REGION VII AREA AGENCY ON AGING

Service Provider Policy Manual

Volume III

Specific Service Requirements

Updated by: Connie Garcia
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Approved by: Megan Twardecki
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VOLUME III:	Specific Service Requirements
POLICY NAME:	General Requirements for Nutrition Service Programs
PURPOSE:	The Michigan Department of Health and Human Services, Bureau of Aging, Community Living, and Supports (ACLS Bureau) 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:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) 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 when requested by the ACLS Bureau, the area agency on aging (AAA), a participant, or a participant's family member or medical provider.

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 staff dietician, regional dietitian, or Dietetic Technician, Registered (DTR).

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 of each program 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 to improve their skills at tasks performed in the provision of service.
h. Volunteers of each program shall receive in-service training at least once each fiscal year.
i. Records shall be maintained which identify the dates of training, topics covered, and persons attending. (Refer to Transmittal Letter #2020-397 for additional guidance on in-service training, including suggested training topics)

j. All staff and volunteers must undergo a background check. (Operating Standards for Area Agencies on Aging (AAA) Indicator #7, Standard B-3, and Transmittal Letter #2012-253)

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.

k. 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 ACLS Bureau 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 one of the following: a registered dietitian (R.D.) or an individual who is dietitian registration eligible, or a DTR

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. Region VII AAA may adjust the number of nutrition grantees to meet the needs of the region.

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

m. 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.

n. 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.

o. 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.

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

q. 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.

r. 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.

s. 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.

t. 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.

u. Programs shall not use funds from ACLS Bureau (federal and state) to purchase vitamins or other dietary supplements.

v. 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.

w. 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 two, 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, including subcontractors of the AAA nutrition provider, and

vii. The plan shall be reviewed and approved by the respective AAA and then submitted electronically to ACLS Bureau 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 seafood, lean meats and poultry, eggs, legumes, nuts, and seeds

5. 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. It should be available to participants but is not required.

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 ACLS Bureau 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 Bureau of Aging, Community Living, and Supports 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.

CHAPTER 1:	Specific Service Requirements
POLICY NAME:	General Requirements for In-Home Service Programs
PURPOSE:	General procedures and policy position for in-home service categories.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

I. Allowable Services

A. Homemaker, Home Care Assistance, Home Delivered Meals, Medication Management, 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 ACLS Bureau 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 in home 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. A comprehensive assessment must be completed no later than fourteen (14) calendar days from the date of the intake.

3. Clients shall be assessed within 14 calendar days of initiating service.
    a. If services are to be provided for 14 calendar days or less, a complete assessment need not be conducted. In such instances, the program must determine the client's eligibility to receive services and gather the Basic Information listed under the Minimum Assessment Form Requirements (B,2, a).

4. When assessments are not conducted by a registered nurse (R.N.), the program must have access to, and utilize, an R.N. for assistance in reviewing assessments, as appropriate, and maintaining necessary 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, from case coordination and support programs, care management programs, home and community- based Medicaid programs, other aging network home care programs, and Medicare certified home health providers. Services can be initiated 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. A copy of the assessment completed by the appropriate referring agency must be on file with the provider prior to the initiation of service.

    d. Clients with multiple needs should be referred to care management programs.

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

8. The assessment should verify an individual to be served has either functional, physical, or mental characteristics that prevent him or her from providing the

service for themselves and that an informal support network is unavailable or insufficient to meet their needs.

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

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

11. 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	6 months/180 days
Home Care Assistance	6 months/180 days
Home Delivered Meals	6 months/180 days
Medication Management	3 months/90 days
Personal Care	6 months/180 days
Respite Care	6 months/180 days
Home Health Aide	3 months/90 days

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

13. Reassessments are to be used to determine changes in client status, client satisfaction, and continued eligibility.

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 (optional)

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 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 Plan

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. To avoid duplication, in-home service programs may accept the service plan developed by a referring case coordination and support, care management, home and community- based Medicaid program, other aging network home care programs, and Medicare certified home health providers.

E. 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

F. Service plans for all programs must be evaluated at all Client reassessments and updates.

G. 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 (and reassessment) 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, the aging network, assessment and observation skills, maintenance of records and files, ethics, 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. Staff of each in-home service program 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 to improve skills at tasks performed in the provision of service.

1. Volunteers of each program shall receive in-service training at least once each fiscal year on training topics per guidance provided by the ACLS Bureau.

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

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

4. Refer to Transmittal Letter #2020-397 for additional guidance on in-service training, including suggested training topics.

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

1. A registered nurse must be available to conduct in-home supervisory visits, when indicated by client circumstances.

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

3. Additional in-home supervisory visits should be conducted as necessary.

4. The program shall maintain documentation of each in-home supervisory visit.

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 3:	Specific Service Requirements
POLICY:	Care Management (CM) A-1
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Care Management (CM) is the provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are medically complex and at risk of, or in need of, a nursing facility level of care due to functional and/or cognitive limitations. Using a person-centered planning process, services are brokered or directly purchased according to an agreed-upon service plan to assist the participant in maintaining independence. CM functions include assessment, service plan development, service arranging, follow up and monitoring, and reassessment. Activities are designed to enhance participant autonomy, respect participant preferences, support caregivers and promote efficient use of available resources. Activities shall be conducted in accordance with the established the ACLS Bureau CM Performance Criteria.
UNIT OF SERVICE:	One unit per month when any CM activity is provided for a client.

I. 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.

B. 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.

C. Care managers shall establish and maintain a confidential record for each participant served. The record shall include, but not be limited to, the following information:
   1. Completed eligibility screen.
   2. Completed assessment.

3. Consent to release confidential information.
4. Participant-approved person-centered service plan.
5. Service orders and instructions to providers.
6. Progress notes for documenting participant progress/status, contacts with participant, providers and others involved in caring for the participant.
7. Reassessment
8. Other documentation and correspondence sufficient to fully disclose the quantity, quality, appropriateness, and timeliness of services provided.

II. 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

III. 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.

IV. Primary Functions of CM

A. Eligibility determination

B. Assessment

C. Person-Centered 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 ACLS Bureau 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 ACLS Bureau.

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. 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 or intern who will be entering clients' homes.
   A. Criminal background checks must be completed on the Internet Criminal History Access Tool (ICHAT) (Michigan Workforce may be used as an alternate option) and a national and state sex offender registry check for each new employee, employee, subcontractor, subcontractor employee, and volunteer who has in-person client contact, in-home client contact, access to a clients personal property, or access to confidential client information.

      a) ICHAT: http://apps.michigan.gov/ichat (or Michigan Workforce-LARA)
      b) Michigan Public Sex Offender Registry: http://www.mipsor.state.mi.us
      c) National Sex Offender Registry: http://www.nsopw.gov
      d) Office of Inspector General-OIG

2. All providers are required to update criminal background checks for all employees and volunteers every three years to identify convictions in the event they occur while an individual is employed or providing volunteer service.

3. The use of information obtained from a criminal background check shall be restricted to determining suitability for employment and/or volunteer opportunities. All programs are required to maintain a copy of the results of each criminal background check for paid and volunteer staff in a confidential and controlled access file. The information should not be used in violation of any applicable Federal or State equal employment opportunity law or regulation.

4. Exclusions No employee or volunteer shall be permitted to work directly with clients or have access to a client's personal property or confidential client information if:
   A. Mandatory Exclusions - The results of the criminal background check show that the person has a federal or state felony conviction related to one or more of the following crimes:
      a) Crimes against a "vulnerable adult" as set forth in MCL 750.145n et seq.,
      b) Violent crimes including, but not limited to, murder, manslaughter, kidnapping, arson, assault, battery, and domestic violence,
      c) Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,

d) Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,
e) Cruelty or torture,
f) Abuse or neglect, or
g) Felony involving the use of a firearm or dangerous weapon.

B. Felony Convictions - The results of the criminal background check show that the person has a federal or state felony conviction within the preceding 10 years from the date of the background check, including but not limited to:
   a) Crimes involving state, federal, or local government assistance programs,
   b) Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion, or
   c) Drug crimes including, but not limited to, possession, delivery, and manufacturing.

C. Misdemeanor Convictions - The results of the criminal background check show that the person has a federal or state misdemeanor conviction within the preceding 5 years from the date of the background check, including but not limited to:
   a) Crimes involving state, federal, or local government assistance programs,
   b) Crimes against a "vulnerable adult" as set forth in MCL 750.145n et seq.,
   c) Financial crimes including, but not limited to, fraud, forgery, counterfeiting, embezzlement, and tax evasion,
   d) Theft crimes including, but not limited to, larceny, burglary, robbery, extortion, false pretenses, false representation, and conversion,
   e) Sex crimes including, but not limited to, rape, sexual abuse, criminal sexual conduct, and prostitution,
   f) Drug crimes including, but not limited to, possession, delivery, and manufacturing,
   g) Cruelty or torture,
   h) Abuse or neglect,
   i) Home invasion,
   j) Assault or battery, or
   k) Misdemeanor involving the use of a firearm or dangerous weapon with the intent to injure, the use of a firearm or dangerous weapon that results in a personal injury, or a misdemeanor involving the use of force or violence or the threat of the use of force or violence.

5. For purposes of the excluded offenses identified above, an individual is considered to have been convicted of a criminal offense when:

a) A judgment of conviction has been entered against the individual or entity by a federal, state, tribal or local court regardless of whether there is an appeal pending,
b) There has been a finding of guilt against the individual by a federal, state, tribal or local court, or
c) A plea of guilty or nolo contendere by the individual has been accepted by a federal, state, tribal or local court.

6. Arrest records, by themselves, do not disqualify an individual.
7. All programs are required to maintain documentation of all criminal background checks, including a list of all paid and volunteer staff that are subject to this policy, the date of the most recently completed criminal background check, and the source of the background check. Employees hired prior to the effective date of this policy are not exempt from this requirement.

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.

VIII. 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.

IX. 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

X. 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

XI. 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.

XII. 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 CAP s.

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.

XIII. 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.

XIV. 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.

XV. 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.

XVI. 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. ACLS Bureau/CM = State or Federal Funded Care Management through ACLS Bureau. The client is enrolled in the ACLS Bureau Care Management Program.

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

a. Enrolled in the ACLS Bureau 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. An in-person reassessment is conducted 90 days after the initial assessment.
3. An in-person reassessment (or an in-person, person centered planning meeting with redeveloped service plan) is completed 180n days after the first/previous reassessment.
4. Repeat the 180-day cycle as listed in number 2 and 3 above.
5. 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 primary caregiver).

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

XVII. 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.

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.

XVIII. 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 be 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.

XIX. 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

XX. 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 reassessments 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

XXI. 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 ACLS Bureau/CM service for non-Medicaid eligible individuals (Reference ACLS Bureau 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.

XXII. 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.

XXIII. 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 ACLS Bureau-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 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. Monitoring contacts

8. Two-week service follow ups

9. Reassessments

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.

XXIV. 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 cancelled 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.

XXV. 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.

XXVI. 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 ACLS Bureau field representative as part of the Annual AAA Assessment process.

a. The AAA completes the ACLS Bureau 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.

c. The assigned field representative also reviews a minimum of five CM participant case records to assess whether required documentation is present.

d. If the CM Program is a TCM provider, the field representative will review at least 2 TCM cases and verify that applicable assessment/reassessment, care planning service arranging, follow-up/monitoring, progress notes and authorized signatures, identifications or certifications are in place to support TCM billing.

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.

XXVII. 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

XXVIII. 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 ACLS Bureau 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. ACLS Bureau is responsible for certifying that providers meet criteria on an annual basis.

7. The certification is conducted as part of the ACLS Bureau 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 ACLS Bureau 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;

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 ACLS Bureau 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 2025 is based on $498.24 ($519 minus the 4% fee)

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

    a. ACLS Bureau 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 ACLS Bureau through the online Aging Information System FIRST module.

Example A

Subject: AAA Targeted Care Management (TCM) Reimbursement – 1st Quarter FY 2025

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 ACLS Bureau, 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 ACLS Bureau 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 ACLS Bureau 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 III: Specific Service Requirements

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

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: The provision of a comprehensive assessment and ongoing monitoring of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible.

UNIT OF SERVICE: One hour of service provided.

XXIX. 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

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. 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.

XXX. 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.

XXXI. 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. Self-identified diagnosis/medical conditions Perceived supportive service needs as expressed by individual and/or his/her representatives

    g. Race and ethnicity

    h. Gender identity (optional)

    i. Sexual orientation

    j. Communication support needs

    k. 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 125% of poverty for referral purposes

    l. Date of intake and Client's signature, if possible

    m. 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.

XXXII. Assessment

A. Assessment Information Requirements

1. All assessments and reassessments can be delivered in-person, telephonically, virtually, or hybrid. At least one in-person contact is preferred every 365 days.

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. Date of Birth

3. Gender identity (optional)

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. Social Supports, such as hobbies, special interests, etc.

11. Spiritual or 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. Durable medical equipment (DME)

17. Psychosocial functioning

18. Cognitive status

19. Limitations in activities of daily living and instrumental; activities of daily living (ADLs and IADLs)

20. History of chronic and acute illnesses

21. Nutritional status

22. Medication management needs and considerations

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

8. Formal support and services (such as those funded through Medicaid)

9. Informal Support Network

10. History of falls and/or hospital visits in the past 180 days or since last assessment

11. Medical/Health insurance information

d. Need Identification Information

1. Client or family perceived need

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

3. Participant/informal support received

4. Assessed needs

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.

XXXIII. 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.

XXXIV. 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 needs, strengths, and resources

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

3. Description of interventions and services used to address identified 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. Assessments and Reassessments

    a. Dated progress notes documenting coordination of care

    b. Participant verification of services and satisfaction with quality of service

    c. Record of all release of information and consent forms

    d. Treatment orders of qualified health professionals, when applicable.

3. 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.

4. 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.

5. 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.

6. 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.

XXXV. 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.

XXXVI. 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.

XXXVII. 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 ¼ (0.25) , ½ (0.50) , ¾ (0.75), 1 (1.0) , 1 ¼ (1.25).

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.

XXXVIII. Staff Requirements

A. Service providers shall employ case managers who have a minimum of a bachelor's degree in a human service field or who have experience or training to effectively determine a participants needs and match those needs with appropriate services.

1. 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.

XXXIX. 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.

E. CCS service components may be delivered in-person, telephonically, virtually, or hybrid. At least one in-person contact is preferred every 365 days.

VOLUME III: Specific Service Requirements

POLICY NAME: Disaster Advocacy and Outreach Services A-3

PURPOSE: The purpose of this policy is to establish uniform procedures for and an action plan that will help keep the elderly safe when a disaster or personal crisis strikes and develop procedures for the delivery and coordination of services to the elderly during an emergency or disaster.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Activities undertaken to assist older persons in their planning, response, or recovery from "disaster" or "emergency" as defined by paragraph 30.402 (e,h) of the Michigan Emergency Management Act of Act 390 of 1976, as amended. All activities must be explicitly aimed at assisting frail and older persons to ensure access to needed service and personal and emotional support necessary to assist with a plan to respond toward recovery.

UNIT OF SERVICE: Each hour of community education activity includes:

- emergency preparedness, including agency plan preparation
- agency staff training
- meeting with state and local emergency managers
- negotiating contracts with service providers
- exercises at the state emergency operation center

Each hour of advocacy and outreach activities with individuals that improve their emergency preparedness or response and recovery activity for up to one year after a disaster or emergency occurs.

I. Minimum Standards

A. Each Area Agency on Aging (AAA) or organization providing aging services to be funded or reimbursed under this service definition must have a "mission statement" defined in an adopted extension of the local emergency preparedness plan prepared under the provisions of the Michigan Emergency Management Act of Act 390 of 1976, as amended.

B. Each AAA or organization of aging services must have an emergency plan with identified alternative plans/approaches for responding to a disaster and undertaking appropriate activities to assist older survivors recover from a disaster, depending on the available resources and structures. The same

functions cited as allowable service components are performed and can be provided by other contracted providers or organizations.

C. All disaster advocacy and outreach activities shall be supervised by an individual/team. The individual/team has the educational and work experience necessary to help advocates determine when individuals need assistance beyond their capabilities. program shall make services available throughout the geographic target area. service providers must identify sites where services will be delivered and develop a schedule for site-specific service delivery.

