the disability in the assessment.

X. Termination Policy

A. The requirements set forth in the Client Population Policy of Chapter 1; General Administrative Procedures regarding Client termination are to be followed for HDMs.

B. Service Providers must establish a written service termination policy which addresses the following:

1. Formal notification to Client

2. The Client's decision to stop receiving services

3. Re-assessment that determines a Client to be ineligible

4. Improvements in the Client's condition so that they no longer are in need of in-home service

5. A change in the Client's circumstances which makes them eligible for in-home services from other sources

6. An increase in the availability of support from friends and/or family

7. Institutionalization of the Client in either acute care or long term care facility
    a. If temporary, services need not be terminated

8. When the program is not able to continue to serve the Client and referral to another provider is not possible

9. Death of Client

C. The termination policy must be approved by the Service Provider's governing body.

XI. Meal and Menu Standards

A. Frequency of Meals

1. Each HDM program shall demonstrate cooperation with other meal programs and providers and other community resources.

2. Meals must be available at least five days a week.

3. Each program may provide up to three meals per day to an eligible client based on need as determined by the assessment.

B. Service Providers are expected to set the level of meal service for an individual with consideration given to the availability of ~~help~~ support from family and friends and ~~subsequent~~ changes in the client's status or condition.

C. Person-centered planning and choice. HDM clients may elect to have all, or part, of the HDM delivered to them.

D. Each nutrition provider should have a form that is updated every six months during the reassessment indicating if the client has chosen to receive only part of the meal.

E. The form should have the following, at a minimum:

1. A statement that indicates the client is choosing to opt out of the full meal, and then indicating which parts of the meal they would like.

2. A statement that the client can opt back into the full meal at any time, by notifying the HDM office, or telling the delivery people.

3. A signature, initials, or mark of the client.

4. The form should be kept in the client's file.

5. This process must include person-centered planning, which may include allowing the client to attend congregate meals when they have transportation and/or assistance to attend.

6. This may also include meal choices such as vegetarian, as long as they meet the AASA Nutrient Standards.

F. The frequency, type, and number of daily meals must be indicated in the service plan.

G. Each HDM Service Provider must have the capacity to provide meals which meet the nutrition guidelines in the most current edition of the *USDA Dietary Guidelines for Americans*, which calls for each meal to be 1/3 of the Dietary Reference Intakes (DRI). Meals shall be available at least five days per week.

H. Use of Commercially Prepared Frozen Entrees

1. Frozen entrees should be field tested before use on a broad scale.

2. Local governing body and public in the area targeted for use should be fully informed about the nature and use of the frozen entrees program to avoid adverse publicity.

3. Delivery routes need to be examined to determine the cost effectiveness of the program.

    a. When the frozen entrees program is not cost effective, the hot and cold meal system should be used.

4. The program shall verify and maintain records that indicate each client can provide safe conditions for the storage, thawing, and reheating of frozen foods, if applicable.

    a. Frozen food storage should be maintained at 0 degrees Fahrenheit.

    b. Each nutrition provider shall develop a system by which to verify and maintain these records.

5. Drivers must determine during the delivery process that the entrees and meal components are not being stockpiled or improperly used.

I. Liquid Supplements

1. Liquid Supplements may be purchased with the OAA Title III-C funds; However, liquid supplements may not be counted as a meal in NAPIS

2. Liquid supplements are a component of a meal, and may be requested by a client, under the following conditions

    a. A physicians' order renewed every six months, stating the need for the additional supplement.

    b. A Service Plan for clients receiving liquid supplements with their meal shall be developed in consultation with the client's physician.

    c. A signed form, kept in the client file, indicating what parts of the meal the client chooses to receive

        a. Beverage

        b. Main entrée

        c. Fruit

        d. Dessert

        e. Liquid supplement

d. The form must also include a statement acknowledging that the client can reinstate any part of the meal at any time, upon request.

3. The regional dietician must approve all liquid ~~meal products~~ supplements to be used by the program.

XII. Sanitation and Safety Standards

A. Monitoring of Food and Temperatures

B. The Nutrition Program shall maintain daily food temperature logs.

1. Temperatures must adhere to Michigan food code

2. At minimum hot foods, milk, protein-based desserts and mayonnaise or salad dressing type salad mixtures must be tested.

3. Logs must be kept on file by the program for one year.

4. Food temperatures shall be taken of the last meal delivered on each route to test the effectiveness of food holding equipment and food safety.

5. For HDMs, a sample meal is to be tested after the last meal is delivered at least once per month.

6. If a Nutrition Provider demonstrates an inability to maintain adequate food temperatures threatening the safety of foods to be served, the program may be placed on probation.

7. Unannounced site evaluations may be conducted by the Region VII AAA to verify food temperatures.

8. The longest delivery route for meals from the time of food preparation completion to delivery to the last client cannot exceed four hours.

C. The following Sanitation, Safety, and Production Standards outlined in the Congregate Meals policy shall be applicable to the HDMs program.

1. Food Contributions

2. Inventory Systems

3. Food Production Rate

4. Health Inspection Report

5. The site will provide special menus to meet the particular dietary needs arising from the health requirements, religious requirements or ethnic backgrounds of eligible clients when:

    a. There are sufficient numbers of people who need the special menus to make this provision practical.

    b. The tools and skills necessary to prepare the special menus are available in the area.

6. The site will provide food containers and utensils for blind and handicapped clients upon request.

7. The meal site must maintain a daily sign-in sheet for clients as outlined for Congregate and HDMs programs.

8. The site must coordinate services with other nutrition service providers in the target area.

9. Services must be targeted to those seniors in greatest economic and social need with particular attention to low-income minorities.

10. Nutrition Services Initiative Program reimbursements cannot be used to replace funds from non-Federal sources, other resources must continue to be generated.

11. The site must have a method of obtaining feedback from clients served.

12. Nutrition Services Initiative Program reimbursements cannot be obtained for meals served to ineligible persons or for second, “leftover” meals served to eligible clients who have already consumed a meal.

D. Uses of Nutrition Services Initiative Program

1. Nutrition Services Initiative Program reimbursements must be expanded in the same program and fiscal year for which they were received.

2. Nutrition Services Initiative Program reimbursements may only be used for the purchase of raw food and commodities.

XIII. Program Income

A. Non-Eligible Clients

1. Service Providers shall have the option of allowing regular program volunteers to receive Congregate Meals on a donated basis.

2. Service providers shall have a written policy on volunteer meals and be able to document that program volunteers have been informed of the policy.