II. Allowable Service Components

A. Activities conducted under the Disaster Advocacy and Outreach service definition may include, but are not limited to the following:

i. Maintaining liaison with local government and volunteer human services agencies to plan for, respond to, or recover from a disaster or emergency.

ii. Taking necessary action to protect the agency's resources and ensure the continuation of the agency's critical functions during a disaster or emergency to ensure continuity of care.

iii. Conducting awareness/preventative campaigns alerting the public of local plans in the event of a public health emergency, disaster, or state emergency.

iv. Providing technical assistance to service providers for developing and implementing plans for assuring the continuation of services in the event of a disaster or state of emergency (i.e., extreme temperatures, flooding, and power outages).

v. Arranging for appropriate services to be expanded to additional eligible participants needing such services due to a disaster or state of emergency.

vi. Developing a sound knowledge base of various relief programs.

vii. Conducting a comprehensive assessment of older disaster survivors, including

viii. individual's needs, mental health, emotional support, and cognitive status.

ix. Providing ongoing support and assistance in returning to normalcy after disaster centers have ceased operations.

x. Assisting older individuals in completing documentation for needed services.

xi. Obtaining and helping provide interagency and public information.

xii. Conducting door-to-door canvassing (outreach) to identify older disaster survivors with multiple visits if necessary.

xiii. Seeking to identify older persons displaced out of the area so they can be notified of the opportunity to apply for disaster services.

xiv. Following up on lists of affected older persons received from other providers and agencies to ensure that older survivors receive services.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Information and Assistance A-4
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Unbiased assistance in accessing resources to older adults and their caregivers including, but not limited to, finding and working with appropriate human service providers that can meet their needs, which may include: information-giving (e.g., listing the providers of a particular service category so an individual may make their own contact directly); referral (making contact with a particular provider on behalf of an individual)/person-centered advocacy (efforts that seek to meet individual needs); advocacy intervention (negotiating with a service provider on behalf of a client); and follow-up contacts with clients to ensure services have been provided and have met the respective service need.
UNIT OF SERVICE:	Provision of direct contacts per day (1 unit equals 1 contact with a participant) when any information and assistance (including warm hand off referral/person-centered advocacy) functions are provided.

(Note: newsletters and media spots are encouraged but are not to be counted as information-giving units of service.)

I. Minimum Standards

A. Each I&A program shall have a resource file, which is current and includes a listing of the following:

   a. Human service agencies
   b. Services available
   c. Pertinent information (resources and ability to accept new clients)
   d. Eligibility requirements

B. The program shall be able to provide adequate information about community resources and agencies to all callers so they may make their own contact directly.

C. I&A can also include a warm handoff referral/person-centered advocacy. The term “warm handoff” originated in customer service and describes the process of a customer being connected to someone who can provide what he or she needs.

a. This can occur either in person or via phone, between the I&A professional and the customer, or in front of the older adult or caregiver (and family if present).

D. Each program shall have bilingual personnel available and/or have the capacity to acquire interpretation services as necessary.

a. Each I&A program is strongly encouraged to have materials in the most commonly spoken languages within the planning and service area (PSA).

b. Additionally, each program must have the capacity to serve deaf and hard of hearing persons and visually impaired persons in a manner appropriate to their needs, such as through the Michigan Relay Center.

E. Where walk-in service is available, there shall be adequate space to ensure comfort and confidentiality to clientele during intake and interviewing.

F. Each program shall maintain records (for three years or until audit has been closed) of the following:

a. nature of calls received
b. the agencies and/or organizations to which referrals/person- centered advocacy are made and the service for which referrals are made
c. the results of follow-up contacts
d. any client files maintained

G. Information regarding service transactions shall be reported to the Area Agency on Aging (AAA) upon request for monitoring and/or planning purposes.

H. A person-centered follow-up contact is encouraged for warm handoff referrals/person-centered advocacy, whether services are negotiated or not, within ten working days, to determine whether services were received, the identified need met, and client satisfaction.

I. Each I&A program is required to have policies and procedures that address follow up for potential vulnerable adults, including mandated reporting of suspected abuse, neglect, or exploitation of an older adult as required by law. Follow-up contacts are not required for information-giving only contacts.

J. At least once per year, each program must determine the quality of I&A services provided through a sampling of no less than 10% of clients. Additionally, each I&A program is required to have policies and procedures that address
a. How the I&A provider will evaluate the data
b. The processes for quality improvement
c. The method utilized to share results with the AAA.

K. Each program shall demonstrate effective linkages with agencies providing long-term care support services within the program area (i.e., case coordination and support, care management, long-term care facilities, veteran services, and community-based Medicaid programs).

L. Older Americans Act (OAA) funded I&A providers must have the capacity to provide ongoing continuing education to their I&A staff.

M. OAA I&A providers are expected to foster coordination among, and collaboration with, other I&A providers and agencies supporting older adults within the PSA.

N. Each I&A program is encouraged to seek agency accreditation and employee certification from the Alliance for Information and Referral Systems (AIRS).

O. Each I&A program shall have a policy that addresses promptness of I&A functions, including the conditions under which timely follow up must be conducted.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Outreach Services A-5
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Efforts to engage, build awareness, and share aging resources and information with older adults, caregivers, community groups, human services agencies, and businesses who interact with the aging community, with an emphasis on those interacting with target populations. Outreach does not include comprehensive assessment of need, development of a service plan, or arranging for service provision.
UNIT OF SERVICE:	One hour of outreach service including identification and contact of older persons, assistance in their gaining access to needed services, follow up, presentations, events, and efforts to reach a broader audience.

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.

6. Each outreach activity located in area where non-English or limited English-speaking older persons are a substantial portion of the audience/population shall have bilingual personnel on site (through staff positions, personal services contracts, or volunteer positions). Bilingual personnel are to be available in-service areas where non-English or limited-English speaking persons constitute five percent of the senior population or number 250 seniors, whichever is less. (See the Older Americans Act (OAA) of 1965, amended through P.L. 116-131, Enacted March 25, 2020, Title III of the OAA, Sec. 305(15)).

7. Each outreach activity shall target those eligible for assistance with a special emphasis on:

    a. Individuals identified in the Older Americans Act (OAA) of 1965, amended through P.L. 116-131, Enacted March 25, 2020, under Title III, Sec. 306, (4)(B); (4)(C); and (6)(G).

8. Recommendation:
    a. Public and Medica (PAM) forms may be used to assist in outreach data collection for group events and media outreach.

D. 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, 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
POLICY NAME:	Transportation Services A-6
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Centrally organized services for transportation of eligible persons to and from community facilities in order to receive support services, reduce isolation, and otherwise promote independent living.
UNIT OF SERVICE:	One, one-way trip per person, or one educational session.

I. Transportation Services

A. 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.

B. Each eligible person is allowed one (1) paid or unpaid care attendant to accompany them on each trip.

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 vehicles to provide door-to-door service or curb-to curb service on demand. The program may include a passenger assistance component.

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

3. Volunteer Reimbursement: characterized by reimbursement of out-of-pocket expenses for individuals who transport older persons in their private vehicles. The program may include a passenger assistant component.

4. Older Driver Education: characterized by systematic presentation of information and training in techniques designed to assist older drivers in safely accommodating changes in sensory and acuity functioning.

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 ACLS Bureau.

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.

3. Within a respective planning and service area, an area agency on aging may use an alternative unit of service (e.g., vehicle miles or passenger miles) when appropriate for consistency among funding sources.

a. Such an alternative unit of service must be approved By the Michigan Commission on Services to the Aging at the time of area plan approval.

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

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 MCL 257.710e regarding seat belt usage.

VOLUME III: Specific Service Requirements

POLICY NAME: Options Counseling A-7

PURPOSE: The purpose of this policy is to establish uniform procedures for providing an interactive and unbiased process that can help older persons and their caregivers to make informed choices.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Options Counseling (OC) is an interactive and unbiased process that can help an older person, their family member, or their caregivers to receive options in their deliberations to make informed choices about long term supports and services.

UNIT OF SERVICE: One unit per month when any OC activity is provided for an individual. One unit equals one individual each month regardless of number, length, or time of contacts within that month.

III. Minimum Standards

A. Each program shall employ staff with a minimum of an associate's degree in a human service field or who, by training or experience, have the ability and knowledge to provide information, assistance, supports, services options, linkages, and strategies for participants.

B. Program staff shall be knowledgeable of long-term care support options available within the planning and service area (PSA).

C. Each program shall develop a network of community resources and resource information, including non-traditional services and assistance, in order to meet non-traditional service needs and requests.

D. Each program shall maintain linkages with Older Americans Act funded Information and Assistance programs within their PSA and establish protocols to identify potential participants for referral (making contact with a particular provider on behalf of an individual)/person-centered advocacy (efforts that seek to meet individual needs).

E. Each program shall demonstrate effective linkages with agencies providing long-term care support services within the program area (i.e., case coordination and support, care management, long-term care facilities, veteran services, and community-based Medicaid programs).

F. An initial screening via a personal interview (either in person or by phone) shall be provided that includes the participant (and/or their representative and/or family caregiver as indicated by the participant) to learn about the person's values, strengths, preferences, concerns, and available resources that they may use for long-term support services.

G. Program staff shall explore with participants potential resources to assist participants with long-term services and supports, including informal support, privately funded services, publicly funded services, and available benefits, among others.

H. Providers of OC must make unbiased referrals/person-centered advocacy reflecting the best outcomes for the participant and shall provide information on all applicable programs to avoid a conflict of interest.

I. Each OC program is required to have policies and procedures that address follow up for potential vulnerable person that includes mandated reporting of suspected abuse, neglect, or exploitation of an older adult as required by law.

J. Decision support shall also be provided to assist the participant in making an informed choice including the evaluation by the participant of the pros/cons with each presented option.

K. The provision of assistance with determining financial eligibility, when appropriate.

L. The provision of assistance with enrollment into public programs and benefits.

M. The program encourages future planning for long-term care.

N. The program shall provide a written summary to the participant, which details important issues discussed, participant desires and preferences, resources, and identified strategies.

O. The program must offer follow-up to each participant provided at their direction. Follow-up may be conducted in person, by phone, or electronically as resources allow and the participant prefers.

P. Each program is encouraged to have bilingual personnel available and/or will have the capacity to acquire interpretation services as necessary. Each OC program is strongly encouraged to have materials in the most commonly spoken languages within the PSA. In addition, each program must have the capacity to serve deaf and hard of hearing persons and visually impaired persons in a manner appropriate to their needs.

Q. Providers of OC services must have the capacity to:

a. Provide private, confidential telephone and face-to-face OC as requested.
b. Respond to participants seeking supports and services by using methods and accommodations, which are compliant with the Americans with Disabilities Act including, but not limited to:
    i. Adequate, accessible, barrier-free, comfortable, and confidential space for OC,
    ii. Website requests,
    iii. Email requests,
    iv. Interpreter requests (including American Sign Language),
    v. Alternative material formats (including Braille),
    vi. The Michigan Relay Center,
    vii. Requests via independent facilitators (someone designated by the individual to speak/obtain information on their behalf), and/or
    viii. Other assistive technology.

c. Provide a standard of promptness for returning calls, e-mails, or other communications within three business days. Urgent requests may require an immediate response.

R. Program staff 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 participants, and to improve their skills in completion of job tasks. In-service training requirements shall also be consistent with Care Management (CM) and Case Coordination and Support (CCS) standards of practice.

S. Each program is encouraged to seek employee certification from the Alliance for Information and Referral Systems (AIRS) for individual OC employees and volunteers.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Care Transition Coordination and Support A-8
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	The Care Transition (CT) program is intended to provide proactive discharge planning, extensive coaching, and post discharge supports by a Community Health Worker (CHW) and/or other health care professional. This coaching is intended to support adults age 60 or older discharging from a medical care institution to the place they consider to be home preventing re-institutionalization. CT supports include intake, assessment, a development of service(s) plan, person centered planning, services arranging, primary care follow-up, medical transportation coordination, red flag warning education, medication review and weekly follow up.
UNIT OF SERVICE:	Each 15 min (.25 hours) for CT activities provided for an individual.

IV. Minimum Standards

A. Each program shall have a written eligibility criteria and intake process.
   a. Age 60 and over.
   b. 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. Eligibility to participate is not based on a person's level of income.
   c. Participant is not receiving medical care institution transition services and support from another state or federally funded program.
   d. Participants must be admitted to a medical care facility or be within 3 business days of status post discharge from a medical care facility.
   e. Participant cannot be enrolled in MI Choice, MI Health Link or Program of All-Inclusive Care for the Elderly (PACE).

B. Participants are contacted pre-discharge when possible and will have their initial assessment completed within three business days of discharge from a medical care institution.

C. A coordination of services mechanism must be used to verify duplication of care transition services, and thus prevention of duplicate payments.
D. Each program shall maintain National Aging Program Information System (NAPIS) registration for each program participant. The intake process shall be initiated within one week after an individual becomes active in the program.

E. Each participant shall receive an initial assessment. Assessors shall attempt to acquire each item of information listed below but must recognize and accept the participant's right to refuse to provide requested items:

a. Basic Information (may be completed by the participant)

I. Individual's name, address, and phone number
II. Name, Address, and phone number of person to
III. contact in case of emergency
IV. Gender as identified by the participant (optional)
V. Participant Sexual Orientation (optional)
VI. Age and date of birth
VII. Race and/or ethnicity
VIII. Is the participant multi-Racial?
IX. Is the participant Hispanic?
X. Living arrangements
XI. Type of housing
XII. Does the participant speak a language other than English at home?
XIII. Legal representative status, (e.g., guardian, durable power of attorney)

b. Health History

I. History of illnesses, injuries, and health problems
II. Allergies to medicine, food, etc.
III. List of current prescription and over-the-counter medications
IV. Orders by physician(s)
V. Names of current physicians
VI. Diagnoses
VII. Reason for most recent hospitalization
VIII. List durable medical equipment needed

F. The program shall operate within the following basic levels of service:

a. **Person Centered Planning:** Discuss goal setting and participant objectives to identify personal needs and wishes, designing a pathway to services that will support a healthy recovery.

b. **Service Arranging:** Program staff shall provide information, assistance, supports, services options, linkages, and service plan strategies for participants.

c. **Accessible Housing Support:** Provide resources and guidance to assure adequate, accessible, barrier-free, supports and durable medical equipment is in place.

d. Follow-Up

1. Primary Care Follow Up: Cueing of 7-day primary care follow up
2. Medical transportation coordination
3. Weekly phone call follow-up/check-in for at least 30 days to ensure service plans are implemented as established and service needs are being met.

e. Red Flag warning

1. Confirm participant is knowledgeable about indications that their condition is worsening and how to respond.

f. Outcome Measures Reporting requirements include:

Reducing Readmissions for the Same Diagnosis

1. Was the participant readmitted to a medical care institution within 30 days?
2. Was the participant readmitted to a medical care institution for the same diagnosis within 30 days?
3. If yes, what factors contributed to the readmission?
4. If the participant was readmitted for the same diagnosis, how did the AAA follow up?
5. Type of medical institution (hospital, nursing facility, clinic, etc.).

Medication Management

1. Was a medication review of current and new medications completed

Primary Care Follow Up

1. Did the participant follow up with their primary care physician within 7 days?
2. If no, what were the barriers that contributed to the inability to follow up within 7 days?

Service Arranging

1. What long term supports and services were recommended?
2. Which recommendations did the participant accept?
3. What long term supports and services were received?

Transportation to Medical Appointments

1. Was medical transportation needed?
2. If so, was medical transportation provided?

Service Delivery

1. Each provider must obtain the views of recipients about the quality of services received using the Care Transition participant feedback survey.

Accessible Housing Support

1. Did the participant request durable medical equipment?
2. Were there barriers to receiving durable medical equipment?

G. Recommendation:

a. Medication consultation/management: Assure participant is knowledgeable about medications and has a medication management system to assure medications are taken as prescribed.

b. AAA to collaborate with local hospital(s) to strengthen the opportunity for predischarge collaboration efforts.

VOLUME III: Specific Service Requirements

POLICY NAME: Chore Services B-1

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINTION: Non-continuous/intermittent household maintenance tasks intended to increase the safety of the individual(s) living at the residence.

UNIT OF SERVICE: One hour spent performing allowable chore task.

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/winterizing 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, scrubbing floors

n. Cleaning residence 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 impeding vegetation

s. Gutter cleaning/repair

t. Replace toilet parts (wax ring, chair, flapper, etc.)

u. Cleaning of furnaces and replacement of furnace filters

v. Installation and the removal of portable AC units

w. Repair/replacement of mailboxes

x. Installation of outside markers on the home

B. 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 $400 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, Home Injury Control, and Weatherization service providers, as available, in the project area to ensure effective coordination of efforts.

VOLUME III: Specific Service Requirements

POLICY NAME: Home Care Assistance B-2

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of in-home assistance with activities of daily living and routine household tasks to maintain an adequate living environment for older persons with functional limitations.

Allowable personal care activities include assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Allowable homemaking tasks include laundry, ironing, meal preparation, shopping for necessities including groceries and light housekeeping. The service also includes observation, recording, and reporting changes in clients' health status and home environment.

Note: social/emotional support of client may be offered in conjunction with other allowable tasks.

UNIT OF SERVICE: One hour spent performing allowable home care assistance activities.

V. Minimum Standards

A. Each program must have written eligibility criteria.

B. All workers performing home case assistance services must be trained by a qualified person and must be tested for each task to be performed prior to being assigned to a client.

a) The supervisor must approve tasks to be performed by each worker.
b) Completion of a recognized nurse's aide training course by each worker is strongly recommended.