3. At the minimum the policy must:

    a. Define the minimum number of hours volunteered and the minimum number of days volunteered per week required in order to receive meals on a donation basis.

    b. Clearly stipulate that volunteers under age 60 may receive a meal on a donation basis only on those fays that volunteer work is actually being performed by the individual.

    c. Require all volunteers to sign-in, with volunteers under age 60 recorded separately as volunteers-eligible.

4. Staff may be allowed to purchase leftover Congregate Meals at the discretion of the Service Provider.

    a. If the Service Provider allows staff to purchase meals, all eligible clients must be served first.

    b. Staff may not reserve meals.

    c. The staff person must sign-in and be recorded as an ineligible client.

    d. The meal counts as on ineligible meal served regardless of whether a full or partial meal is served.

    e. The staff must pay the raw food cost of the meal as stated in the current budget.

    f. The full raw food cost must be paid regardless of the items served, and a receipt issued.

5. All other non-eligible persons receiving meals are required to pay a guest fee as established by the Service Provider.

    a. The guest fee must reimburse the Service Provider for the total cost of the meal based on the total line of the Planned Expenditures section of the C-1 budget summary, divided by the total contracted meal level.

    b. A receipt must be issued when guest fees are paid.

B. Client Contributions

1. Each Service Provider with input from program clients must establish a suggested donation amount that is to be posted at each meal site.

    a. The program may establish a suggested contribution scale based on income ranges, if approved by the Region VII AAA.

2. Client contributions must be obtained and utilized as outlined in the Program Income Policy of the General Administrative Procedures chapter of this manual.

3. Nutrition Client contributions shall be used for the following purposes only.

    a. To increase the number of meals: program income can be used to purchase raw food, expand available labor hours, and provide for additional meal or bulk food delivery needs.

    b. Food service or delivery equipment, excluding vehicles, may also be purchased under this allowance.

    c. To facilitate access to meals, program income may be utilized on a limited basis for transportation services for potential nutrition clients.

    d. Requests for using program income for transportation services require prior Region VII AAA approval.

    e. Program income can be used to conduct outreach activities in order to increase the number of clients in the program.

    f. Outreach activities require the prior approval of the Region VII AAA and must conform to the definition of Outreach activities as outlined under the Outreach Policy of this manual.

g. To provide supportive services directly related to improving clients' nutritional status. Any such use must be approved by the Region VII AAA.

C. Bridge Cards are to be accepted as donations/contributions for the Congregate Meals program.

1. Each Service Provider shall have in place a written procedure for handling all donations/contributions that includes, at a minimum, the following information:

a. Daily counting and recording of all receipts by two individuals at each meal site

b. Provisions for sealing written acknowledgement and transporting of daily receipts to deposit in a financial institution

c. Reconciliation of deposit receipts and daily collection records by someone other than the depositor or counter

2. Each Service Provider shall be responsible for assuring that program staff and/or volunteers properly implement procedures for handling program income.

3. All other requirements listed in the Program Income Section of the Policy Manual apply.

XIV. Emergency Planning

A. Emergency Shelf Stable Meals

1. All nutrition providers shall provide to HDM program clients shelf-stable meals to be used in an emergency, or when it has been determined ahead of time that meals will not be delivered because of weather or other interruptions.

2. Educational materials must be distributed along with the shelf-stable meals to instruct the client when to use the meal, along with a list of recommended emergency food and equipment (e.g. manual can opener) that should be kept in the home.

3. In order to assure continuation of services when home delivered meals may be interrupted, or during an emergency, service providers will have emergency shelf stable meals available with a shelf life of one year.

4. A five-day shelf stable menu must be kept on hand that can be delivered to seniors for use when home delivery is unavailable due to emergency weather conditions.

5. HDM volunteers, drivers, and staff should create a plan to regularly check with clients to assure they still have their shelf-stable meal.

    a. If the client no longer has the shelf-stable meal, another must be delivered as soon as possible.

6. Shelf-stable meals should be replaced at regular intervals.

B. Home Delivered Meals

1. When a nutrition provider has to cancel Home Delivered Meals, they must immediately complete the meal cancellation report and submit to AAA.

2. The following information must be provided:

    a. Name of nutrition provider

    b. Reason for cancellation

    c. Geographical area affected

    d. Method by which Home Delivered Meals Client/contacts will be notified

    e. Date of the last shelf stable meal distribution.

C. Home Visit Safety

1. Assessors, HDM drivers, delivery people and other nutrition program staff are not expected to be placed in situations that they feel unsafe or threatened.

2. Nutrition providers shall work with their AAA to create a “Home Visit Safety Policy” that addresses verbal and physical threats made to the assessor(s), drivers or other program persons, by clients, family members, pets (animals) or others in the home during the assessment

3. This policy should include, but is not limited to:

a. Definition of a verbal or physical threat;

b. How a report should be made/who investigates the report;

c. What actions should be taken by the assessor or driver if they are threatened;

d. What warnings should be given to the client;

e. What actions should be taken for repeated behaviors;

f. What information gets recorded in the chart; and

g. Situations requiring multiple staff/volunteer

VOLUME III: Specific Service Requirements

(11) POLICY NAME: Nutrition Services – Congregate Meals

PURPOSE: This section outlines procedures that must be followed by nutrition programs funded by Region VII AAA. Topics covered include Menus, Sanitation and Safety, Food Cost Control, Program Eligibility, Intake Procedures, Client Contributions, Meal Fees for Non-Eligible Clients, Nutrition Services Initiative Program Requirements, Site Facilities, and Staff Requirements

AUTHORITY: AASA Operating Standards for Service Programs

UNIT OF SERVICE: Each meal served to an eligible client

I. Congregate Nutrition

A. Congregate nutrition is the provision of nutritious meals to older individuals in congregate settings

B. The service includes the provision of nutrition education services and other appropriate nutrition services.

1. Congregate nutrition promotes better health among the older population through improved nutrition.

2. Congregate nutrition reduces social isolation often experienced by older persons.

3. Congregate nutrition sites may include churches, community centers, senior citizen centers, schools and other public or private facilities where other social and rehabilitation services can be obtained.

C. A client may only be counted once during the reporting period.

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

II. Eligibility

A. Each program must have written eligibility criteria, that places emphasis on serving older individuals in greatest need and includes at a minimum the following:

1. An eligible person must be 60 years of age or older

2. A spouse under the age of 60 who accompanies an eligible adult to the meal site

3. Family members of an eligible adult who are living with a disability and permanently live with the eligible adult in a non-institutional setting

4. An unpaid caregiver who is under the age of 60 and is registered in the National Aging Programs Information System (NAPIS) and accompanied person being cared for to meal site.