C. Individuals employed as home care assistance workers must have previous relevant experience or training and skills in assisting with:

a) Personal care needs
b) Housekeeping
c) Household management
d) Good health practices
e) Observation
f) Recording and reporting client information

D. Semi-annual in-service training is required for all home care assistance workers. Required topics include:

a) Safety
b) Sanitation
c) Emergency procedures
d) Body mechanics
e) Universal precautions
f) Household management

VOLUME III: Specific Service Requirements

POLICY NAME: Home Injury Control B-3

PURPOSE: To provide adaptations to the home environment of older persons to prevent or minimize the occurrence of injuries to older adults.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Providing adaptations to the home environment to prevent or minimize the occurrence of injuries to older adults. Home injury control does not include any structural or restorative home repair, chore, or homemaker activities.

UNIT OF SERVICE: Individuals served

VI. Minimum Standards

A. Prior to initiating service, each program must determine whether a potential client is eligible to receive services available through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made.

B. Each program must develop working relationships with chore, homemaker, home care assistance and home repair service providers, as available within the program area, to ensure effective coordination of efforts.

C. Each program is encouraged to utilize evidence-based toolkits and/or resources (i.e. Safe AT HOME Checklist) for fall prevention for older adults.

D. Each program may track key data for home injury control including:

1. Number and type of device(s) placed and/or installed in the home.
2. Total time (in hours) of completing the safety assessment and installing device(s).

E. Each program must utilize a home environment assessment tool to formally evaluate the circumstances and needs of each client.

F. Allowable home injury control tasks may include any of the following:

- Completion of a home safety assessment by a licensed professional (e.g., Registered Nurse, Physical Therapist, and/or Occupational Therapist).
- Minor home safety modifications including installation or maintenance of the following:
    a. enhanced lighting including night lights
    b. ramps for improved and/or barrier-free access
    c. surge protectors
    d. shower chair
    e. transfer bench
    f. raised toilet seat
    g. grab bars (including versa frames)
    h. handheld shower
    i. non-slip treatments
    j. vision or hearing adaptive devices
    k. stairway and/or hallway handrails
    l. smoke, carbon monoxide, and/or gas alarms
    m. devices or bars that help with transfer safety to and from bed, chairs, and/or toilet

G. Each program must maintain a record of safety improvements made at each residence including dates, tasks performed, materials used, and cost.

H. All safety devices installed must conform to local building codes and meet respective UL® safety standards.

I. Funds awarded for home injury control may be used for labor costs, allowable tasks, and to purchase safety devices to be installed. The program must establish a limit on the amount to be spent on any one residence in a 12-month period. Each program should seek contributions of labor and supplies from the private sector and volunteer organizations, as may be feasible. Equipment or tools needed to perform home injury control tasks may be purchased or rented with grant funds up to an aggregate amount equal to 10% of total grant funds.

VOLUME III: Specific Service Requirements

POLICY NAME: Homemaking B-4

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Homemaking does not include provision of chore or personal care tasks. Allowable homemaking tasks are limited to one or more of the following:

- laundry
- ironing
- meal preparation
- shopping for necessities (including groceries) and errand running
- light housekeeping tasks (dusting, vacuuming mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe environment

Note: Social/emotional support may be offered in conjunction with other allowable tasks.

UNIT OF SERVICE: One hour spent performing allowable homemaking activities.

I. 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.

II. 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

POLICY NAME: Home Delivered Meals (HDM) B-5

PURPOSE: This section outlines procedures that must be followed by Home Delivered Meals nutrition programs funded by the Region VII AAA.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: The provision of nutritious meals to homebound older persons.

UNIT OF SERVICE: One meal served to an eligible participant.

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, or

    e. 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.

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

5. The individual is able to feed him/herself.

6. The individual must agree to be home when meals are delivered, to contact the Service Provider when absences are 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 18-59, living with a disability, who residefull-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 Bureau of Aging, Community Living, and Supports 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 (optional)

f. Age and date of birth

g. Race and/or ethnicity (optional)

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
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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 and date when goal has been met

    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.

    7. Client approval (verbal or in writing) or other disposition

    8. Signatures of assigned case managers

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 dated

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 and HIPPA (privacy notice) forms that are time-limited for no more than one (1) year 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 support from family and friends and 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 ACLS Bureau 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 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 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 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/volunteers.

VOLUME III: Specific Service Requirements

POLICY NAME: Home Health Aide B-6

PURPOSE: To provide health-oriented services prescribed to an individual by a physician.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Performance of health-oriented services prescribed for an individua by a physician which may include: assistance with activities of daily living (ADL), assisting with a prescribed exercise regimen, supervising the individual's adherence to prescribed medication and/or special diets, changing non-sterile dressing, taking blood pressure, and other health monitoring activities.

UNIT OF SERVICE: One hour spent performing home health aide activities.

VII. Minimum Standards

A. Each program must have written eligibility criteria that includes determination that the health-related needs of the individual can be adequately addressed in the home.

B. After each home health aide client is reassessed, progress must be reported to the client's physician with a request for renewal of orders for the service plan.

C. In determining which providers will be selected for home health aide services, preference is to be given to certified home health agencies or agencies corporately related to a certified home health agency.

D. All aides performing home health aide services must be directly supervised by an RN.

a. Each aide must have completed a home health aide or nurse aide training curriculum approved by the AAA and be trained for each task to be performed.

b. The supervising nurse must approve tasks to be performed by each aide.

c. An RN must be available for advice and consultation by telephone or otherwise at all times aides are providing services.

VOLUME III: Specific Service Requirements

POLICY NAME: Medication Management B-7

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Direct assistance in managing the use of both prescription and over-the-counter (OTC) medication

Allowable program components include:

- Face-to-face review of client's prescription, OTC medication regimen, and use of herbs and dietary supplements.
- Regular set-up of medication regimen (Rx Pills, Rx injectables, and OTC medications).
- Monitoring of compliance with medication regimen
- Cueing via home visit or telephone call
- Communicating with referral sources (physicians, family members, primary caregivers, etc.) regarding compliance with medication regimen
- Family, caregiver and client education and training

UNIT OF SERVICE: Each 15 minutes (.25 hours) of component activities performed

I. Minimum Standard

A. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls.

B. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented, and supervised.

C. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and the appropriate caregiver.

D. Each program shall implement a procedure for notifying the client's physician(s) of all medications being managed.

E. The program shall be operated within the three basic levels of service as follows:

Level 1: Telephone reminder call/cueing with maintenance of appropriate documentation. Program staff performing this level of service shall be delegated by the supervising nurse.

Level 2: In-home monitoring visit/cueing with maintenance of appropriate documentation. Program staff performing level 2 services shall be delegated by the supervising nurse.

Level 3: In-home medication set up, instructions, and passing and/or assistance with medications (e.g. putting in eye drops, giving pills and injections). Program staff performing level 3 services shall be delegated by the supervising nurse.

F. The program shall maintain an individual medication log for each client that contains the following information:

1. Each medication being taken
2. The dosage for each medication
3. Label instructions for use of each medication
4. Level of service provided and initials of person providing service
5. Date and time for each time services are provided

G. The program shall report any change in a client's condition to the client's physician(s) immediately.

H. Each program shall have a uniform intake procedure that identifies and documents client medications.

1. Priority must be given to older individuals in the greatest social and economic need and those individuals caring for someone with mental and/or developmental disabilities.
2. Specifically, those seniors that participate in the care management or CCS programs will be provided service.

3. Service Providers must be able to demonstrate that the content of the medication safety education addresses the needs of older persons.

4. Each Service Provider must have an established screening system targeting and serving Older Adults in greatest social and economic need, with special emphasis on reaching low-income minority.

II. Eligibility

A. Individuals 60 and older

III. Component Functions

A. Service Providers will conduct assessments of the person's medications and specifically identify the purpose of the drug.

B. Each program, at a minimum, must provide intake, training, and education.

C. Service Providers must identify the topics to be covered in medication safety training.

IV. Medication Safety Program Plan

A. Allowable programs for family, caregiver, and client education training

1. Licensed, certified, trained members, nurses, or pharmacists can offer workshops to provide practical ideas for managing multiple medications.

2. Programs that allow clients to learn what to ask their doctor and pharmacist about their prescriptions and over the counter drugs, gain information about drug reactions and interactions and how to use them safely

3. Development of brochures that inform older adults of programs and organizations that can help them manage their medications.

B. The format for the mediation safety program may include the following:

1. Individual and group intervention programs that address home medical tests that detect early problems

2. Specialized information programs for small groups on organizing and managing individual medications

3. How to develop and maintain home medical records

4. Information about programs that concern Medication Management

5. Information about antacids and acid reducer ingredients that can be harmful

6. Precautions for the use of bulking agents and laxatives

7. Precautions about long-term use of anti-diarrheas

8. Safe and proper use of cough preparations, decongestant, and cold and allergy remedies

9. Use of antihistamines to treat colds

10. Precautions for using over-the-counter pain relievers

11. Sources of information for the use of prescription medications and when to call a professional

12. Medication-related problems susceptible to the Older Adults

13. The use and effect of antibiotics

14. Learn cost effective strategies to stretch medication dollars

V. Medication Safety Cost

A. Service Providers who offer medication safety programs can bill as a unit of service one activity session, counseling, or hour of education when an initiative provides support activities such as:

1. Information and assistance meetings

2. Senior events that promote education for caregivers

3. Events that connect the community with resources

4. Individual counseling

B. Printed materials that are developed and distributed for education programs pertaining to medication safety as well as current research and public policy are not considered units of service, but are billable items.

VI. Staffing Requirements

A. Staff will understand the needs and aspects of Medication Management.

B. Each program shall employ staff who are appropriately licensed, certified, trained, oriented, and supervised.

VOLUME III: Specific Service Requirements

POLICY NAME: Personal Care B-8

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINTION: Provision of in-home assistance with activities of daily living (ADL) for an individual including assistance with bathing, dressing, grooming, toileting, transferring, eating, and ambulation. Person care does not include health-oriented services as specified for Home Health Aide Services.

UNIT OF SERVICE: One hour spent performing personal care activities

I. Minimum Standards

A. Each program must have written eligibility criteria.

B. 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

POLICY NAME: Assistive Devices and Technology B-9

PURPOSE: This service helps individuals to learn about and acquire devices, equipment and supporting technologies that assist in the conduct of activities of daily living. Such devices may include, but are not limited to: Personal Emergency Response Systems (PERS), wheelchairs, walkers, lifts, medication dispensers, etc.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: A service that provides assistive devices and technologies which enable individuals to live independently in the community according to their preferences, choices, and abilities.

UNIT OF SERVICE: One device, plus installation and training as appropriate, provided to a program specialist.

VIII. Minimum Standards

A. Each program must coordinate with other appropriate service providers in the community in order to avoid an unnecessary duplication of services.

B. All devices installed must conform to local building codes, as applicable, and meet respective UL® safety standards.

C. Funds awarded for assistive devices and technologies may be used for labor costs and to purchase devices to be installed.

D. With regard to Personal Emergency Response Systems (PERS), the following additional requirements must be met:
   1. Equipment used must be approved by the Federal Communication Commission and must meet UL® safety standards specifications for Home Health Signaling Equipment.
   2. Response center must be staffed 24 hours/day, 365 days/year with trained personnel.
      a. Response center will provide accommodations for persons with limited English proficiency
   3. Response center must maintain monitoring capacity to respond to all incoming emergency signals.

4. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first service basis.
5. Provider will furnish each responder with written instructions and provide training as appropriate.
6. Provider will verify responder and contact name semi-annually to assure current and continued participation.
7. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.
8. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and responders in the use of the devices, as well as to provide performance checks.
9. Provider will maintain individual participant records that include the following:
    i. Service order.
    ii. Record of service delivery, including documentation of delivery and installation of equipment, participant orientation, and monthly testing.
    iii. List of emergency responders.
    iv. Case log documenting participant and responder contacts.

VOLUME III: Specific Service Requirements

POLICY NAME: Respite Care B-10

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: 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). Respite care may be provided at locations other than the client's residence.

UNIT OF SERVICE: Each hour of respite care provided.

I. Service Definition

A. 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.

B. Respite care services include:

1. Attendant Care (client is not bed bound): companionship, supervision, and/or assistance with toileting, eating, and ambulation;

2. Basic Care (client may or may not be bed bound): assistance 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.

C. 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

POLICY NAME: Friendly Reassurance B-11

PURPOSE: To provide regular contact with older adults who may be socially isolated to check on their health, safety, and wellbeing.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Making regular contact, through either telephone or in-home visits with homebound older persons to assure their wellbeing and safety and to provide companionship and social interaction.

UNIT OF SERVICE: Each contact with a homebound older person.

IX. Minimum Standards

A. Friendly reassurance programs may use service funds to pay wages for reassurance workers. Service funds may also be used to pay for calling expenses, out of pocket expense for in home visits, and program supplies.

B. Reassurance workers shall receive an orientation training which covers at a minimum:
   1. The needs of the isolated, homebound elderly persons
   2. The functions and limitations of reassurance contacts
   3. Communication and interpersonal skills
   4. Emergency procedures

C. Each program shall have a staff person designated to provide direction to both paid and volunteer reassurance workers and be available for contact in emergency or problem situations.

D. Each program shall establish and provide to all paid and volunteer reassurance workers a copy of procedures to be followed in emergencies and when a client does not call or answer or is not home as arranged. These procedures must include at a minimum:

   3. Provision for an immediate visit to the clients home by program staff or emergency service personnel
   4. Contact of the individual named to be notified in case of an emergency regarding each individual client
   5. Verification that either subsequent contact has been made with the client or that the client's location has been identified

E. Each program shall develop procedures for screening prospective clients and reassurance workers to attempt to match persons who are compatible.
F. Each program shall require each paid and volunteer reassurance worker to agree to not solicit contributions of any kind, attempt the sale of any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy while making a reassurance contact.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Carry Out Meals B-12
PURPOSE:	To provide complete meals to older adults at the point of service to be consumed off-site, without in-person or virtual interaction sponsored by the Nutrition Provider.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	The provision of nutritious meals to eligible recipients via carry out.
UNIT OF SERVICE:	One meal served to an eligible participant..

X. Minimum Standards

A. Carry-Out Meals (COM), also known as “Grab ‘n Go” or “Curbside Pick-up”, include Carry-Out Weekend Meals and Carry-Out Second Meals. COM are complete meals offered to participants at the point of service to be consumed off-site, without in-person or virtual interaction sponsored by the Nutrition Provider. Meals may be provided via shelf-stable, pick up, carry-out, drive-through or similar method. These meals are designed to offer participant choice via person-centered planning. They are meant to serve those who are most economically and socially disadvantaged as defined by ACLS Bureau, and who may not qualify for traditional Home-Delivered Meals (HDM) and may be unable to or choose not to participate in traditional congregate dining.

B. COMs are an optional meal service allowable for both Congregate and HDM meal programs when included as part of an approved area plan or area plan amendment when the following requirements are met:

a.Title III-C1 Congregate Meals may be provided as set forth in §1321.87(a)(1)(i) of the 45 CFR:
i. Meals shall not exceed 25% of the funds expended by the State agency under Title III, part C1, to be calculated based on the amount of Title III, part C1 funds available after all transfers as set forth in § 1321.9(c)(2)(iii) are completed;
ii. Meals shall not exceed 25% of the funds expended by any area agency on aging under Title III, part C1, to be calculated based on the amount of Title III, part C1 funds available after all transfers as set forth in § 1321.9(c)(2)(iii) are completed.
iii. Meals provided as set forth in paragraph (a)(1)(i) of this section may be provided to complement the congregate meal program:

A. During disaster or emergency situations affecting the provision of nutrition services;
B. To older individuals who have an occasional need for such meal; and/or
C. To older individuals who have a regular need for such meal, based on an individualized assessment, when targeting services to those in greatest economic need and greatest social need.

b. Title III-C2 Home-Delivered Meals may be provided as set forth in §1321.87(a)(1)(i) of the 45 CFR:

i. Eligibility criteria for home-delivered meals may include consideration of an individual's ability to leave home unassisted, ability to shop for and prepare nutritious meals, degree of disability, or other relevant factors pertaining to their need for the service, including social need and economic need.

ii. Home-Delivered meals service providers may encourage meal participants to attend congregate meal sites and other health and wellness activities, as feasible, based on a person-centered approach and local service availability.

C. Each program shall have written eligibility criteria for participants. Eligibility includes the following, at a minimum, the participant must:
   a) Be 60 years of age or older.
   b) Complete the required registration process.

D. Extended Eligibility: The nutrition provider and AAA should work together to determine extended eligibility based on meal availability and funding. Those determined to be eligible for COMs must complete the necessary National Aging Program Information Systems (NAPIS) documentation. Extended eligibility may apply to the following persons:
   a) A spouse of any age of the eligible COM participant.
   b) Family members of an eligible adult who are living with a disability and permanently live with the eligible adult in a non-institutional setting.
   c) People with disabilities who live in housing facilities where mainly older adults live, and which also provide congregate nutrition services.
   d) People who provide volunteer services during the meal hours.

E. At the provider's discretion, persons not otherwise eligible may be served, if meals are available, and they pay the full cost of the meal. The full cost includes raw food, preparation costs, and any administrative and/or supporting services costs.