5. To be eligible for a donation-based meal, persons described in items 2-4 must, on most days, accompany the eligible adult to the meal site and eat the meal at the meal site.

6. Individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided may participate in the meal

7. A volunteer under the age of 60 who directly supports meal site and/or food service operations may be provided a meal.

    a. Such meals may be provided only after all eligible clients have been served and meals are available.

    b. A fee is not required for volunteers under the age of 60, but contributions should be encouraged and accepted. These meals are to be included in the National Aging Programs Information System (NAPIS) meal counts.

8. A person under 60 years of age and doesn't meet any other eligibility requirements must pay the established guest fee for any meal.

    a. The full cost includes raw food, preparation costs, and any administrative and/or supporting service costs.

    b. There shall be documentation that full payment has been made and documentation must be maintained. Persons not eligible under item #1 who pay the full price for a meal, and are 18 and over, must wait until all eligible persons have been served, unless the meal has been reserved in advance.

    Children (under the age of 18) who accompany a meal client who is over the age of 60, must pay full price, but may go through the line with the adult they are with.

9. If a regular congregate meal client is unable to come to the site due to illness, the meal may be taken out of the site to the individual for no more than seven days. If needed for more than seven days, the client should be evaluated for HDMs. If the person taking out the meal for the ill client is also a regular congregate client, they may also take their meal out.

10. Provide a required fee for non-senior nutrition program staff to purchase leftover meals to be eaten at the meal site.

11. This practice and the set fee must be approved by Region VII AAA and shall apply only to agency staff working directly on nutrition program operations.

12. Each Congregate nutrition provider shall be able to provide information relative to eligibility for HDMs and be prepared to make referrals for persons unable to participate in the congregate program and who appear eligible for a HDM program.

B. The service provider shall submit to the Region VII AAA a copy of the written eligibility criteria at the beginning of each multi-year cycle.

C. Ineligible clients include all persons under age 60 who do not meet the eligibility criteria.

D. The provision of meals to eligible persons shall take priority over the provision of meals to ineligible persons.

1. Eligible persons shall be served first in the event of a meal shortage.

E. When a reservation system is in place and a meal shortage occurs, clients with reservations shall be given priority over walk-ins.

III. Intake Procedures

A. Each program must use a uniform intake process at each site and maintain a client card for each program client.

1. The intake process must be initiated within one week after an individual becomes active in the program.

2. Each intake or client form should contain as much of the following information as possible to determine:

a. Individual's name, address and telephone number

b. Individual's age and date of birth

c. Gender

d. Name, address, and telephone number of a person to contact in case of an emergency

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

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

g. Special dietary needs

h. Race and/or ethnicity

i. Whether or not the individual's income is at or below 185 percent of the poverty level and/or sources of income

j. Potential supportive services needs as expressed by the client

k. information on special skills or interests of the client; if the client is not age 60, he or she is eligible as a spouse, handicapped resident of facility or disabled younger person residing with accompanying senior

l. Client signature and date

m. statement of disability information for persons with disabilities under age 60 who resides with and accompanies an eligible older person to the program

B. An intake form or card must be completed and maintained on file for each eligible client.

1. The form must be updated and signed yearly at the start of each new contract or a new form or card completed.

2. Only one client card must be maintained for each client when the meal site is located in a center funded for Senior Center Operations and/or Senior Center Staffing.

3. The completion of a client card is not a prerequisite to eligibility and may not be presented to potential clients as a requirement.

4. For active clients who refuse to complete an intake form, the site manager should complete as much of the information as possible based upon his or her knowledge of the client.

5. Each Congregate Nutrition Provider must be able to provide information relative to eligibility for Home Delivered Meals and be prepared to make referrals for persons unable to participate in the congregate program and who appear eligible for a Home Delivered meals program.

6. Client records must be kept on site in controlled access files.

IV. National Aging Program Information System (NAPIS)

A. Each program shall develop and utilize a system for documenting meals served for purposes of the Nutrition Services Incentive Program (NSIP).

1. Meals eligible to be included in NAPIS meal counts reported to Region VII AAA are those served to eligible individuals as described under respective program eligibility criteria and that meet the specified meal pattern requirements

2. The most acceptable method of documenting meals is by obtaining signatures daily from clients receiving meals.

3. Other acceptable methods of documenting home delivered meals include maintaining a daily or weekly route sheet signed by the driver that identifies the Client's name, address, and number of meals served to them each day.

B. Each program shall use a uniform intake process and maintain a NAPIS registration for each program client.

1. Completion of NAPIS registration is not a prerequisite to eligibility and may not be presented to potential clients as a requirement.

V. Facilities Requirements

A. All Older Americans Act and State funded meal sites must be certified and documented as an accessible facility.

1. Accessibility is defined as persons with disabilities being able to enter the facility, use the restroom, and receive service that is at least equal in quality to that received by an able-bodied client.

2. Each meal site must be documented and certified as an accessible facility by a local building inspector or preferably a licensed architect.

3. A program may also conduct accessibility assessments of their meal sites when utilizing written guidelines approved by Region VII AAA.

B. The nutrition program must operate according to current provisions of the Michigan Food Code. Minimum food safety standards are established by the respective local Health Department.

1. Each program must have a copy of the Michigan Food Code available for reference.

2. Programs are encouraged to monitor food safety alerts pertaining to older adults.

C. All meal sites must comply with the requirements of Michigan Public Act 368 of 1978, Part 129, and local public health codes regulating food service establishments as documented by a license from a local Health Department.

D. Inspection of Home Delivered Meals delivery and packaging systems must be included in the evaluation of kitchens and meal sites for licensure as food service establishments.

E. Each meal site and/or kitchen operated by a Congregate Meal Provider must be appropriately licensed by the Department of Public Health as a food service establishment.

F. The local Public Health Department is responsible for periodic inspections and for determining when a facility is to be closed for failure to meet Health Code Standards (P.A. 368 of 1978).

1. Each program must submit copies of inspection reports on all facilities to Region VII AAA within 10 days of receipt of such reports.

2. It is the responsibility of each program to address any violation noted in the inspection report as soon as possible. Failure to correct violations may be cause for relocation of program operations to another facility

3. The local health department rulings supersede any state rules/mandates concerning licensing of food service establishments, including congregate meal sites and off-site meals.