F. Each COM program must provide and collect registration from each participant within 10 working days after an individual enters the program. At a minimum, registration must be updated and collected within 365 days from the date of the initial registration. Registration may be completed by the individual and returned in person or may be completed with program staff face-to-face, in-person or virtually. Yearly follow up shall follow the same process as the initial registration

or may be completed by telephone. All registrations must be signed and submitted.

a. Registration and follow up must, at a minimum, include the following:
    i. Basic Information (NAPIS/State Performance Report elements)
        A. Name, Address, Phone Number
        B. Demographics: date of birth, age, gender (optional), geography (rural or non-rural), poverty status, living arrangement, ethnicity, race, gender (optional).
        C. Nutrition Risk Score via DETERMINE Checklist
        D. Functional Status
            - Activities of Daily Living (ADLs)
            - Instrumental activities of daily living (IADLs)

b. Additional individualized assessment information must be collected, and reassessed annually to determine the regular need for COMs, including:
    i. Prioritizing criteria
    ii. Rationale explaining the need for regular COMs
    iii. At the discretion of the provider and the AAA, documentation of existing supports and the needs for additional services and/or referrals.

G. A written procedure for the distribution and documentation of meals is to be developed by the nutrition provider and approved by the AAA. This includes, but is not limited to, how and when participants obtain a meal, the distribution of nutrition education, and allowing a proxy to pick up meals on behalf of the participant.

H. Each nutrition provider, with the approval of the AAA, may decide the frequency of meals provided. This process must include person-centered planning, which may include allowing the participant to attend congregate meals when they have a willingness to attend. It may also include meal choices such as vegetarian as long as they meet the ACLS Bureau Nutrition Standards.

I. Nutrition Education: Guidelines for nutrition education can be found in the "Business Practices" section of the General Requirements for Nutrition Service Programs. In addition, food safety education should be provided to participants when meals are taken off-site. Each nutrition provider shall develop a system by which nutrition education shall be administered.
    a. At a minimum, food safety nutrition education must be provided when COMs are initiated, and annually thereafter, when the registration is renewed. This must include information on food storage and can be provided in-person, virtually, or in a written format via a standard flyer.

b. Each meal shall be labeled with participant instructions for safe storage, reheating, and expiration dates.

J. Each COM program shall be prepared to coordinate with HDM and Congregate Meal programs and shall maintain linkages with community resources, as available, within the Planning and Service Area (PSA).

K. Each COM provider may utilize a waitlist for meals when HDM and/or COM meals are in high demand. When an agency has a waitlist, the following must be considered:
   a. Each program must develop a prioritization system which should include a screening tool and monitoring plan.
   b. All participants placed on a waitlist must screened to assess waitlist prioritization.
   c. Each program must be able to document how individuals on the waitlist are prioritized.

XI. Meal Requirements

A. Each COM provider shall have the capacity to provide meals which meet the Older Americans Act and/or state nutrition guidelines by complying with the most recent USDA Dietary Guidelines for Americans and meeting a minimum of 1/3 of the Dietary Reference Intakes (DRI).

B. All menus to be approved by a dietitian, an individual who is registration eligible, or a registered Nutrition and Dietetic Technician (NDTR). Menus should include key nutrients and follow dietary recommendations that relate to lessening chronic disease and improving the health of older adults.

For more information on meeting the nutrition guidelines, please review the “Meal Planning and Suggested Meal Patterns” section in the General Requirements for Nutrition Service Programs.

VOLUME III: Specific Service Requirements

POLICY NAME: Adult Day Services C-1

PURPOSE: This section outlines procedures, requirements, and guidelines that must be followed by Adult Day Services programs receiving funds from the Region VII AAA.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Adult Day Services provides respite to caregivers.

Daytime care of any part of a day but less than 24-hour care for adults with functional and/or cognitive impairment, including dementia provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the participant's and/or caregiver's home.

Adult Day Services (ADS) provide meaningful activity, socialization, and enrichment opportunities for eligible participants to help; maximize optimal functioning, promote community living for as long as possible and delay placement into nursing home or other institutional settings.

UNIT OF SERVICE: One hour of care provided per client.

I. Adult Day Services

A. Adult Day Services are daytime care of any part of a day, but less than twenty-four (24) hour care, for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the Client's home.

B. Region VII AAA funds shall be limited to full or partial payment for units of service to older Clients who meet the eligibility criteria and service priority guidelines.

C. Client Counts

1. A Client receiving Adult Day Services may only be counted once during the contract period.

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

D. Coordination with Health Care Facility

1. Each program must be able to demonstrate a working relationship with a hospital and/or other health care facility to assist clients in obtaining additional planned or emergency health care services as needed.

E. Transportation Requirements

1. If the program operates its own vehicles for transporting clients to and from the service center, the following transportation minimum standards shall be met:

a. All drivers and vehicles shall be appropriately licensed and all vehicles used shall be covered by liability insurance.

b. All drivers shall be required to assist persons to get in and out of vehicles. Such assistance shall be available unless expressly prohibited by either a labor contract or an insurance policy.

c. All drivers shall be trained to respond to medical emergencies.

d. Each program must operate in compliance with P.A. I of 1985 regarding seat belt usage.

e. Each program shall develop standards regarding criteria for safe driving records of persons responsible for providing transportation.

f. The program will ensure there is a written plan for safe transport that is part of the participant's service plan. This may include any level of assistance: on and off the vehicle, curb to curb, door to door, or door to in-home.

II. Client Eligibility

A. All care recipients must be age 60 or older.

B. Each program shall establish written eligibility criteria, which will include at a minimum:

1. Clients must require continual supervision in order to live in their own homes or the home of a primary caregiver/relative.

2. Clients must require a substitute caregiver while their primary caregiver is in need of respite or otherwise unavailable.

3. Clients must have difficulty or be unable to perform activities of daily living (ADL) without assistance.

4. Clients must be capable of leaving their residence with assistance in order to receive service.

5. Clients are in need of intervention in the form of enrichment and opportunities for social activities in order to prevent and/or postpone deterioration that would likely lead to institutionalization.

6. Clients may be socially isolated, lonely and/or distressed as the result of declining social activity.

7. Clients may have frequent hospitalizations or emergency room visits.

8. Clients may be at risk of placement into an institutional setting due to functional level and/or caregiver stress/burnout.

9. Clients may have a dementia related diagnosis, display symptoms of a dementia, or are living with a chronic health condition. A physician's diagnosis is recommended.

C. Adult Day Services Providers must establish and utilize a priority rating system for determination of Clients to receive Region VII AAA funded Adult Day Service.

1. All requirements specified in the Client Population Policy for Prioritizing Service Levels shall be followed.
2. The priority system must evaluate function, social/environmental and financial need, with additional weight given to Clients demonstrating greatest economic need.

3. The priority system must be approved by the Region VII AAA and the Service Provider's governing body.

III. Client Record-keeping Procedures

A. Screening and Intake

1. Each program must have uniform preliminary screening procedures and maintain consistent records.

2. Such screening may be conducted over the telephone or virtually.

3. Records for each potential client must include at a minimum:

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

    b. Individual's age or date of birth

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

    d. Name, address, and telephone number of a person to contact in case of an 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 the individual

    g. Race and sex (optional at preliminary screening)

    h. An estimate of whether or not the individual has an income at or below the poverty level

4. Intake is not required for individuals referred by a case coordination and support, care management or HCBS/ED waiver program.

B. Assessment

1. If preliminary screening indicates an individual may be eligible for Adult Day Services, a comprehensive individual assessment of need shall be performed before or at the time of admission.

2. All assessments shall be conducted face to face.

C. Assessors must attempt to acquire and/or verify each item of information listed below, but must also recognize and accept the client's right to refuse to provide requested items.

1. Basic Information

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

    b. Age, date, and place of birth

c. Sexual orientation, gender identity (optional)

d. Marital Status

e. Race and/or Ethnicity

f. Living arrangements

g. Condition of environment, if known

h. Income and expenses, by source

i. Previous occupation(s), special interests, and hobbies

j. Religious affiliation (optional)

k. Emergency contact(s)

l. Medical/Health insurance and long-term care insurance information

m. Guardianship documents (if applicable)

2. Functional Status

a. Vision, hearing, and speech

b. Oral status—condition of teeth, gums, mouth, and tongue

c. Prostheses

d. Psychosocial functioning

e. Cognitive functioning

f. Difficulties in activities of daily living and/or instrumental activities of daily living (IADLs)

g. History of chronic and acute illnesses

h. Medication regimen—Rx, OTC, supplements, herbal remedies, and other physician orders

i. Eating patterns (diet history) and special dietary needs

j. Physicians orders (if applicable)

3. Supporting 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

   d. Extent of family and/or informal support network

   e. Hospitalization history

   f. Preferred Hospital

   g. Medical/health insurance information

   h. Long-term care insurance

   i. Faith-based support contact, address, and telephone number

4. Needs Identification

   a. Client perceived

   b. Caregiver perceived, if available

   c. Assessor perceived

   d. Determination of whether individual is eligible for program

5. Admission to the program may be determined through assessment, a trial visit, or recommendation/referral.

   a. The assessment shall have been completed within the 30 days prior to the referral and a copy must be on file with the Adult Day Services Provider.

   b. Program participation cannot be initiated unless completed assessment is on file.

6. Caregiver Information and Assessment

a. Caregiver information, such as the NAPIS data set, must be updated on a yearly basis.
b. Each program is encouraged to use the Modified Caregiver Strain Index on a yearly basis as appropriate.

IV. Service Plan

A. A service plan shall be developed for each individual admitted to an Adult Day Services Program.

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

1. The service plan must contain at a minimum:

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

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

c. A description of methods and/or approaches to be used in addressing needs

d. An identification of basic and optional program services to be provided

e. Treatment orders of qualified health professionals, when applicable

f. A statement of medications being taken while in the program

g. Persons demonstrating significant impairments in cognition, communication and personal care activities of daily living may require one of more of the following:
1. Modifications in environmental cues, communication approach, and task breakdown to enhance comprehension and participation in identified activities
2. Supervision to maintain personal safety
3. Hands-on assistance to perform activities of toileting, grooming, and hygiene

C. Each program must have a written policy/procedure to govern the development, implementation, and management of service plans.

D. Each client is to be reassessed every six (6) months to determine the results of implementation of the service plan.

1. If observation indicates a change in client status, a reassessment may be necessary before six (6) months have passed.

E. Client Files

1. Each program shall maintain comprehensive and complete client files that include at a minimum:

   a. Details of client's referral to Adult Day Care program

   b. Intake records

   c. Recent photograph of participant

   d. Assessment of individual need or copy of assessment and reassessments from referring program

   e. Service plan with notation of any revisions

   f. Listing of client's emergency contact(s) and attendance

   g. Progress notes in response to observations at least monthly indicating maintenance, decline, or improvement

   h. Documentation of all medications taken on premises, including:
      1. The name of each medication
      2. The dosage, frequency, and time each medication is to be taken
      3. Actual time each medication dosage is taken and initials of staff person administering or reminding
      4. Reason given by the participant if refused
      5. Reason for each administration of prescribed PRN medication
      6. Medications must be administered from original pharmacy labeled package

   i. Notation of basic and optional services provided to the client

   j. Notation of any and all release of information about the client, signed release of information form, and all client files shall be kept confidential in controlled access files.

   k. Each program shall use a standard release of information form which is time-limited and specific as to the information being released.

F. Discharge/Termination Procedures

1. Each Service Provider must establish a written policy/procedure for discharging individuals from the program, which includes at a minimum one or more of the following:

a. The client's desire to discontinue attendance

b. Improvement in the client's status so that they no longer meet eligibility requirements

c. An increase in the availability of caregiver support from family, and/or friends

d. Permanent institutionalization of client

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

V. Provision of Services

A. Each adult day care program shall provide directly or make arrangements for the provision of the following services. If arrangements are made for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

1. Transportation

2. Personal Care: consisting of assistance with ADLs as specified in the participant service plan

3. Program/Activities: An array of planned activities suited to the needs and preferences of the participants designed to encourage physical exercise, maintain, or restore abilities, prevent deterioration, and offer social interaction. Activity choices should be person- centered and allow for each individual to decide whether or not to participate. If a participant declines an activity, an alternative should be offered.

4. Nutrition, one hot meal per eight-hour day which provides one-third of the recommended daily allowances and follows the meal pattern specified in the Congregate Meals policy of the General Requirements for Nutrition Programs.

5. Clients in attendance from eight to fourteen (14) hours shall receive an additional meal or snacks that meet required nutrition standards.

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

    a. Each individual receiving a modified diet must have a written physician's order.

    b. Meals shall be acquired from a congregate meal provider where possible and feasible.

7. For meal provision within the Adult Day Services setting, Title III-C-1 (OAA congregate meal funding) and state congregate meal funding may only be used as specified in the ACLS Bureau Operating Standards for Services Programs General Requirements for Nutrition Service Programs and C-3 Congregate Meals Service Standard
    a. The program shall demonstrate awareness of and offer referrals to other caregiver supports and services as needed.

8. Recreation consisting of planned activities suited to the needs of the client and designed to encourage physical exercise, to maintain or restore abilities and skills, to prevent deterioration, and to stimulate social interaction.

B. Optional Service Components

1. Each Adult Day care program may provide directly or make arrangements for the provision of the following optional services

    a. Rehabilitative—physical, occupational, speech, and hearing therapies provided under order from a physician by licensed practitioners.

    b. Medical support—Laboratory, x-ray, and pharmaceutical services provided under order from a physician by licensed professionals.

    c. Nursing services: provided by a licensed R.N. or by a licensed L.P.N. under R.N. supervision, or by another staff person under R.N. direction and supervision

    d. Dental—under the direction of a dentist

    e. Podiatric—provided or arranged for under the direction of a physician

    f. Ophthalmologic—provided or arranged for under the direction of an ophthalmologist

g. Health counseling

h. Shopping assistance/escort

2. If arrangements are made for provision of any service at a place other than program-operated facilities, a written agreement specifying supervision requirements and responsibilities shall be in place.

VI. Medications Policy and Procedure

A. Each ADS program shall establish a written policy for medication management and must designate which staff are trained and authorized to administer medications. The medication management policy, which must include a medication training program, must be approved by a registered nurse, physician, or pharmacist. Licensed nurses are required to oversee medication administration but administering medications can be a delegated task performed by trained staff. The policies and procedures must address:

1. Written consent from the participant, or participant's guardian, or designated representative, for assistance when taking medications

2. Verification of medication regimen, including prescriptions and dosages

3. Training and authority of staff to assist clients in taking medications

4. Procedures for medication set up

5. Disposal of unused medications

6. Instructions for entering medication information in client files, including times and frequency of assistance

7. Secure storage of medications belonging to and brought in by clients

VII. Facility Requirements

A. First Aid and Emergency Procedures

1. Each program shall have written policies and procedures that address medical emergencies.

2. Each program shall have first aid supplies available at the service center.

3. A staff person certified in first aid procedures, including CPR, shall be present at all times clients are in the service center.

4. It is recommended that programs have an AED present and in good working condition.

5. Each program shall have written policies and procedures that address emergency situations.

6. Procedures to be followed for emergency situations (fire, severe weather, etc.) and evacuation shall be posted in each room of the service center.

7. Practice evacuation and tornado drills shall be conducted at least once every six months. The program shall maintain a record of all practice drills.

8. Each service center must have the following furnishings:

    a. At least one straight back or sturdy folding chair for each client and staff person

    b. Lounge chairs and/or day beds as needed for naps and rest periods

    c. Storage space for clients' personal belongings;

    d. tables for both ambulatory and non-ambulatory clients

    e. A telephone that is accessible to all clients

    f. Special equipment as needed to assist persons with disabilities

    g. Locked storage space is to be made available at the request of a participant or the participant's guardian or designated representative

    h. Bathroom facilities to accommodate persons with disabilities. A minimum of one toilet per ten participants is recommended

    i. Adequate space available for safe arrival and departure

9. All equipment and furnishings in use shall be maintained in safe and functional condition.

10. Each service center shall demonstrate that it is in compliance with fire safety standards and the Michigan Food Code.

11. A monthly calendar of activities must be prepared and posted in a visible place.

VIII. Staffing

A. General Requirements

1. Each program must employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional.

2. At least two staff members must be present on the premises whenever two or more participants are in the ADS facility.

    a. Volunteers may be counted towards the staffing minimums if they have received the same level of training as paid staff.

    b. The program shall continually provide support staff at a minimum of one staff person for each five participants.

3. The program shall continually provide support staff at a ratio of no less than one staff person for each ten clients.

4. Health support services may be provided only under the supervision of a Registered Nurse.

5. If the program acquires either required or optional services from other individuals or organizations, it shall be accomplished through a written agreement that clearly specifies the terms of the arrangement.