4. The program shall submit copies of inspection reports on all facilities to the respective AAA within ten days of receipt.

G. All meal sites must comply with state and/or local fire and safety standards as documented by the local fire department.

1. Each meal site must be inspected by a local fire official at least every three years.

2. Where a local fire official is unavailable, after a formal written request, a program may conduct fire safety assessments of its meal sites when utilizing written guidelines approved by Region VII AAA.

a. Written guidelines must include the use of a private agency certified to do fire inspection.

H. Each program, through a combination of its meal sites, must provide meals at least once a day, five or more days a week. Programs may serve up to three meals per day at each meal site.

I. Each site shall serve meals at least three days per week with a minimum annual average of 10 eligible clients per serving day.

J. If the service provider also operates a HDM program, HDMs sent from a site may be counted toward the 10 meals per day service level.

K. Waivers to this requirement may be granted by the respective AAA only when the following can be demonstrated.

1. Two facilities must be utilized to effectively serve a defined geographic area for three days per week.

2. Due to a rural or isolated location, it is not possible to operate a meal site three days per week.

3. Seventy-five percent or more of clients at a meal site with less than 10 clients per day are in great economic or social need. Such meal sites must operate at least three days per week.

VI. Site Openings and Relocations

A. Congregate meal sites currently in operation by the program may continue to operate unless the respective AAA determines relocation is necessary to serve socially or economically disadvantaged older persons more effectively.

1. New and/or relocated meal sites shall be located in an area which has a significant concentration of the 60 and over population living at or below the poverty level or with an older minority or ethnic population comprising a significant concentration of the total over-60 aged population.

2. AASA must approve, through the Congregate Meal Site Database, the opening of any new and/or relocated meal site prior to the provision of any meals at that site.

B. The AASA must approve, in writing, the opening of a new and/or relocated meal site prior to the provision of any meals at that site.

C. Service providers proposing to open a new meal site or relocate an existing meal site must submit a rationale request to the Region VII AAA outlining the need for the new site or relocation, including the following:

1. Explanation of the need for the new site or site relocation

2. Demographic data that supports the selected location, especially as it relates to concentrations of low income or minority seniors.

    a. New and/or relocated meal sites must be located in an area that has a significant concentration of the over 60 population living at, below the poverty level, or with an older minority or ethnic population comprising a significant concentration of the total over 60 population.

3. Certification of compliance with the meal site criteria, including required licenses, must be included in the request sent to the Region VII AAA.

4. A new site must submit a justification of the cost effectiveness of the site, including an explanation of how meals will be obtained for the site.

5. Certification that the meal site will meet the 25 client per day average

6. Copies of the latest inspection reports for the new meal site

7. Certification that the new site is handicap accessible

D. The request package for site openings and/or relocations must be submitted to the Region VII AAA for review and recommendations prior to the provision of any meals at the site.

E. The Region VII AAA review will include a site evaluation.

F. Region VII AAA will coordinate arrangements with AASA for final disposition on each request.

VII. Site Closures

A. When a service provider proposes to permanently close a meal site, the following procedures must be followed:

1. The provider must notify the Region VII AAA in writing of the intent to close a meal site.

2. The Service Provider must present a rationale for closing the meal site, which is based on lack of attendance, inability to meet minimum standards and/or other requirements, loss of resource, or other justified reason.

3. Region VII AAA shall review the rationale and determine that all options for keeping the site open or being relocated have been exhausted.

4. When there remains a need for service in the area that was served by the meal site, efforts should be made to develop a new meal site and/or assist clients to attend another existing meal site.

5. Service Provider must notify clients at a meal site of the intent to close the site at least 30 days prior to the last, day of the meal service and assist with transportation arrangements to other meal sites.

B. Region VII AAA shall complete the steps for closure in the AASA online database. The following information is needed to close a site and should be entered into the database.

1. Rationale for closing the site

2. How clients will be notified

3. Closest meal site to the closed site, and transportation options to get clients to the different site.

C. AASA will review the documents and the request to close the site. If approved, AASA will notify the requestor, the respective AAA and field representative

D. The Region VII AAA may require a Service Provider to close or relocate a site for the following reasons:

1. Participation has fallen below 10 eligible persons per day and a waiver has not been granted.

2. The site is not in operation at least 3 days per week and a waiver has not been granted.

3. The site has consistently been cited by the Region AAA health department evaluations for improper food handling practices or the presence of fire and safety hazards.

4. The program must relocate a site if the physical plant hazards exist and the building owner has refused to rectify.

5. The site is determined, through an analysis of census data, to be located in an area that no longer has a concentration of low income or minority seniors due to population shifts.

E. The local health department can initiate site closures if critical violations are found on health department inspection reports.

1. It is the responsibility of the service provider to notify the Region VII AAA if a meal site is to be closed due to health code violations.

2. It is the responsibility of the service provider to submit a copy of the health department's inspection reports within 10 days of inspection.

3. The Region VII AAA will require a copy of the written corrective action plan for the facility and an interim plan for the provision of nutrition services until the site can be reopened.

F. Waivers for Site Closures

1. Service Providers may request waivers for meal sites unable to meet the following meal site criteria:

a. The site will serve a minimum of three days per week.

b. The site will serve a minimum annual average of 10 eligible persons per serving day.

2. Waivers based on the above standard will be granted only in the following situations:

a. When it can be demonstrated that two facilities must be utilized to serve effectively a defined geographic area for three days per week

b. When it can be demonstrated that due to a rural or isolated location it is not possible to operate a meal site three days per week

c. When it can be demonstrated that 75 percent or more of clients at a meal site with less than 10 clients per day are in greatest economic or social need. Such meal sites must operate at least three days per week.

3. Waivers must be requested for each site on an individual basis and the following information must be submitted to the Region VII AAA for each site for which a waiver is requested.

a. A rationale for requesting the waiver, including a discussion of previous attempts by the service provider to bring the site into compliance through alternative methods

b. Documentation to support the waiver request such as demographic, geographic, economic and statistical information

c. Proof of compliance with the remaining meal site criteria

4. The Region VII AAA will process waiver requests within 90 days of receipt of a completed waiver request.

5. Waiver requests require Region VII AAA Board approval.

6. A site evaluation may also be performed to ensure general site requirements are being met.

G. Temporary Meal Site Closings.

1. If a meal site must be closed or moved temporarily, the nutrition provider must notify the AAA.

2. This form must be completed and submitted prior to the closing, or as soon as possible after the closing.

3. A link to the form is located on the business partner site: https://www.osapartner.net

VIII. Additional Meal Site Requirements

A. Each Service Provider must have written agreements with the owners of all leased facilities used as meal sites, except those donated for use at no cost. Written agreements are recommended for donated facilities, but not required.

B. The agreements must address at a minimum:

1. Responsibility for care and maintenance of the facility, specifically including ~~that includes~~:

a. Sanitation of restrooms and common areas

b. Equipment

c. Cleaning of range hoods, fans, vents, walls, floors, and other major cleaning

d. Storage areas and areas of common use

e. Snow and garbage removal

f. Minor/major repairs

g. Agreement on amount of rent or utility payment, as applicable

h. Responsibility for obtaining health, fire and safety inspections and appropriate licensing by the local health department

i. Responsibility for site security and procedures

j. Responsibility for insurance coverage

k. Responsibility for approval of outside programs, activities and speakers;

l. An assurance that both parties will comply with applicable Federal, State, and local laws

m. Other issues as desired or required

C. Each meal site shall display at a prominent location the AASA Community Nutrition Services poster.

D. Each program shall make available, upon request, food containers (assistive plates, bowls, cups), and utensils for clients who are ~~blind or have~~ living with disabilities.

E. Each service provider must ~~be able to~~ document that appropriate preparation has taken place at each meal site for procedures to be followed in case of an emergency including the following:

1. Annual fire drill

2. Staff and volunteers shall be trained on procedures to be followed in the event of a severe weather storm or natural disaster~~s,~~ and the county emergency plan

3. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency

IX. Site Evaluation

A. Region VII AAA will conduct unannounced site evaluations for each service provider providing Older Americans Act and/or State funded services.

B. Site evaluations will address the following:

1. Verifying food temperatures

2. Determining if proper food handling practices exist at the site

3. Use of proper portion control practices

4. Utilization of standardized recipes

5. Other applicable program operations to determine compliance with nutrition program requirements.

6. Region VII AAA will call the service provider's office the morning of a scheduled evaluation to notify the Project Director of the location and itinerary for the site evaluation.

C. Technical assistance may be provided on-site by the Region VII AAA when needed.

D. Site Evaluation Feedback

1. Service Providers will receive written feedback reports indicating site evaluation findings and observations.

2. Feedback reports will include required corrective action and recommendations.

3. Areas of non-compliance with applicable laws, regulations, and policies will be specified and will require immediate corrective action.

4. Feedback reports will be distributed to service providers within thirty (30) days of each site evaluation.

5. Feedback reports require service provider's written responses to be received on/or before the due date indicated.

6. Service provider responses should include the following:

    a. A plan of action taken to correct deficiencies and the estimated completion date of all non-compliance findings

    b. Concurrence/non-concurrence with findings

    c. Action to prevent recurring of non-compliance findings

X. Meal Pattern Menu Specifications

A. Cycle menu usage is encouraged for cost containment and convenience, but not required.

    1. Service Providers are encouraged to consult with Region VII AAA's dietician during the menu development process.

B. Potlucks

    1. Congregate meal service providers receiving funds through Region VII AAA may not contribute towards, provide staff time, or otherwise support potluck dinner activities, or allow program foodstuff to be combined with foods brought in by clients.

C. Efforts must be made to provide accurate substitutions on the menus when the situation dictates, such as vegetable for vegetable, fruit for fruit.

    1. A service provider must have a policy of procedure in place dictating when substitutions will be made and the process how the dietician will be notified.

    2. A Service Provider must be able to justify substitutions.

D. Menu Evaluation and Certification

1. Menus shall be submitted to the Region VII AAA Dietician on the correct form for both congregate and home delivered meals two months in advance of production.

2. Menus will be reviewed by the Region VII AAA Dietician, the review form completed, and the menus returned for correction as necessary.

3. The menus must utilize written, standardized recipes.

4. Upon receipt of a correct or reviewed menu, the Region VII AAA Dietician will notify the project site that the menu has been certified.

5. The certification process from submittal to the Region VII AAA Dietician to certification shall not exceed one month.

6. Prior to the start of the new fiscal year, approved service providers shall submit menus to the Region VII AAA Dietician for review, revisions, and re-certification, as deemed appropriate.

    a. This shall include previously approved menus.

7. Service providers wishing to revise the certified menu and/or the approved alternate meals must submit a substitute nutrition analysis to the Region VII AAA Dietician prior to the production of the meal.

8. Service providers shall conduct a client survey at least once each fiscal year to determine satisfaction with the menu and meals.

    a. Survey results will be reviewed by Region VII AAA at the time of assessment.

E. Menu Retention and Posting

1. The certified menu, its alternates and holiday menus shall be retained by the Nutrition Director and the Region VII AAA Dietician for a period of one year.

2. The menu shall be updated annually by the Nutrition Director and resubmitted for certification by the Region VII AAA Dietician.

3. The menu to be served in any given service area must be published in the local newspaper or senior newsletter.

4. The daily menu must be posted at each meal site in a conspicuous place and in the food preparation kitchen.

a. The daily menu must be labeled with the day and date, and reflect any changes or substitutions made.

F. Modified Diets

1. The diet currently served at congregate meal sites is considered a regular diet.

2. Service providers may develop a modified diet menu, where feasible and appropriate, when at least 10 percent of clients at a meal site request a modified diet.

3. A modified diet is defined as diabetic, low-sodium, low fat, and texture modified.

4. The Provider must assure that a current physician's written diet order is on file for clients consuming the modified diets.

G. Commercial Nutrition Supplements and Vitamins

1. The display, marketing, or use of vitamin pills or commercial food supplements at nutrition sites or through the nutrition program is prohibited.

H. Portion Control

1. Service providers shall use standardized portion control utensils and practices to ensure that each meal served is uniform and satisfies each meal pattern requirement.

2. Standard portions may be altered only at the request of a client for less than the standard serving of an item or if a client refuses an item.

3. Service providers shall not decrease standard portion sizes in order to increase the number of meals that can be served in a given day.

I. Second Meal

1. Nutrition providers may elect to offer second meals at any dining site. A second meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food-borne illness. A congregate meal client may qualify for a second meal if:

a. The client eats the regularly scheduled meal at the meal site; and

b. The client has requested a second meal following the nutrition providers process (i.e. phone registration)

c. The second meal must meet the AASA nutrition standards.

d. Donations may be accepted for second meals.

e. The second meal is given to the client when they leave the congregate site. It must be stored properly until the client is ready to leave for the day.

f. The second meal is to be counted as a congregate meal in all record keeping.

g. The second meal option does not apply to NSIP-only sites.