B. Staff Training

1. Program staff shall be provided with an orientation training that includes topics specified in the General Requirements for All Service Programs, and the following:
    a. Introduction to the program
    b. The Aging Network
    c. Maintenance of records and files (as appropriate)
    d. The aging process
    e. Ethics
    f. Emergency procedures
    g. Diversity, equity, and inclusion
    h. Normal aging vs. disease symptoms
    i. Techniques for effective communication with program participants
    j. Adult Protective Services law and mandated employee reporting requirements

k. Participant rights and responsibilities
l. Assessment and management of responsive behavior
m. Blood Borne Pathogens and Universal Precautions
n. Confidentiality/HIPAA
o. First Aid and CPR/AED
p. Training to understand, respond to, and address the needs of participants with Alzheimer's disease and other dementias. Including but not limited to:
    1. Explanation of Alzheimer's disease and other dementias and their progression
    2. Assessing and managing responsive behavior
    3. Communication approaches and techniques
    4. Effect of environmental factors on the participant
    5. Impact of the disease on family caregivers

2. It is recommended that Initial training programs include the following:
    a. Impact of caregiver stress
    b. Regional caregiver supportive services
    c. Therapeutic 1:1 and small group engagement
    d. Physical care techniques related to activities of daily living
    e. Food Safety
    f. Information and referral resources in the event of a crisis situation such as:
        1. Illness or death of the primary caregiver
        2. Suicidal ideation of the caregiver or participant
        3. Adverse incident during the delivery of service

3. Program staff shall be provided in-service training at least twice each year which is specifically designed to increase their knowledge and understanding of the program, aging process issues, and to improve their skills at tasks performed in the provision of service. One training per year shall be focused on caregiving for persons with dementia. Other trainings may include updates, and refresher trainings on an of the above listed orientation training topics, or other pertinent topics related to Adult Day Services which increase staff knowledge and understanding while incorporating new developments and advancements in geriatric and dementia care.

    a. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation.

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

C. Hybrid Services/ Activities

1. Participants receiving approved days of adult Day services are at times unable to attend in person due to various uncontrollable reasons. These reasons may include closure of the service provider, medical, personal, weather, or family related. The provider and/or the agency authorizing services will assess and document the need for provision and/or term intermittent hybrid Adult day Services to ensure continuity of care. Offering hybrid adult day Services is optional and at the discretion of the agency authorizing services and the ADS service provider.

    a. Hybrid Services/ Activities may include, but are not limited to:

        a. Phone calls with family caregivers and participants
        b. Weekly “support group” phone calls with family caregivers and participants
        c. Activity packet development and dissemination to participants
        d. Use of Adult Day Services staff to deliver particpants’ food and other essential items
        e. Monthly participant assessments
        f. Any other creative activity that helps to engage the participant and relieve the caregiver in a safe and effective manner.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Nutrition Services – Congregate Meals C-3
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:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	The provision of nutritious meals to older individuals in congregate settings.
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 accompanies 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. 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 line-item A (1-8), 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.

c. 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 HDM or Carry Out Meals. 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 (optional)

    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 or Carry Out 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 or Carry Out Meals.

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 meals and/or Carry Out Meals 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. ACLS Bureau 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 ACLS Bureau must approve, in writing, the opening of a new and/or relocated meal site prior to the provision of any meals at that site. LISTED ONE ABOVE

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 ACLS Bureau 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 ACLS Bureau 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. ACLS Bureau will review the documents and the request to close the site. If approved, ACLS Bureau will notify the requestor, the respective AAA and field representative

   a. The site can be found at: https://www.osapartner.net/congmeal/.

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 and ACLS Bureau by using the on-line Temporary Meal site Closure form.

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:

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 ACLS Bureau Community Nutrition Services poster.

D. Each program shall make available, upon request, food containers (assistive plates, bowls, cups), and utensils for clients who are living with disabilities.

E. Each service provider must 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 disasters~~,~~ 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. 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.

J. 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 ACLS Bureau 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.

K. Adult Foster Care (AFC) and other Residential Care Clients.

1. AFC or other residential providers that bring 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.

L. 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 ACLS Bureau and must follow the nutrition standards.

M. 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 nutrition program adopt a policy that ensures 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. At Least 6 hours training must be provided annually.

4. 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 millage 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 ACLS Bureau 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 ACLS Bureau, prior to the activity, of the date, time, and the name of the sponsoring agency.

VOLUME III: Specific Service Requirements

POLICY NAME: Nutrition Counseling C-4

PURPOSE: To provide an individualized advice and guidance to older adults who are at nutritional risk.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of individualized advice and guidance to individuals, who are at nutritional risk because of health and/or nutritional history, dietary intake, medications use or chronic illness, about options and methods for improving their nutritional status.

UNIT OF SERVICE: One hour of advice and guidance.

XII. Minimum Standards

A. Nutrition counseling services shall be performed by a registered dietitian.

B. Each program shall conduct an individual assessment of need for each client which includes at a minimum: nutritional history; both chronic and acute health problems; and a listing of all prescription and over the counter medications being taken including vitamin and mineral supplements and any herbal treatments being used.

C. Each program shall develop a nutritional care plan for each client based on the individual assessment of need that includes at a minimum:

   a. A statement of the client's problems, needs, strengths, and resources.
   b. Specific goals and objectives for the client.
   c. Descriptions of methods and approaches to be used.
   d. Identification of other community resources currently being utilized by the client.
   e. Current treatment orders, if any, from client's physician including special diets and orders for liquid nutrition supplements.

D. Each program shall be able and prepared to offer services in a variety of settings including the client's residence as well as community-based settings.

VOLUME III: Specific Service Requirements

POLICY NAME: Nutrition Education C-5

PURPOSE: To provide an educational program which promotes better health by providing culturally sensitive nutrition information.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: An educational program which promotes better health by providing culturally sensitive nutrition information (which may also address physical fitness and related health issues) and instruction to participants, and/or caregivers, in group or individual settings.

UNIT OF SERVICE: One educational session.

XIII. Minimum Standards

D. Nutrition education services shall be provided by, or be supervised by, a registered dietician or an individual with comparable expertise.

E. Each program shall establish linkages with local sources of information that meet the standards for accuracy and reliability as set by the American Dietetic Association. Programs may incorporate the purchase of fresh produce as a component of nutrition education services.

F. Nutrition education sessions shall be conducted at senior centers and congregate meal sites, to the extent feasible.

VOLUME III: Specific Service Requirements

POLICY NAME: Disease Prevention and Health Promotion C-6

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: A service program that provides information and support to older individuals with the intent to assist them in avoiding illness and improving health status

Allowable programs include:

- Health Risk Assessments
- Health Promotion Programs
- Physical fitness, group exercise, music, art, dance movement therapy; programs for Multi-Generational Participation
- Medication management, screening, and education to prevent incorrect medication and adverse drug reactions
- Mental Health Screening Programs
- Education programs pertaining to the use of Preventative Health Services covered under Title XVIII of the Social Security Act
- Information programs concerning diagnosis, prevention, treatment and rehabilitation of age-related diseases and chronic disabling conditions

UNIT OF SERVICE: One activity session or hour of related service provision, as appropriate

I. Minimum Standards

A. Each program in targeting services shall give priority to geographic areas that are medically under-served and in which there are a significant number of older individuals who have the greatest economic need for such services.

B. Each program is encouraged to facilitate and utilize a regional health coalition to plan for and implement services. Members of the regional health coalition should include one or more members of the Michigan Primary Care Association and other organizations such as local public health departments, community mental health boards, cooperative extension agents, local aging service providers, local health practitioners, local hospitals, and local MMAP providers.

C. Disease prevention and health promotion services shall be provided at locations and in facilities convenient to older clients.

D. Each program shall follow regional specific program guidelines as established by the respective area agency on aging and included in the request for proposal (RFP) materials.

E. Each program shall have a uniform intake procedure that identifies and documents Client needs. Priority must be given to older individuals in the greatest social and economic need.

F. Service Providers must be able to demonstrate that the content of the program addresses the needs of older persons.

G. Each Service Provider must have an established screening system targeting and serving the Older Adults in greatest social and economic need, with special emphasis on reaching low-income minority.

H. Each program, located in areas where non-English or limited English-speaking older persons are concentrated, shall have a written policy to provide access to services for persons with limited English proficiency.

I. Service Providers shall publicize information about the availability and nature of the service throughout the service area.

II. Component Functions

A. Service Providers will conduct assessments of individual's needs and identify the components of assistance needed.

B. Service Providers must be able to demonstrate that the content of the program addresses the needs of older persons. Service Providers must specifically identify the service to be provided.

C. Service Providers must identify the topics to be covered.

III. Service

A. A program may offer one or more of the following services:

1. Health services that provide blood pressure checks, cholesterol checks, and other evaluations

2. Medication management services may be provided to individual Clients with Title II Part D funds only through the use of the ACLS Bureau Medication Management service definition, service number B-7 of the ACLS Bureau Operating Standards for Service Programs.

3. Guidance on creating a healthy home environment

4. Infection control

5. Fall prevention programs

6. Nutrition

7. Locating resource centers

8. Stress management

9. Geriatric evaluation services provided to individual Clients through the Region VII AAA Geriatric Evaluation service definition

10. Hearing impaired and deaf services programs provided to groups and/or individual Clients through the use of the ACLS Bureau Assistance to the Hearing-Impaired and Deaf service definition

11. Provision of vision services for individual Clients and/or groups through the use of the ACLS Bureau Vision Service definition

12. Development of brochures and other media resources

IV. Program Cost

A. Service Providers who offer programs can bill as a unit of service one activity session or hour of education when an initiative provides support activities such as:

1. Information and assistance meetings

2. Senior events that promote education for the Older Adults

3. Events that connect the community with resources

B. Printed materials that are developed and distributed for education programs pertaining to the physical, emotional, and spiritual aspects of preventing disease or promoting good health, as well as current research and public policy, are not considered units of service, but are billable items.

V. Staffing Requirements

A. Each program shall utilize staff that has specific, training, and/or experience in the particular service area being provided. Continuing education of staff in specific service areas is encouraged.

B. Medication management services may be provided to individual clients with Title III-Part D funds only through use of the "In-home Services Medication Management" service definition, service number B-7 of the *ACLS Bureau Operating Standards for Service Programs.*

C. In addition, the staffing requirements of the Medication Management program must meet the basic requirements listed in each service definition.

VOLUME III: Specific Service Requirements

POLICY NAME: Health Screening C-7

PURPOSE: To provide screening of an older adults health status to identify and/or monitor health problems. And determine if referral for medical intervention is needed.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: A systematic screening of an older individual's health status, supervised by a registered nurse, in order to identify and/or monitor actual and potential health problems and to determine if referral for medical intervention is indicated.

UNIT OF SERVICE: One complete health screening for each client, including referral and follow-up. Should not exceed one time per year per client.

XIV. Minimum Standards

1. Each client shall receive an annual physical, social and psychological assessment which shall include:

   (NOTE: Assessors shall attempt to acquire each item of information listed below but must recognize and accept the client's right to refuse to provide requested items.)

   a. Basic Information (may be completed by client)
      i. Individual's name, address, and phone number
      ii. Name, address and phone number of person to contact in case of emergency.
      iii. Gender (optional)
      iv. Age and date of birth
      v. Race and/or ethnicity
      vi. Living arrangement
      vii. Type of housing
      viii. Whether or not individual's income is below the poverty level and/or sources of income (particularly SSI and GA)
      ix. Date of last physical by a physician.

   b. Health History (can be completed by client)
      i. History of illnesses, injuries, health problems, and abnormal signs and symptoms
      ii. Limitations in activities of daily living
      iii. Health habits including eating patterns, smoking, and alcohol intake

iv. Allergies to medicine, food, etc.
v. Prescription medications and over-the-counter medications currently taken
vi. Other treatments and orders by a physician
vii. Names of all current physicians and when last seen by each
viii. Health or support services currently received or received in the past
ix. Social and psychological history

c. Nurse Assessment (by an RN including review of the client's health history)
   i. Physical Status (visual review)
      a. Edema in lower extremities
      b. Stability of walking
      c. Shortness of breath
   ii. Mental and social status
   iii. Abnormal signs or symptoms observed by the RN and reported by client.
   iv. Review of results of screen tests

d. Vision
   i. Date of last eye exam
   ii. Condition of glasses
   iii. Age of glasses
   iv. Able to read
   v. Able to drive

e. Hearing
   i. Date of last hearing exam
   ii. Does the assessor have to shout
   iii. Does the client read lips

f. Hearing Appliance Used
   i. Condition of hearing aid
   ii. Check for wax in ears

g. Dental
   i. Date of last dental exam
   ii. Condition of dental hygiene

2. Each program shall offer or otherwise provide for the following annual screening tests or procedures (a client may choose not to participate in one or more tests):

   a. Vital signs-temperature, pulse, respiration, and blood pressure.
   b. Hemoglobin or hematocrit
   c. Stool sample for blood detection
   d. Height and weight

e. Breast exam or instruction in breast exam
f. Urine test
g. Tuberculosis skin test
h. Influenza immunization
i. Referral for mammogram and pap test as appropriate
j. Pneumonia vaccine
k. Information on prostate exams
l. Referral for dental exams if needed

3. Each program may offer the following annual screening tests or procedures:
   a. Tetanus and diphtheria immunizations
   b. Random plasma glucose if venous blood draws are done in a non-fasting
   c. state or fasting plasma glucose if venous blood draws are done in a fasting
   d. state
   e. Blood chemistry
   f. Hearing test
   g. Vision test
   h. Glaucoma test
   i. Yearly urinalysis and serum cretin

4. All health screening tests and immunizations shall be done under the on-site supervision of a registered nurse.

5. The program shall be able to offer basic health information in response to screening results and to make referrals for medical intervention as indicated.

6. A follow-up contact with the client shall be made on referrals for medical intervention within 30 days. If the client chooses not to seek medical intervention, an appropriate notation shall be made on his/her screening records. Follow-up shall be made on all annual screens.

7. Each program shall maintain complete records for each client screening including at a minimum:

   a. The annual physical, social, and psychological assessment
   b. Results of tests
   c. Immunizations received
   d. Notes in response to follow-up client contact.

VOLUME III: Specific Service Requirements

POLICY NAME: Assistance to the Hearing Impaired and Deaf Community C-8

PURPOSE: To provide assistance to older persons with hearing impairments or who are deaf, to enable them to better compensate for these losses in daily life.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of assistance to older persons with hearing impairments or who are deaf, to enable them to better compensate for these losses in daily life.

Allowable activities include: education/training relative to community services for rights and benefits of hearing impaired and deaf persons; assistance in obtaining benefits and services; training in techniques for adjusting lifestyle and living arrangements in response to hearing impairments and deafness; and community education on hearing impairments, and deafness and prevention.

UNIT OF SERVICE: One hour of allowable support activities or each community education session.

XV. Minimum Standards

G. Each program shall have staff who are fluent in American Sign Language and other communication modes suitable to the deaf and hearing impaired.

H. Each program shall establish linkages with other local and state-wide programs offering services to the hearing impaired and have knowledge of the deaf community culture.

I. Each program shall make Services available throughout the geographic target area. service providers must identify sites where services will be delivered and develop a schedule for site-specific service delivery.

VOLUME III: Specific Service Requirements

POLICY NAME: Home Repair Services C-9

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Permanent improvement to an older person's home to prevent or remedy sub-standard condition or safety hazard. Home Repair Service offers permanent restoration and/or renovation to extend the life of the home and may involve structural changes. Home repair does not involve making aesthetic improvements to a home, temporary repairs, chore, or home maintenance that must be repeated. Allowable home repair tasks include:

- Roof repair/replacement
- Siding repair/replacement
- Door and window repair/replacement
- Foundation repair/replacement
- Floor repair/replacement
- Interior wall repair
- Plumbing and drain repair/replacement
- Insulating/weatherization (including water heater wrap, low-flow shower head, socket sealers, draft stoppers, and door sweeps)
- Stair and exterior step repair/replacement
- Heating system repair/replacement
- Ensuring safe and adequate water supply
- Electrical wiring repair/replacement
- Obtaining building permits
- Painting to prevent deterioration in conjunction with repairs

UNIT OF SERVICE: Performance of one hour of allowable home repair tasks.

I. Minimum Standards

A. 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. 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.

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

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

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

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

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

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

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

IV. Client Procedures

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

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

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

B. The service provider must utilize a written agreement with the 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(s) 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
POLICY NAME:	Legal Assistance C-10
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Provision of legal assistance through cases, projects, community collaborations and other services that provide the most impact whether for an individual, client, or group of older adults. Such assistance may be provided by an attorney, paralegal or student under the supervision of an attorney. Legal Services is a priority service under the Older Americans Act (OAA).
UNIT OF SERVICE:	Provision of one hour of an allowable service component.

I. Each area agency on aging (AAA) should contract with the legal assistance program with the capacity to perform the full range of allowable service components that is best able to serve the legal needs of the community given the resources available.

   A. AAAs are able to contract with Legal Services Corporation (LSC) grantees, non-LSC non-profit legal programs, private attorneys, law school clinics, legal hotlines or other low-cost legal services delivery systems.

   B. It is a conflict of interest for any AAA to have in-house counsel serve as the Title IIIB legal services provider.

II. Minimum Standards

   A. Allowable service components are as follows:

      1. Intake

         a. The initial interview to collect demographic data and identification of the client's legal difficulties and questions

      2. Advice and Counsel

         a. Where the client is offered an informed opinion, possible course of action and clarification of his/her rights under the law

3. Referral

    a. If a Legal Assistance program is unable to assist a client with the course of action that he/she wishes to take, an appropriate referral should be made as available.

    b. Referral may also be necessary when the individual's need is outside of program priorities or can be more appropriately addressed by another legal entity.

4. Representation

    a. If the client's problem requires more than advice and counsel and the case is not referred to another entity, the legal assistance program may represent the person in order to achieve a solution to the legal problem.

    b. Representation may include legal research, negotiation, preparation of legal documents, correspondence, appearance at administrative hearings or courts of law, and legal appeals where appropriate.

5. Legal Research

    a. The gathering of information about laws, rights, or interpretation of laws that may be performed at any point after intake has occurred to resolve an individual's legal problems.

    b. This information is used to assist legal assistance programs in case work, client impact work and program and policy development.

6. Preparation of Legal Documents

    a. Documents such as contracts, wills, powers of attorney, leases, or other documents may be prepared and executed by legal assistance programs.

7. Negotiation

    a. Within the rules of professional responsibility, program staff may contact other persons concerned with the client's legal problem in order to clarify factual or legal contentions and possibly reach an agreement to settle legal claims or obtain services and supports.

8. Legal Education

    a. Legal assistance program staff may prepare and present programs to inform older adults of their rights, the legal system, and possible courses of legal action.

9. Community Collaboration and Planning

    a. Legal assistance programs should participate in activities that impact elder rights advocacy efforts for older adults such as policy development, program development, planning and integration activities, targeting and prioritizing activities, and community collaborative efforts.

III. Minimum Standards

A. A Client receiving Legal Assistance services may be counted only once during the contract period.

B. Only the unduplicated count of eligible Clients age 60 or older served by the program shall be reported to the Region VII AAA.

C. A Client file must be established for all Clients reported under the Region VII AAA's contract.

D. Clients receiving only advice and counsel by telephone should not be reported to the Region VII AAA as duplication of Clients is inherent in this method of service delivery.

IV. Service Design and Delivery

A. Service Providers must specifically identify the components of Legal Assistance services to be provided.

    1. Each program must at a minimum, provide intake, advice and counsel, representation and education service components.

B. Where applicable, Service Providers must identify the topics to be covered in providing Legal Education.

    1. This shall include speaking engagements, training, and the development and dissemination of printed material to senior citizens in the service area.

2. Service Providers must be able to demonstrate that the content of Legal Education activities addresses the legal needs of older persons.

C. Service Providers must establish a written plan to assure that all contracted service components will be made available and accessible to potential Clients in all localities of the specified service area.

D. Service Provider must have an established screening system for targeting and serving Older Adults in greatest social and economic with special emphasis on reaching income minority Older Adults.

E. Service Providers shall identify separately the number of units proposed for the provision of Advice and Counsel only and the number of units proposed for the delivery of other allowable Legal Assistance components.

1. Advice and Counsel, for the purposes of this requirement, refers to services given via telephone contacts where a Client cannot be documented.

2. For reporting and reimbursement purposes, Service Providers must maintain records documenting units provided, such as time spent, providing Advice and Counsel on behalf of Clients.

F. Coordination of Service Delivery

1. Each legal assistance program shall have an established system for targeting and serving older adults in greatest social and economic need within the OAA defined program target areas of income, health care, long term care, nutrition, housing, utilities, and protective services, defense of guardianship, abuse, neglect and discrimination.

2. Each program shall complete and re-evaluate annually a program priority report and plan for targeting services to the most socially and economically vulnerable.

a. This report shall be provided to the AAA and the Bureau of Aging, Community Living, and Supports (ACLS Bureau).

3. Each legal assistance program shall work to develop outcome measures to reflect the impact of legal services intervention on individual clients and older adults in the greatest social and economic need in the service area.

a. These outcomes shall be used for program development

4. Services may be provided by an attorney licensed to practice law in the State of Michigan or a paralegal or student under the supervision and guidance of an attorney licensed to practice law in the State of Michigan.

5. Legal assistance programs may engage in and support client impact work, including but not limited to class action suits where a large group of older adults are affected by a legal inequity.

6. For client impact work, programs are encouraged to utilize technical assistance resources such as the Michigan Poverty Law Program (MPLP).

7. Each legal assistance program must demonstrate coordination with local long-term care advocacy programs, aging services programs, Aging and Disability Resource Centers (ADRCs), elder abuse prevention programs and service planning efforts operating within the project area.

8. When a Legal Assistance Service Provider identifies issues affecting clients which may be remedied by legislative action, such issues should be brought to the a attention of Region VII AAA, ACLS Bureau, MPLP, and other programs offering technical assistance to legal providers.

9. Each program that is not part of a Legal Services Corporation project grantee must have a system to coordinate its service with existing Legal Services Corporation projects in the planning and service area.

V. Record-keeping and Reporting

A. Client Intake and Records

1. Service Providers must obtain the minimum intake information required for all Region VII AAA funded service programs.

2. Service Providers must utilize a case file system that tracks the service components and the progress of each Client's case from intake to final resolution or dismissal.

    a. Units of service rendered on behalf of a Client must be documented in the individual's case file for each entry of service activity.

3. In instances when Clients are referred to an outside attorney, the Service providers shall assure the provision of follow-up to determine the status of the referral and whether or not the Client obtained service.

B. Documentation of Units of Service

1. The Service Provider shall establish a uniform system for recording and documenting the units of service provided by program staff.

2. At the minimum, the Service Provider shall assure the maintenance of daily activity logs by program staff and the use of pay roll timesheets.

3. Units reported to the Region VII AAA for reimbursement purposes shall be documented through examination of activity logs and timesheets, and be in accordance with the provisions under the contract.

VI. Staffing Requirements

A. Service Providers must have a minimum of one (1) full-time attorney on staff who is a graduate of an accredited law school and is licensed to practice law in the State of Michigan.

B. Minimum staff qualifications for each component of legal assistance services

1. Licensed Attorneys may provide all allowable components of Legal Assistance Services.

2. Paralegal are defined as individuals trained in accredited paralegal courses or in the specific legal service subject areas in which they will be assisting an attorney and can perform any of the components listed above with the exceptions of representation in court and final review of legal documents.

a. Although paralegal may represent a Client at an administrative hearing, representation in court must be by an attorney.

b. Preparation of legal documents may be assigned to paralegal; however, all finalized documents must be reviewed and approved by an attorney.

C. Law students who have completed 30 hours of course work at an accredited law school can perform any of the service components under legal assistance acting under the guidance and supervision of a licensed attorney.

VII. Compliance and Maintenance of Effort

A. Each Service Provider must provide assurance that it operates in compliance with regulations promulgated under the Older American Act as set forth in 45 CFR Section 1321.71

B. As part of an integrated legal services delivery system, each legal assistance program that is not part of a Legal Services Corporation (LSC) project grantee shall have a system to coordinate its services with the existing LSC projects in the planning and service area in order to concentrate the use of funds provided under this definition to individuals with the greatest social and economic need.

C. Each program shall also coordinate with the Legal Hotline for Michigan Seniors (LHMS) and the Counsel and Advocacy Law Line (CALL).

D. Where feasible, each program should also coordinate with other low-cost legal service delivery mechanisms, the private bar, law schools, and community programs in the service area to develop the targeting and program priority plan.

E. Service Providers must ensure that Legal Assistance Services are not provided in fee generating cases, as defined in 45 CFR Section 1609.2 unless adequate representation is unavailable from private attorneys.

F. Each program must make reasonable efforts to maintain existing levels of Legal Assistance for older individuals being furnished with funds from sources other than Title III Part B of the Older Americans Act.

G. A legal assistance program may not be required to reveal any information that is protected by attorney/client privilege.

H. Each program shall make available non-privileged, non-confidential, and unprotected information which will enable the AAA to perform monitoring of the provider's performance, under contract, with regard to these operating standards.

I. Each legal assistance program should participate in statewide and local legal service planning groups including MPLP's Elder Law Task Force.

J. Each legal assistance program is expected to participate in at least two Task Force meetings per year.

    1. Participation by conference call/webinar is acceptable

K. Each legal assistance program should participate in elder law training and technical assistance activities.

L. Each legal assistance program shall report program data through the Legal Services Information System (LSI) application of ACLS Bureau's Aging Information System (AIS).

M. Legal assistance program will submit/post data in the LSI quarterly.

N. Data shall be submitted no later than 30 days after the end of the quarter.

O. AAAs will utilize the LSI to retrieve needed legal services program data and will consult with ACLS Bureau prior to requiring additional reports or data from the legal program.

P. The requirement for legal assistance programs to report data through the LSI shall be included in AAA/legal assistance program contracts.

VOLUME III: Specific Service Requirements

POLICY NAME: Long-Term Care Ombudsman/Advocacy C-11

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of advocacy, education, information and assistance, and case investigation and resolution to residents of nursing homes, homes for the aged, and adult foster care homes, their family members and friends, staff, and the general public. Each Area Agency on Aging (AAA) or subcontractor providing long term care ombudsman services shall utilize designated ombudsmen to provide services to protect the health, safety, welfare, and rights of residents as follows:

Access – Provision of in-person or virtual visits and response to telephone calls and email messages to ensure residents have timely access to ombudsman services.

Advocacy – Activities related to identifying obstacles and deficiencies in long term care delivery systems and developing recommendations for addressing identified problems at the local, state, and national levels.

Community Education - Provision of information to the public including long term care residents, regarding all aspects of the long-term care system including elder abuse, neglect, and exploitation of vulnerable adults. This component includes formal presentations, consultation, engagement with the media, and distribution of consumer informational materials.

Complaint investigation – Intake, investigation, verification, and attempted resolution of individual complaints from residents or others acting on their behalf regarding any action or inaction which may adversely affect the health, safety, welfare, and rights of a long-term care facility resident. Complaint resolution processes include active listening, negotiation, and conflict resolution skills.

Information and Assistance – Provision of assistance to residents, family members, staff, and the general public regarding any long-term care topic including but not limited to placement options,

resident rights, abuse prevention, and community transition services.

Volunteer Support - Conduct of recruitment, training/mentoring, supervision, and ongoing support activities related to volunteer ombudsmen.

UNIT OF SERVICE: Each closed complaint and completed ombudsman activity is a unit of service. Ombudsman activities include:

- Providing information and assistance
- Participation in a resident or family council
- Participating in a facility survey
- Conducting a facility visit
- Providing training/education

I. Minimum Standards

A. Each entity desiring to operate a local Ombudsman program shall be designated by the State Long-Term Care Ombudsman (SLTCO) to provide services in the State of Michigan.

1. Individuals employed by local Ombudsman providers must be certified as local ombudsman by the SLTCO.
2. Individuals employed by and volunteers of the entity must be designated by the SLTCO to provide long term care ombudsman services.
3. Long term care ombudsman program services are reported annually to the Administration on Community Living b the SLTCO through the National Ombudsman Reporting System.
4. Long term care ombudsmen (ombudsmen) shall, in accordance with the policies and procedures established by the SLTCO and the State Unit on Aging:

   a. Identify, investigate, and resolve complaints made by or on behalf of residents that relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the residents. With respect to identifying, investigating, and resolving complaints, and regardless of the source of the complaint (i.e., complainant), the ombudsman serves at the direction of the resident of a licensed long term care facility and shall investigate a complaint, including but not limited to a complaint related to abuse, neglect, or exploitation, for the purposes of resolving the complaint to the resident's satisfaction and of protecting the health, welfare, and rights of the resident. The ombudsman may identify, investigate, and resolve a complaint impacting multiple residents or all residents of a facility.

   b. Provide services to protect the health, safety, welfare, and rights of residents by:

1. Providing information and assistance on long term care issues to residents, their family members and friends, staff members, and the public;
2. Referring residents, their family members, and friends to other resources and programs;
3. Providing unbiased information about long term care facilities, the rights of residents, sources of payment for care, and guidelines in selecting a long-term care facility or other service to residents and the public;
4. Offering education sessions to residents and long-term care staff members on a variety of long-term care topics;
5. Participating in health fairs and other community events to educate participants on long term care ombudsman services and other long term care topics; and
6. Participating in facility surveys conducted by the state survey agency and providing feedback to the state survey agency regarding ombudsman observations of the long-term care setting.

c. Support residents and their family members when a provider announces intent to end participation in the Medicare or Medicaid program or cease operation voluntarily or due to regulatory action, which requires the relocation of residents to other settings, is a component of the ombudsman program. The local ombudsman will visit the home frequently to ensure residents' rights and choices are honored as well as monitor and report concerns with care and service delivery during these events. The ombudsman program follows up with relocated residents to address any concerns they may have related to the move.

d. Assure that residents in the service area have regular and timely access to the services provided through the ombudsman program and that residents and complainants receive timely responses to requests for information and complaints, in accordance with established ombudsman program policy and procedures.

    1. Complaint Response - Complaints alleging abuse, neglect, or exploitation, significant harm to the resident, or involuntary discharge will be responded to within two working days. All other complaints will be responded to within seven working days.

    2. Facility Visits - Each federal fiscal year (October 1 – September 30), in-person visits will be conducted as follows:
        a. Fifty percent (50%) of nursing homes will receive four routine access visits (the same facility visited once each quarter) meeting the program requirements for observation and resident interaction during the visit;
        b. All other nursing homes will receive an in-person visit every 6 months; and
        c. Ten percent (10%) of licensed homes for the aged and adult foster care homes will receive an in-person visit.

Note: Each federal fiscal year, the group of nursing homes receiving routine access visits required at (2)(a) will alternate with the group of nursing homes receiving in-person visits required at (2)(b).

e. Promote and provide technical support for the development of resident and family councils as well as provide ongoing support including attendance at council meetings as requested by resident and family councils.

f. Coordinate media requests for interviews or ombudsman program information with the SLTCO.

g. Complete data entry related to case investigation and ombudsman activities by the 10th of the month for the work completed in the previous month by the ombudsman and any volunteers managed by the ombudsman. If the 10th falls on a weekend or holiday, the local ombudsman has until the next workday to complete the data entry. The local ombudsman must complete data entry for the work completed by ombudsman volunteers as volunteers are not granted access to the ombudsman database.

h. Where the AAA or subcontractor utilizes ombudsman volunteers, the local ombudsman shall be responsible for the management of volunteer ombudsmen including, but not limited to:

1) Recruiting potential volunteers;
2) Coordinating onboarding and training with the State Office;
3) Providing Initial mentoring of the volunteer during training status;
4) Providing ongoing consultation and case support to volunteers;
5) Assigning homes and setting visiting expectations;
6) Overseeing service delivery;
7) Ensuring at least 18 hours of continuing education is completed annually;
8) Establishing communication tools for referrals and reporting of services;
9) Completing data entry for service provision;
10) Providing recognition of volunteers; and,
11) Processing reimbursement for allowable expenses, if applicable.

5. Ombudsmen shall make resources and information available to residents, their families and friends, staff and the general public regarding prevention, identification, and reporting of abuse, neglect, and exploitation (ANE).

6. Ombudsmen shall participate in local or state-level teams to address ANE including death review teams and interdisciplinary abuse prevention teams.

B. Each designated local ombudsman program will adhere to program directions, instructions, guidelines, and Ombudsman reporting requirements issued by the SLTCO in the following areas:

1. Recruiting, interviewing and selection, initial training, apprenticeship and assessment of job readiness and credentialing of new local ombudsman staff and ombudsman volunteers;

2. Ongoing education, professional development, performance evaluation, as related to the annual certification and designation process;

3. Assignment to workgroups, task forces, special projects, meetings, both internal and external

4. Conduct of local ombudsman work and activities;

5. Attendance at training/professional development events, staff meetings, quarterly training sessions and other educational events, or attendance as a presenter, as necessary;

6. Implementation and operation of the ombudsman volunteer program.

C. Each program shall maintain the confidentiality of client identity and client records in accordance with policies issued by the SLTCO.

D. Each program shall work to prevent elder abuse, neglect and exploitation by conducting professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.

E. Each program shall participate in coordinated, collaborative approaches to prevent elder abuse, neglect and exploitation which shall include the participation of, at a minimum, adult protective services staff or local Department of Human Services, long-term care ombudsman/advocacy programs, and legal assistance programs operating in the project service area.

F. Each program shall operate in compliance with Long-Term Care Ombudsman program instructions, issued by the SLTCO, as required by federal and state authorizing legislation and federal ombudsman program regulations.

G. Each AAA shall maintain a financial management system that fully and accurately tracks, and accounts for the use of, all funds received or allocated for Long Term Care Ombudsmen services.

H. Each AAA or subcontractor providing ombudsmen services shall comply with Long Term Care Ombudsman/Advocacy Operating Standards and SLTCO program policy standards.

II. Each program must provide the following elements:

A. Consultation/Family Support

1. Provision of assistance to older adults and their families in understanding, identifying, locating, evaluation, and/or obtaining long term care services.

B. Investigation/Advocacy

1. Receipt, investigation, verification and attempted resolution of individual complaints from resident or others acting on their behalf regarding any action which may adversely affect the health, safety, welfare and rights of a long-term care facility resident.

2. Complaint resolution processes include negotiation, mediation, and conflict resolution skills.

3. This component also includes activities related to identifying obstacles and deficiencies in long-term care delivery systems and developing recommendations for addressing identified problems.