J. Weekend Meal(s).

1. Nutrition providers may elect to offer weekend meals at any dining site.

2. A weekend meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food-borne illness.

3. A congregate meal client may qualify for a weekend meal if:

   a. The client is registered at the meal site and eats meals at the regularly scheduled time during the week; and

   b. The client has requested weekend meal(s) following the nutrition

   c. provider's process (i.e. phone request).

4. The weekend meal must meet the AASA nutrition standards

5. Donations may be accepted for weekend meals.

6. Arrangements for weekend meal pick up should be made with the nutrition provider/site manager in advance.

7. The weekend meal is to be counted as a congregate meal in all record keeping.

8. The weekend meal option does not apply to NSIP-only sites.

K. Client Choice

1. Person-centered planning involves client choice

2. Persons in this program are allowed to participate in both the HDM and congregate program at the same time.

    a. For example, an HDM client may have a friend or family member that can take them to a congregate site one day per week, or on a random basis.

3. Proper documentation must be kept as to the HDM schedule and the congregate meal schedule.

4. An agreement between programs is encouraged.
5. Clients using this option should be reminded to contact the HDM office to cancel their meal for the days they are at the congregate site.

L. Voucher Meals

1. Nutrition providers may develop a program using vouchers for meals to be eaten at a restaurant, café, or other food service establishment.

2. The program must meet the following standards.

    a. The restaurant, café, or other food service establishment must be licensed, and follow the Michigan Food Code, and is inspected regularly by the local health department.

    b. The restaurant, café, or other food service establishment agrees to provide at least one meal that meets AASA nutrition standards for meals.

    c. The restaurant, café, or other food service establishment must be barrier-free and Americans With Disabilities Act (ADA) compliant.

    d. The nutrition provider and restaurant, café or other food service establishment must have a written agreement that includes:

        i. How food choices will be determined;

        ii. How food choices will be advertised/offered to voucher holder;

        iii. How billing will be handled (will a tip be included in the unit price, i.e. if the meal reimbursement is $6.25, will $.25 be used toward the tip?);

iv. How reporting takes place (frequency and what is reported);

v. Evaluation procedures;

vi. A statement that voucher holders may take leftovers home; and that they may purchase additional beverages and food with their own money.

e. A copy of the written agreement shall be given to the AAA nutrition program coordinator.

f. A written plan must be developed and kept on file that includes consideration of the following items.
   i. Location of the restaurant, café, or other food service establishment in relation to congregate meal site locations;

   ii. Establishment of criteria for program participation- how restaurants, cafe, or other food service establishments are selected to participate and how new establishments can apply to participate;

   iii. How older adults qualify for and obtain their vouchers, i.e. senior centers, nutrition provider office, nutrition program representative meets with older adults at the restaurant, cafe, or other food service establishment to issue vouchers and collect donations; and

   iv. How frequently menu choices will be reviewed and revised by the AAA Dietitian or DTR.

g. Nutrition providers must allow older adults to use congregate meal sites and voucher programs interchangeably. If a nutrition provider chooses to do so, the plan described in item vi. above must detail how this will be done.

M. Adult Foster Care (AFC) and other Residential Care Clients.

1. AFC or other residential providers that <u>bring</u> their residents to congregate meal sites shall be requested to pay the suggested donation amount for meals provided to residents and staff 60 years of age or older.

2. For those AFC residents and staff under the age of 60, the guest charge must be paid as posted at each meal site.

3. The congregate meal provider may request the AFC program to provide staff to assist the residents they bring with meals and other activities that they wish to attend.

4. AFCs, adult day programs, or other residential providers may enter into a contractual agreement regarding donations and payment for meals if the practice occurs regularly or is long-term.

N. Complimentary Programs/Demonstration Projects.

1. AAAs and nutrition providers are encourage to work together to provide programming at the congregate meal sites that include activities and meals. Suggestions for demonstration projects include, but are not limited to:

a. Offering a take-out meal upon completion of an activity at the meal site that does not occur immediately before or after the meal;

b. Mobile congregate sites that move to different locations to serve, also known as 'pop-up' sites; and

c. New meal options such as smoothies, vegetarian choices, and other non-traditional foods.

d. All demonstration projects must be approved by the AAA and AASA and must follow the nutrition standards.

O. Prayer

1. Older adults may pray before a meal that is at a site that is funded through AAA, AoA, or State of Michigan.

2. It is recommended that each individual client has a free choice whether to pray either silently or audibly.

3. The prayer is not officially sponsored, let, or organized by persons administering the Nutrition Program or the meal site.

XI. Standard Recipe

A. Nutrition programs must utilize standardized recipes. Standardized recipes shall be developed for all existing menu items and all new menu items.

B. The recipes must include the number of servings to prepare, serving size, pan size, time, temperature, specific preparation steps, and portion control tool to use for service specific instructions and ingredient amounts.

C. Standardized recipes for categories of foods shall be developed defining the techniques to be used when preparing these foods.

D. Examples of categories of food include meat roasts, pastas, frozen and canned vegetables, gelatins, white sauces, and quick breads, muffins and biscuits.

E. A master file of standardized recipes shall be maintained in the service provider's central office with the current menu and must be updated annually.

1. Instructions for adjusting yields shall be a part of the recipe file.

F. Leftovers

1. Leftovers from the meal (items not eaten by the client) may be taken out of the meal site if the following conditions are met.

    a. The local health department has no restrictions against it;

    b. A sign shall be posted near the congregate meal sign informing the meal clients that all food removed from the site becomes the responsibility of the individual that is removing the food;

    c. All new congregate clients receive written material about food safety and preventing food-borne illness when they sign up;

    d. All clients receive written material about food safety and preventing food-borne illness annually;

    e. The individual is required to sign a waiver statement that states that they understand that they are responsible for food taken out of the site; and

    f. Containers may not be provided through federal or state funds by the nutrition provider for the leftovers.

2. Each Service provider shall make every effort to avoid the accumulation of leftovers through the use of standardized recipes, portion control, proper purchasing, correct food preparation procedures, and the use of a reservation system.

3. Each Service provider must implement procedures designed to minimize waste of food leftovers/uneaten meals which at a minimum, includes the following:

    a. The Service provider shall maintain the variance between the number of meals prepared and the number of meals served at not more than one meal per day or 3 percent of total meals served, whichever is greater at each meal site.

    b. The amount of each menu item left after the clients have been served once shall be recorded on the daily cook's sheet.

    c. Leftovers may be offered for a second helping.

    d. When staff is permitted to purchase leftovers, it may be consumed only after clients have been offered the second helping.

    e. If food is not taken/consumed, it must be destroyed at satellite sites.

    f. Leftover foods occurring at on-site preparation facilities may be retained when feasible and appropriate for later use in the meal program.

    g. Bread items, fresh fruits, cake, brownies, cookies and closed milk containers may be removed from the site by clients

    h. Program staff shall be prohibited from removing leftover food from any meal site or preparation facility.

    i. Leftovers shall not be frozen for use as home delivered meals.

4. The safety of food after it has been served to a client and when it has been removed from the meal site is the responsibility of the client.

G. Reservation System

1. Nutrition Service Providers must utilize a reservation system to determine the number of meals to be prepared.

H. Inventory System

1. Each Service Provider must use an adequate food cost and inventory system at each food preparation facility.

2. The storage area shall be arranged in an orderly manner.

3. The site shall display evidence that a raw food issuing system for dry, refrigerated and frozen storage is in effect through the use of sign-out sheets or other accurate food usage records.

4. The inventory control must be based on the first-in first-out method and conform to generally accepted accounting principles.

5. The system must be able to provide daily food costs, inventory control records, and monthly compilation of daily food costs.

6. Daily food costs record information includes the following:

    a. Food item

    b. Unit size

    c. Unit number

    d. Cost per unit

    e. Cost per meal prepared for the day

    f. Number of meals prepared

7. Inventory control records information includes the following:

    a. Name of food item

    b. Description of food item such as sliced or diced

    c. Unit size

    d. Purchase rice or cost per unit

    e. Date of receipt

    f. Number of items

    g. Number of items for preparation

    h. Total inventory

8. Monthly compilation of Daily Food Costs information includes the following:

    a. Number of persons served per day

    b. Cost of food from storeroom per day

    c. Food cost per person per day

    d. Cost of food purchased this date

    e. Total monthly inventory

9. The Region VII AAA requires sites that produce both congregate and home delivered meals determine Food Cost Per Meal Per Day.

10. The inventory records shall be compiled and maintained in the Service Provider's central office.

11. For programs operating under a cost-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year is to be deducted from the total amount expensed during that year.

12. For programs operating under a unit-rate reimbursement contract, the value of the inventory on hand at the end of the fiscal year does not have to be considered.

I. Food Production Rate

1. Food production rates shall meet the following criteria:

    a. 6 meals per staff hour for 25 to 49 populations to include home delivered meals.

    b. Ten (10) meals per staff hour for 50 to 99 populations to include home delivered meals.

    c. Thirteen (13) meals per staff hour for 100 and more populations to include home delivered meals.

2. The food production rate shall be calculated as follows:

$$\frac{\text{Total Number of Meals for That Day}}{\text{Total Actual Food Production Hours Worked That Day}}$$

3. Food production hours shall include:

    a. Food production preparation, cooking, shopping and related paperwork

    b. Clean-up, dishwashing, and related paperwork

    c. Food ordering and related paperwork

4. Other hours include:

    a. Packaging

    b. Delivering of home delivered meals

    c. Cleaning areas outside of the kitchen

    d. Heavy janitorial tasks in the kitchen such as cleaning ovens, refrigerators, floor washing, and wall washing.

J. Project Council

1. Each program shall have a project council, comprised of program clients to advise program administrators about services being provided.

2. Program staff shall not be members of the project council.

3. Program clients should be made aware of the existence of the project council, its membership and the scheduled meeting dates.

4. The project council shall meet at least once per year, in person, and notes from all meetings shall be shared with Region VII AAA nutrition program, as well as saved for future reference

XII. Program Income

A. Non-eligible Clients

1. Service providers shall have the option of allowing regular program volunteers to receive Congregate Meals on a donated basis.

2. Service providers shall have a written policy on volunteer meals and be able to document that program volunteers have been informed of the policy.

3. At the minimum the policy must:

    a. Define the minimum number of hours volunteered and the minimum number of days volunteered per week required in order to receive meals on a donation basis.

    b. Clearly stipulate that volunteers under age 60 may receive a meal on a donation basis only on those days that volunteer work is actually being performed by the individual.

    c. Require all volunteers to sign-in, with volunteers under age 60 recorded separately as volunteer-eligible.

4. Staff may be allowed to purchase leftover Congregate Meals at the discretion of the Service Provider.

    a. If the Service Provider allows staff to purchase meals, all eligible clients must be served first.

    b. Staff may not reserve meals.

    c. The staff person must sign-in and be recorded as an ineligible client.

    d. The meal counts as one ineligible meal served regardless of whether a full or partial meal is served.

    e. The staff must pay the raw food cost of the meal as stated in the current budget.

    f. The full raw food cost of the meal as stated in the current budget.

5. All other non-eligible persons receiving meals are required to pay a guest fee as established by the Service Provider.

    a. The guest fee must reimburse the Service Provider for the total cost of the meal based on the total line of the Planned Expenditures section of the C-1 budget summary, divided by the total contracted meal level.

    b. A receipt must be issued when guest fees are paid.

B. Client Contributions

1. Each Service Provider, with input from program clients, must establish a suggested donation amount that is to be posted at each meal site.

a. The program may establish a suggested contribution scale based on income rangers, if approved by the Region VII AAA.

2. Client contributions must be obtained and utilized as outlined in the Program Income Policy of the General Administrative Procedures chapter of this manual.

3. Nutrition Client contributions shall be used for the following purposes only:

   a. To increase the number of meals: program income can be used to purchase raw food, expand available labor hours, and provide for additional meal or bulk food delivery needs.

   b. Food service or delivery equipment, excluding vehicles, may also be purchased under this allowance.

   c. To facilitate access to meals, program income may be utilized on a limited basis for transportation services for potential nutrition clients.

   d. Requests for using program income for transportation services require prior Region VII AAA approval.

   e. Program income can be used to conduct outreach activities in order to increase the number of clients in the program.

   f. Outreach activities require the prior approval of the Region VII AAA and must conform to the definition of Outreach activities as outlined under the Outreach policy of this manual.

   g. To provide supportive services directly related to improving clients' nutritional status, any such use must be approved by the Region VII AAA.