C. Non-Complaint Related Facility Visits

1. Quarterly visits to each long-term care facility in the project area. More frequent visits may occur where problems exist.

D. Community Education

1. Provision of information to the public including long-term care facility residents, regarding all aspects of the long-term care system elder abuse, neglect and exploitation.

2. This component includes formal presentations, licensed facility and agency consultation, activities with the print and electronic media, development of consumer information materials.

E. Volunteer Support

1. Conduct of recruitment, training, supervision, and ongoing support activities related to volunteer advocates assigned to assist residents of identified long-term care facilities.

2. Ombudsman/Advocates act as spokespersons for residents in voicing concerns to appropriate staff members/officials of a facility, and to social and regulatory agencies, and to follow up to ensure action is taken.

3. This element may include support to families, residents, or prospective residents of long-term care facilities.

F. Education provides information and/or training on long-term care issues.

G. A client is one current resident or prospective of a long-term care facility, age 60 or over, who receives assistance or information or on whose behalf information/assistance is furnished.

H. At the minimum, a case file must be established and an intake form completed in order to count an eligible individual as a client under the Region VII AAA's contract.

1. A client may be counted only once during the contract year.

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

III. Scope of Service

A. Geographical Considerations

1. Each program shall be capable of providing assistance to residents at each long-term care facility in the service target area.

2. Service Provider shall publicize information about the availability and nature of the service throughout the service area. Planned publicity activities using media promotion and direct mail approaches shall be undertaken at least once each quarter.

B. Allowable Tasks & Activities

1. Complaint resolution through facility staff and/or officials

2. Complaint resolution through social and regulatory agencies

3. Follow-up to ensure action is taken

4. Provision of information on long-term care facilities to residents, families, or prospective residents

5. Provision of information on rules appropriate to long-term care settings

6. Education on resident rights

7. Education and/or training on long-term care issues

8. Referrals to community resources

C. Coordination

1. Service Providers must develop and maintain an effective working relationships with the following agencies:

    a. State and local law enforcement agencies

    b. Courts of competent jurisdiction

    c. Local nursing home closure team for their area as designated by the Department of Community Health, Bureau of Health Systems

    d. Local offices of the Department of Human Services, and local county public health agencies

    e. ACLS Bureau funded Care Management

    f. Michigan Department of Community Health Home and Community Based Waiver services and community transition services operating in the project service area including knowledge of the referral and intake process.

2. Working relationships shall be demonstrated through current written agreements, case records, or activity log documentation.

3. Service Providers must establish linkages with local CCS Providers and Care Management programs, if available within the service area.

4. Each program must establish linkage with Legal Assistance and Medicare/Medicaid Assistance Programs (MMAP) operating in the project

service area and be able to assist clients in gaining access to available services, as necessary.

IV. Record-Keeping Requirements

A. Activity Log

1. Format

a. Long-Term Care Ombudsman direct service staff must maintain a daily activity log for the purpose of verifying units reported to Area Agency.

b. The format shall include, at the minimum, a column for recording time spent performing Advocacy/Complaint Resolution, a column for recording time spent in Education activities, and a column for describing the specific activity.

2. Minimum Entry

a. 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).

b. Example: If direct service staff members complete 10 6-minute telephone calls to clients for the purpose of follow-up, the activity log entry should be described as “Telephone Contacts - Client follow-up."

c. One (1) hour should be indicated in the “Advocacy/Complaint Resolution" column, and each client contacted should be listed in the client column to facilitate transfer of the contact into the individual client file.

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

3. Use of Activity Log

a. For any given month, the total Long-Term Care Ombudsman units reported to the Region VII AAA shall be comprised of the sum of direct service staff hours recorded on the activity log as “Advocacy/Complaint Resolution"

b. The direct service staff hours are recorded as "Education" activity.

c. Time recorded in an "Administrative" column must not be included in the tally of units reported to the Region VII AAA.

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

e. Client-specific activity recorded in the activity log will be transferred into individual Clients' file.

B. Client Files

1. A Client or case file must be established in order to count an individual as a Client under the Region VII AAA contract.

    a. At the minimum, the case file must include a completed and dated intake form with the required basic information, and progress notes.

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

3. The Service Provider must use a standardized signed release of information form that is time-limited and specific as to the information released.

4. Ombudsmen shall maintain the confidentiality of residents' and complainants' identity and program records of ombudsman service provision in accordance with policies issued by the SLTCO.

V. Staffing

A. Supervision

1. Each Service Provider must establish a support system to supervise direct service staff or volunteers visiting long-term care facilities.

2. Direct service staff/volunteers shall have at least monthly telephone or in-person contact with supervisory personnel.

B. Training

1. Long-Term Care Ombudsman staff must receive quarterly in-service training on long-term care issues.

2. Program staff must receive training on the following topics:

    a. common characteristics, conditions and treatments of long term care residents

    b. Long term care facility operations

    c. Long term care facility licensing and certification requirements

    d. Titles XVIII and XIX of the Social Security Act

    e. Investigating

    f. Culture change

    g. Michigan Public Health Code

    h. Medicare and Medicaid

    i. Interviewing skills

    j. Mediating skills

    k. Negotiating skills

    l. Management of volunteer program, and

    m. Other areas as designated by the SLTCO

3. Ombudsmen shall be knowledgeable of resources and information related to appeals, legal assistance, and other potential remedies and be able to assist residents with referrals to available services, as requested by the resident. These services and programs may include but are not limited to

    a. legal services agencies
    b. local law enforcement
    c. the state survey agency
    d. Medicaid fair hearing office
    e. Medicaid functional and financial eligibility
    f. local health department
    g. Michigan Medicare Assistance Program (MMAP)
    h. Medicare appeal and complaint resolution services
    i. Adult Protective Services
    j. Attorney General Healthcare Fraud Unit.

4. Ombudsman candidates must complete initial designation training and mentoring in accordance with program policies issued by the SLTCO. Following initial designation, ombudsmen must complete 18 hours of continuing education per federal fiscal year by attending training or case consultation calls hosted by the SLTCO, participating in webinars and other training on long term care topics. In addition, volunteer ombudsmen may report mentoring and case consultation time with the paid ombudsman as continuing education hours.

5. Program staff must be familiar with the complaint resolution processes of the Michigan Department of Community Health's Bureau of Health Systems; the Department of Human Services, Bureau of Child and Adult Licensing; MPRO; and the Michigan Office of the Attorney General's Health Care Fraud Unit.

i. All staff training must be documented in the individual employee's personnel file.

VOLUME III: Specific Service Requirements

POLICY NAME: Senior Center Operations C-12

PURPOSE: This policy sets forth the definitions, procedures, and policy positions of Region VII AAA with respect to the ACLS Bureau Standards for Senior Center Operations

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of support for the operation of a senior center. A senior center is defined as a community facility where older persons can come together for services and activities which enhance their dignity, support their independence, and encourage their involvement in and with the community.

UNIT OF SERVICE: One hour of senior center operation.

I. Minimum Standards

A. Senior Center Operations Client

1. A Client served under Senior Center Operations may be counted only once during the contract period for reporting purposes.

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

3. A completed intake form or card must be on file for each reported Client.

II. Limitations on Senior Center Operations Funding

A. Allowable senior center operational costs are limited to:

1. Rent

2. Utilities

3. Communications

4. Insurance

5. Custodial Services

6. Ground Maintenance

7. Supplies

B. Region VII AAA Senior Center Operations funds cannot be used to displace other local resources used to finance Senior Center Operations.

III. Specific Requirements for Senior Centers

A. Service Provider Information

1. If the center is part of a larger organization or governmental unit, the Service provider must be duly incorporated, with incorporation papers filed with the State of Michigan as required, and must have written, approved by-laws that govern the organization and set forth its purpose and responsibilities.

2. If the umbrella organization applies for Senior Center Operations funds and is approved for funding, it is responsible for any liabilities resulting from the Senior Center Operations contract.

3. Any center that makes direct application to the Region VII AAA for Senior Center Operations funds must have filed incorporation papers with the State of Michigan and must be governed by written, approved by-laws that state the center's purpose and responsibilities.

4. Each senior center shall be appropriately incorporated under Michigan law or be operated by an organization which is appropriately incorporated, or a local unit of government. Each senior center should seek 501 (c) (3) tax exemption unless prohibited by the nature of its incorporation.

5. Each senior center shall strive to adhere to the Principles for the Operation of Senior Centers as established by the National Institute of Senior Centers.

6. If the center is approved for funding, it is responsible for any liability resulting from the Senior Center Operations contract.

B. Personnel Policies/fiscal Management Special Requirement

1. When the center is part of a larger umbrella organization, the umbrella agency is responsible for the development and use of personnel policies and fiscal management procedures, as outlined in the General Administrative Procedures.
2. If the center is an autonomous organization, it is directly responsible for the development and use of policies and procedures to meet the requirements of the Region VII AAA.

C. Client Input

1. Representation of senior center clients must be established through councils or other bodies utilized to govern the senior center.

    a. Each senior center shall provide an opportunity for center clients to have input regarding the governance of the center at the policy making level as well as in daily operations.

    b. At a minimum, an Advisory Council must be utilized to allow regular input from senior clients.

2. A written center assessment must be completed on an annual basis.

3. The center assessment shall provide opportunities for client input through one or more of the following methods:

    a. Questionnaire distributed to clients

    b. Suggestion box at the center

    c. Advisory Council review of center activities

D. Facility and Program Requirements

1. Each senior center must be certified as an accessible facility.

    a. Accessibility is defined as the ability of a person with a disability to enter the facility, use the restroom, and receive service that is at least equal in quality to that provided to able-bodied clients.

2. Each senior center shall be open a minimum of three (3) days per week and at least twenty-four (24) hours per week.

3. The size and layout of the center should be adequate to accommodate the number of clients and the programming needs.

4. Each senior center shall be a meal site for a congregate nutrition program funded through Title III, Part C, of the Older Americans Act.

5. Each senior center shall provide directly or make arrangements for the provision of the following services:
    a. Outreach

    b. Information and assistance

    c. Socialization/recreation

    d. Education

    e. Volunteer opportunities

    It is not required that such service provision be reported to ACLS Bureau

6. Each senior center must demonstrate that it is in compliance with fire safety standards and applicable Michigan and local public health codes regulating food service establishments.

7. Each senior center shall document that appropriate preparation has taken place for procedures to be followed in case of an emergency, including:

    a. An annual fire drill

    b. Posting and training of staff and regular volunteers on procedures to be followed in the event of severe weather or a natural disaster

    c. Posting and training of staff and regular volunteers on procedures to be followed in the event of a medical emergency.

IV. Senior Center Procedures

A. Client Intake

1. Each senior center must use a uniform intake process.

2. An intake form or card must be completed and maintained for each individual reported to the Region VII AAA as a Senior Center Operations Client.

3. The intake form need not be completed until after the individual's third visit to the center.

4. The intake form must contain the following minimum information:

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

    b. Individuals date of birth and age

    c. Gender (optional)

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

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

    f. Special dietary needs

    g. Race and/or ethnicity

    h. Whether or not the individual's income is below the poverty level and/or sources of income

    i. Individual interests or skills

    j. Service needs expressed by individual

    k. Signature of individual and date

5. The intake form or card must be signed and dated by the Client in order to verify that service was received during the contract year.

6. At the start of a new contract year, the information on the intake form card must be updated and a new Client signature and date obtained.

7. Completion of the Client intake form may not be a prerequisite to eligibility for any service and may not be presented to potential clients as a requirement for attendance.

8. If clients do not wish to answer one or more sections, mark the intake form "N/A" in the appropriate space.

9. Only one Client intake form needs to be maintained for congregate meal clients or Senior Center Staffing Clients who are also reported to the Region VII AAA as Clients for Senior Center Operations.

B. Center Calendar

1. A calendar of monthly activities must be posted at the center.

2. The schedule of activities planned at the center shall be publicized at least on a monthly basis.

3. Copies of senior center program plans must be kept on file.

C. Program Income

1. The collection of program income for Senior Center Operations must be separate and distinct from the collection of program income for other service programs provided at the center.

2. The program income requirements discussed under General Administrative Procedures also apply.

VOLUME III: Specific Service Requirements

POLICY NAME: Senior Center Staffing C-13

PURPOSE: This policy outlines the definitions, procedures, and policy positions of Region VII AAA with respect to The ACLS Bureau Standards for Senior Center Staffing.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of funding to support staff positions at a senior center which may include a senior center director, a senior center program coordinator or a senior center specialist.

UNIT OF SERVICE: One hour of staff time worked

I. Senior Center Staffing

A. Only the following positions may be financed with Senior Center Staffing funds.

1. Senior Center Director

a. A person occupying this position must have the authority to perform the administrative functions of the senior center such as accountable for personnel, funds, and services provided to seniors under the auspices of the senior center.

2. Senior Center Program Coordinator

a. A person occupying this position must be responsible for the continuing development and implementation of three or more senior center programs at any given time.

b. Tasks will include such things as assessing needs of center clients and seniors in the geographic area of the center, seeking out the appropriate resources people, funds, and facilities to meet the needs identified and evaluating the impact of the program initiatives to meet the needs.

c. This position need not be restricted to one facility.

3. Senior Center Specialist

a. A person occupying this position must be responsible for overseeing the operation of a variety of programs and services within the senior center.

B. Senior Center Staffing Client

1. A Client served by the Senior Center Staffing person may be counted only once during the contract period for reporting purposes.

2. Because a Client is counted once, only the unduplicated count of Clients served are reported to Region VII AAA.

3. A completed intake form or card must be on file for each reported Client.

II. Allowable Senior Center Staffing Cost

A. The allowable line item expenditures for Senior Center Staffing are limited to:

1. Wages for this position

2. Fringe benefits for the position

3. Travel costs for the position

4. Training costs for the position

5. Supplies not to exceed $200 per year for the position and to be used only in support of the position

B. Region VII AAA Senior Center Staffing funds cannot be used to displace other funds currently or previously used to finance a Senior Center Staffing position.

III. Specific Requirements for Senior Center Staffing Placement

A. Service Provider Incorporation

1. If the center is part of a larger organization or governmental unit the service provider must be duly incorporated with incorporation papers filed with the State of Michigan as required and must have written approved by-laws that govern the organization and set forth its purpose and responsibilities.
2. If the umbrella organization applies for Senior Center Staffing funds and is approved for funding, it is responsible for any liabilities resulting from the Senior Center Staffing contract.

3. Any center that makes direct application to the Region VII AAA for Senior Center Staffing funds must have filed incorporation papers with the State of Michigan and must be governed by written, approved by-laws that state the center's purpose and responsibilities.

4. The center must apply for exemption from Federal taxes as a 501(c) (3) organization.

5. If the center is approved for funding, it is responsible for any liability resulting from the Senior Center Staffing Contract.

B. Personnel Policies/Fiscal Management Special Requirement

1. When the center is part of a larger umbrella organization, the umbrella agency is responsible for the development and use of personnel policies and fiscal management procedures as outlined in the General Administrative Procedures.

2. If the center is an autonomous organization, it is directly responsible for the development and use of policies and procedures to meet the requirements of the Region VII AAA.

C. Client Input

1. In addition to the requirements outlined in the Program Evaluation Policy of Chapter 1 General Administrative Procedures, Senior Center Staffing programs must assure the following:

a. Representation of senior center clients must be established through councils or other bodies utilized to govern the senior center.

b. Representation must client and have input in policy-making functions and management of daily center operations.

c. At a minimum, an Advisory Council must be utilized to allow regular input from senior clients.

d. A written center assessment must be completed on an annual basis.

e. Written center assessment shall provide opportunities for client input through one or more of the following methods:

f. Questionnaire distributed to clients

g. Suggestion box at the center

h. Advisory Council review of center activities

D. Facility and Program Requirements

1. The senior center must be certified as an accessible facility.

2. The senior center must be open a minimum of three (3) days per week and at least twenty-four (24) hours per week.

3. The size and layout of the center should be adequate to accommodate the number of clients and the programming needs.

4. The senior center must be a congregate nutrition program meal site.

5. The senior center shall provide directly or make arrangements for the provision of the following services:

   a. Outreach

   b. Information and referral

   c. Socialization or recreation

   d. Education

   e. Volunteer opportunities

6. The senior center must demonstrate compliance with fire safety standards and applicable state and local public health codes regulating food service establishments.

7. The senior center must document that preparation has taken place for procedures to be followed, including:

   a. An annual fire drill

   b. Posting and training of staff and volunteers on procedures to be followed in severe weather or a natural disaster

   c. Posting and training of staff and volunteers on medical emergency procedures

E. Senior Center Staffing Procedures

1. An intake form or card must be completed for each individual reported to the Region VII AAA as a Senior Center Staffing Client.

2. The intake form need not be completed until after an individual's third visit to the center.

3. The intake form must contain the following minimum information:

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

    b. Individual's date of birth and age

    c. Gender (optional)

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

    e. physicians' name, address, and telephone number

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

    g. Special dietary needs

    h. Race and/or ethnicity

    i. Whether or not the individual's income is below the poverty level and/or sources of income

    j. Individual interests or skills

    k. Service needs expressed by individual

    l. Signature of individual and date

4. The intake form or card must be signed and dated by the Client in order to verify that service was received during the contract year.