4. Bridge Card is to be accepted as donations/contributions for the Congregate Meals program.

C. Procedures for Handling Program Income

1. Each Service Provider shall have in place a written procedure for handling all donations/contributions that includes at a minimum the following information:

a. Daily counting and recording of all receipts by two individuals at each meal site

b. Provisions for sealing written acknowledgement and transporting of daily receipts to deposit in a financial institution

c. Reconciliation of deposit receipts and daily collection records by someone other than the depositor or counter

2. Each Service Provider shall be responsible for assuring that program staff and/or volunteers properly implement procedures for handling program income.

3. All other requirements listed in the Program Income Section of the Policy Manual apply.

D. Volunteers

1. Volunteers must receive at least two training programs per year in addition to an initial orientation. Topics should include:

a. Purpose of the program

b. Program regulations/assessment procedures

c. Temperature controls

d. Menu requirements

e. Client related emergency procedures

2. Staff or volunteers preparing and serving meals must be trained in proper food service practices and must follow appropriate procedures to preserve nutritional value and food safety.

E. Site Managers

1. No more than four hours per day of site managers' time shall be paid using funds from the Region VII AAA (including matching funds) for activities directly related to the nutrition program.

2. When selecting site management staff, the project must utilize the following guidelines:

a. Site managers must be knowledgeable about and sensitive to the special needs of the Older Adults population, especially handicapped individuals.

b. Site managers should have the ability to organize activities that encourage participation and the development of leaders.

c. Site managers must have the ability to collect and report data such as meal statistics and Client information accurately and in a timely manner.

3. Site managers must receive in-service training at least twice each fiscal year that is specifically designed to increase their knowledge and understanding of the program and to improve their skills at tasks performed in the provision of service.

a. Comprehensive records identifying dates of training and topics covered are to be maintained in each employee's personnel file.

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

F. Food Service Staff

1. Service Providers are responsible to provide food service staff with specific training that will enhance their ability to perform according to food production rates and health/safety requirements.

2. A minimum of $500 must be utilized per fiscal year to provide training to food service staff.

XIII. Nutrition Services Initiative Program (NSIP) Reimbursements

A. Region VII AAA Funded Congregate Meals

1. The United States Department of Agriculture NSIP reimbursements may be sought for meals served to eligible individuals that meet meal pattern requirements of this policy.

2. In order to obtain NSIP funds, documentation of each meal served to an eligible individual must be maintained.

3. NSIP reimbursement cannot be obtained for meals served to ineligible persons or second leftover meals served to eligible clients who have already consumed a meal.

4. For the Congregate Meals program, a daily sign-in sheet for clients must be maintained.

    a. The sheet must include each client's name, signature, and eligibility status (over age 60, guest, staff, volunteer, etc.).

    b. Each person who receives a meal must sign the sheet.

    c. The site manager or other staff may only sign a client's name if the client is not capable of signing their own.

B. NSIP Only Meal Sites

1. A program may enter into an agreement with an organization operating a congregate meal site in order for that organization to receive Nutrition Services Incentive Program (NSIP) funding for meals served to persons aged 60 and over, upon approval of Region VII AAA.

2. Service Providers may request NSIP reimbursements for meals served through meal sites funded with mill age foundation, or other local resources or where no Older American Act or State nutrition funds are utilized.

3. A contractual agreement must be signed between the Region VII AAA and the site sponsoring Service Provider before reimbursements can be released for such sites.

C. In order to receive NSIP funds, the following minimum requirements must be met.

1. Any meal site receiving NSIP-only funding must operate in compliance with all federal requirements and state operating standards pertaining to the congregate meal program and assure the availability of adequate resources to finance the operation of the meal site without charge to program clients.

2. The program shall have a written agreement with each organization operating NSIP-only meal sites, which shall include a statement indicating the provider allows anyone that meets the eligibility for a congregate meal indicated in these standards is permitted to participate in the NSIP-only meal program.

3. The definition of eligible versus non-eligible nutrition Clients in this policy manual must be used.

4. Clients will be provided with the opportunity to contribute toward the cost of the meal.

    a. Contributions must be used to expand the meal program.

5. Meal sites will be located in relation to concentrations of individuals age 60+, preferably within walking distance or where transportation is available.

6. Outreach and publicity activities will be utilized to allow all eligible individuals the opportunity to participate.

7. Site staff is knowledgeable about the needs of older persons.

8. The site will comply with all State and local health laws concerning the preparation, handling and serving of food.

9. The site will provide special menus to meet the particular dietary needs arising from the health requirements, religious requirements or ethnic backgrounds of eligible clients when:

    a. There is sufficient numbers of people who need the special menus to make this provision practical.

    b. The tools and skills necessary to prepare the special menus are available in the area.

10. The site will provide food containers and utensils for blind and handicapped clients upon request.

11. Each meal served will contain at least 1/3 of the current recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences and meet the meal pattern requirements of this policy.

12. The meal site must maintain a daily sign-in sheet for clients as outlined for Congregate and Home Delivered Meals programs.

13. The site must coordinate services with other nutrition Service Providers in the target area.

14. Services must be targeted to those seniors in greatest economic and social need with particular attention to low-income minorities.

15. NSIP reimbursements cannot be used to replace funds from non-Federal sources. Other resources must continue to be generated.

16. The site must have a method of obtaining feedback from Clients served.

17. NSIP reimbursement cannot be obtained for meals served to ineligible persons or for second, "leftover" meals served to eligible clients who have already consumed a meal.

D. Uses of Nutrition Services Initiative Program

1. NSIP reimbursements must be expanded in the same program and fiscal year for which they were received.

2. NSIP reimbursements may only be used for the purchase of raw food and commodities.

XIV. Off-site Meals

A. Congregate Nutrition meal programs may offer off-site meals for senior activities.

1. Off-site meal activities may include, but are not limited to, picnics, bike rides, hikes or organized field trips by motor vehicle.

B. Off-site meals that are part of an organized older adult activity are allowed if the following conditions are met:

1. The activity must be sponsored by an aging network agency/group such as a Council, Division, or Commission on Aging or a senior center.

2. The activity, including the meal, must be open to all eligible clients.

3. The take-away meal must meet all the requirements of food safety and be foods that are low risk for food-borne illness.

4. Local health department rules and regulations, if any, supersede this standard and must be followed.

C. The service provider must provide written notification of the activity to Region VII AAA 30 days prior to the activity.

1. The AAA nutrition program staff person must inform AASA Nutrition Program Coordinator of the following:

a. Date

b. Time

c. Location

d. Sponsoring Agency

e. verification of the menu

D. Region VII AAA must inform the field representative from the AASA, prior to the activity, of the date, time, and the name of the sponsoring agency.