5. At the start of a new contract year, the information on the intake form/card must be updated, and a new Client signature and date obtained.

6. Completion of the Client intake form may not be a prerequisite to eligibility for any service and may not be presented to potential clients as such.

    a. If clients do not wish to answer one or more sections, mark the intake form "N/A" in the appropriate space.

7. Only one Client intake form needs to be maintained for Congregate Meal clients or Senior Center Operations Clients who are also reported to the Region VII AAA as Clients for Senior Center Staffing.

F. Center Calendar

1. A calendar of monthly activities must be posted at the center.

2. The schedule of activities planned at the center shall be publicized at least on a monthly basis. Copies of senior center program plans must be kept on file.

G. Program Income

1. The collection of program income for Senior Center Staffing must be separate and distinct from the collection of program income for other service programs provided at the center.

IV. Nine Principles for the Operation of Senior Centers

A. Senior Center Staffing programs will adhere to the operation principles established by the National Institute of Senior Centers

B. Nine Principles for the Operation of Senior Centers

1. A senior center shall have a written statement of its purposes consistent with the senior center philosophy, and a written statement of its goals based on its purposes and on the needs and interests of older people in its service area. These statements shall be used to govern the character and direction of its operation and program.

2. A senior center shall be organized to create effective relationships among the clients, staff, governing body, and the community in order to achieve its purposes and goals.

3. A senior center shall form cooperative arrangements with community agencies and organizations in order to serve as a focal point for older people to obtain access to comprehensive services. A center shall be a source of

services designed to respond to the interrelated needs and interests of older people in its service area.

4. A senior center shall provide a broad range of group and individual activities.

5. A senior center shall have clear administrative and personnel policies and procedures that contribute to the effective management of its operation. It shall be staffed by qualified, paid, and volunteer personnel capable of implementing its program.

6. A senior center shall practice sound fiscal planning, management, record keeping, and reporting.

7. A senior center shall keep complete records required to operate, plan and review its program. It shall regularly prepare and circulate reports to inform its board, its clients, staff, sponsors, funders, and the public about its operation and program.

8. A senior center shall make use of appropriate facilities for its program. Such facilities shall be designed, located, constructed, or renovated and equipped to promote effective access to and conduct of its program and to provide for the health, safety, and comfort of clients, staff, and public.

9. A senior center shall have adequate arrangements to monitor, evaluate and report on its operations and program.

VOLUME III: Specific Service Requirements

POLICY NAME: Vision Services C-14

PURPOSE: To provide specialized vision services for the visually impaired and older blind persons

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Provision of specialized vision services for the visually impaired and older blind persons which include:

- orientation and mobility training
- rehabilitation for activities of daily living (ADL)*
- optometric services to help persons with severe vision loss to utilize remaining vision as effectively as possible
- group education on prevention of or adjustment to visual impairment

*ADL includes personal hygiene and grooming, meal preparation and kitchen safety, homemaking, and leisure pursuits.

UNIT OF SERVICE: One hour of service provided or one group education session.

XVI. Minimum Standards

A. Program staff providing rehabilitation training shall have experience and be trained in communication skills including Braille, typing, handwriting, use of recording devices, telephone dialing, manual alphabet, and other appropriate skills.

B. Program staff providing orientation and mobility training shall have experience and be trained in techniques, methods, and use of travel aids to visually impaired clients.

C. Optometric services shall be provided by an optometrist that has graduated from an accredited College of Optometry and is licensed to practice optometry in Michigan.

D. The program shall have a coordinator with a minimum of a bachelor's degree in Blind Rehabilitation, Occupational Therapy, Rehabilitation Teaching, or a related field.

E. Each vision services program shall demonstrate working relationships with other local agencies and organizations offering programs for the blind and with the Commission for the Blind of the Michigan Department of Human Services.

VOLUME III: Specific Service Requirements

POLICY NAME: Prevention of Elder Abuse, Neglect, and Exploitation C-15

PURPOSE: The purpose of this policy is to establish uniform procedures for providing an interactive and unbiased program to help prevent elder abuse, neglect, and exploitation.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation

UNIT OF SERVICE: One hour of contact with organizations to develop coordinated, comprehensive services for the target population. In addition to contact with other aging subcontract organizations, elder abuse subcontract agencies shall count contact with the Department of Human Services, Adult Protective Services, law enforcement, health care professionals, community mental health, and other relevant service entities when the reason for the contact is to meet the above service definition.

XVII. Minimum Standards

A. Professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.

B. The coordinated, comprehensive approaches to prevent elder abuse, neglect, and exploitation shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long-term care ombudsman/advocacy programs, and legal assistance programs operating in the service area.

VOLUME III: Specific Service Requirements

POLICY NAME: Counseling Services C-16

PURPOSE: The purpose of this policy is to establish uniform procedures for providing an interactive and unbiased program to help caregivers to prevent or treat problems related to psychological issues.

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: Professional counseling services provided to older adults, and National Family Caregiver Support Program (NFCSP) eligible caregivers, in order to prevent or treat problems which may be related to psychological and/or psychosocial dysfunction.

The program may also establish peer-counseling programs that utilize older adults as volunteer counselors.

UNIT OF SERVICE: Each hour of counseling services (including direct client contact and indirect client support). (Indirect client support means information gathering, maintenance of case records, and supervisory consultation on behalf of the client.)

XVIII. Minimum Standards

A. Each program shall conduct a comprehensive assessment of each client which addresses social and psychological function.

B. A treatment plan shall be developed for each client based on the comprehensive assessment. The treatment plan shall be developed in cooperation with and be approved by the client, and/or the client's guardian or designated representative. The treatment plan shall contain at a minimum:

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

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

3. A description of the methods and/or approaches to be used.

4. Identification of services to be obtained/provided from other community agencies.

5. Treatment orders of qualified health professionals, when applicable.

C. Each program shall have a written policy and procedure to govern the development, implementation, and management of treatment plans.
D. The program may provide individual, family and/or group counseling sessions. Family members of clients are eligible for family counseling when appropriate to resolve the problems of the client.

E. The program shall have the flexibility to provide services in a range of settings, appropriate to the client's needs.

F. Paid staff counselors must have appropriate education and experience and be licensed to practice in the State of Michigan.

G. The program may utilize volunteer peer counselors who area appropriately trained and supervised by paid program staff.

H. The program shall assure that case supervision is available on a weekly basis for each staff counselor. All open cases shall undergo a quarterly case review by the respective staff counselor and appropriate supervisory staff.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Caregiver Supplemental Services C-18
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	A program intended to provide goods and services to support caregivers (including kinship caregivers) in response to needs that cannot otherwise be met.
UNIT OF SERVICE:	One good or service purchased.

I. Minimum Standards

A. Each program must maintain linkage with caregiver focal points, as available, within the PSA

B. Programs may offer Caregiver Supplemental Services to caregivers of any age when the care recipient is aged 60 or over and is unable to perform at least two activities of daily living or requires substantial supervision due to a cognitive or other mental impairment.

C. Programs may offer Caregiver Supplemental Services to individuals aged 55 and over who are kinship caregivers.

D. Payments directly to family caregivers are not permitted.

E. Reimbursement for allowable expenses may be made with proof of purchase.

F. Each program, in targeting services, shall give priority to geographic areas in which there are a significant number of older individuals who have the greatest economic and/or social need for such services.

G. Programs may offer Caregiver Supplemental Services to the following:

1. Caregivers 60 or older who care for a recipient 60 or older

2. Caregivers 60 or older who care for a recipient under 60

3. Caregivers under 60 who care for a recipient 60 or older

4. Individuals 55 and older who are kinship caregivers for a child no more than 18 years old may be provided with Caregiver Supplemental Services.

H. The program may not provide a service otherwise available under the approved area plan.

I. For supplemental services the Client is the caregiver

J. A caregiver must live within the Region VII AAA planning and service area.

II. Requirements

A. Caregiver Supplemental Services provides for one time funding per Client per fiscal year.

1. Repeated request in following years will be reviewed and given priority based on available funding, timely need, and the category of the need such as home assistance or financial help.

B. Supplemental funds will only cover material for ramp building up to $500.

C. All other funding sources must be attempted prior to accessing supplemental funds.

D. Intake

1. Service Providers may request Caregiver Supplemental Services by filling out a Region VII AAA Request Form and NAPIS form.

2. Service Providers must have authorization from Region VII AAA before purchasing any Caregiver Supplemental Service.

3. Service Providers will be paid directly by Region VII AAA after the service is provided and a bill submitted.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Kinship Support Services C-19 **FOR FY2024 ONLY**
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Provision of support services (which include respite care supplemental and education, support, and training services) in kinship care situations where an individual aged 55 or over is the primary caregiver for a child no more than 18 years old. Kinship support services may be provided at locations other than the client's residence.
UNIT OF SERVICE:	Each hour of support services provided, or each activity session, as appropriate.

Minimum Standards

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

    a) That the child must require support services as a result of the kinship care relationship

    b) That the kinship caregiver must be a grandparent or relative caregiver who has a legal relationship to the child or is raising the child informally.

2. Each program shall conduct an evaluation of the care giving situation to ensure that the skills and training of the respite care worker to be assigned coincides with the situation.

    a) The program may utilize volunteer respite care workers.

3. Each program must develop and maintain procedures to protect the safety and wellbeing of the children being served by the program.

4. An emergency notification plan shall be developed for each care recipient and respective caregiver.

5. Supervision must be available to program staff at all times.

6. Support Services

a) Service Providers can provide one or more of the following programs:

1. Kinship respite care services

a. Services may be provided at locations other than the Client's residence.

2. Health Care

3. Kinship support group meetings

4. Parenting classes

5. Legal assistance

6. Tutoring and mentoring programs for children

7. Social events

8. Day care

9. After school programs

10. Enrolling grandchildren in school

11. Budgeting and money management programs

12. Kinship care hot line connecting to other providers

13. Supplemental education, support, and training

14. Newsletters

15. Counseling

b) Funding for any program must be pre-approved by Region VII AAA before the service begins.

c) If a service listed above is currently being provided by other programs, kinship funds can be used to expand the existing program.

7. Component Functions

a) Service Providers will identify the needs of the kinship recipient and the child and determine how to address those needs.

b) Kinship support programs will provide personal attention and assistance to special and exceptional needs.

c) Service Providers will develop programs or ways of meeting the unmet needs of the kinship Client.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Kinship Support Services C-19 **FOR FY2025 ONLY**
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Provision of any caregiver service(s) for Kinship Caregivers as described in #2 below
UNIT OF SERVICE:	Determined by Service Delivered

Minimum Standards

1. Kinship Caregivers must meet one of the following criteria (as defined in the Older Americans Act Section 372 (a) (4)):
    a. Individuals age 55 and older who live with and are the primary caregiver for children not more than 18 years of age
    b. Relatives, including parents, age 55 and older who live with and are the primary caregiver for adults aged 18-59 with disabilities
2. The following services may be provided:
    a. Caregiver Information and Assistance
    b. Caregiver Support Groups
    c. Caregiver Training
    d. Caregiver Education
    e. Caregiver Outreach
    f. Respite Care
    g. Caregiver Supplemental Services
    h. Caregiver Counseling Services
    i. Caregiver Case Management

VOLUME III:	Specific Service Requirements
POLICY NAME:	Caregiver Education C-21 FOR **FY2025 ONLY**
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	Contacts with a group of older adults, their caregivers, or the general public to inform them of caregiver services or resources available within their communities. Examples include but are not limited to, health fairs, publications, newsletters, brochures, caregiver conferences, publicity or mass media campaigns, and other similar informational activities. These activities are directed at groups and large audiences of caregivers.
UNIT OF SERVICE:	Activity

Minimum Standards:

1. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate in education programs. Respite care may be provided to enable caregiver participation, as an additional service, in conjunction with caregiver education programs.

2. Program leaders shall be educated in topics being presented.

3. Caregiver education activities may be provided in community settings, virtually, or on-line through self- guided programs.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Caregiver Training C-22 FOR **FY2025 ONLY**
PURPOSE:	The purpose of this section is to establish uniform minimum requirements for service delivery under the Area Plan.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	A service that provides instruction to improve knowledge and performance of specific skills relating to caregiving roles and responsibilities. Skills may include, but are not limited to, activities related to health, nutrition, financial management, personal care, and/or communication.
UNIT OF SERVICE:	One hour of training

Minimum Standards:

1. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate in training programs. Respite care may be provided to enable caregiver participation, as an additional service, in conjunction with caregiver training programs.

2. Program leaders shall be educated in caregiver training topics being presented.

3. Services may be provided in the community, in-home settings and/or virtually.

VOLUME III:	Specific Service Requirements
POLICY NAME:	Caregiver Support Groups C-23 **FOR FY2025 ONLY**
PURPOSE:	A program intended to provide assistance to caregivers in understanding and coping with a broad range of issues associated with caregiving. Allowable information may include initiatives that provide support activities for caregivers. (support groups, counseling, and information and assistance in connecting with community resources).
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	A Service that is led by a trained individual, moderator, or professional, to facilitate discussions on common experiences, concerns of caregivers, and to develop a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the phone, or online.
UNIT OF SERVICE:	Session

I. Minimum Standards

A. Each program must maintain linkage with community focal points, and respite care programs, as available, in the planning and service area to help facilitate opportunities for caregivers to participate group support programs. Respite care may be provided to enable caregiver participation, as an additional service, in conjunction with caregiver support programs.

B. Program leaders shall be educated in caregiver support.

C. Services may be provided in community settings and/or virtually.

II. Eligibility

A. Priority must be given to older individuals in the greatest social and economic need and those individuals caring for someone with mental retardation and/or developmental disabilities.

1. Caregivers 60 or older who care for Care Recipient 60 or older

2. Caregivers 60 or older who care for a recipient under 60
3. Caregivers under 60 who care for a recipient 60 or older.

III. Intake

A. This program shall have a uniform intake procedure that identifies and documents Client needs.

IV. Staffing Requirements

A. Staff will understand the needs and aspects of the caregiver support group program.

B. Each program shall employ staff who are appropriately licensed, certified, trained, oriented, and supervised.

C. Program leaders shall be educated in caregiver training topics being presented.

1. Continuing education of staff in specific service areas is encouraged.

VOLUME III: Specific Service Requirements

POLICY NAME: Caregiver Case Management (CCM) C-24

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

AUTHORITY: Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs

DEFINITION: A service provided for a caregiver that assesses needs, and arranges, coordinates, and monitors services to meet the individual needs of the caregiver.

UNIT OF SERVICE: Hour

Minimum Standards:

1. Caregiver Case Management (CCM) functions shall be carried out by an individual who has a bachelor's degree in a human service field or who has experience and training to effectively determine a caregiver's needs and match those needs with appropriate services.
2. Each CCM program must have uniform intake procedures and maintain consistent records for each potential participant shall include:
    a. Name, address and telephone number
    b. Date of birth
    c. Emergency contact information, if applicable
    d. Race and ethnicity
    e. Gender identity (optional)
    f. Sexual orientation (optional)
    g. Communication support needs, if applicable
    h. Physician's name, address, and telephone number
    i. Pharmacy name, address, and telephone number
    j. Informal Support system- family/ friends
    k. Hospitalization history
    l. Medical/health insurance available
    m. Clergy name, address, and phone number, if applicable
3. Following the intake process, an initial assessment shall include as much of the following information as possible:
    a. Participant information gathered at intake
    b. Current status of physical and mental health
        i. Vision, hearing, speech, oral status, prosthesis, Psychosocial functioning
        ii. Limitations in activities of daily living
        iii. History of chronic or acute illnesses

iv. Eating patterns or diet history
v. Prescriptions, medications, and other physicians orders

c. Needs of the caregiver
    i. Caregiver perceived needs
    ii. Assessor's perceived needs
d. Statement of strengths and challenges
e. Existing resources
    i. Physician, family/extended family, services currently receiving or received in the past, medical/ health insurance available, clergy, etc.

4. A service plan shall be developed with the caregiver to coordinate the formal and informal resources and services to meet the identified needs of the caregiver. Each plan shall include:
    a. Statement of goals and objectives and interventions utilized for meeting identified needs.
        i. The caregiver's satisfaction with services received
        ii. The caregiver's satisfaction with program staff performance
        iii. The caregiver's satisfaction with the consistency of services provided.
    b. Description of identified resources and supports.
    c. Description of interventions and services used to address the caregiver's identified needs.
        i. When caregiver appears to be in need of and eligible for additional benefits and services, a referral should be made to the appropriate resource.
        ii. The caregiver must first give consent to the referral.
5. Each caregiver shall be reassessed yearly, or as needed, to evaluate service plan implementation. At minimum, monitoring contacts shall be attempted 90 days following the initial assessment, and ongoing monitoring contacts shall be attempted every 180 days thereafter.
    a. Consents and Release of Information
        i. The Consents and Release of Information must be time-limited, not to exceed one year from the signature date, be service specific, and specific as to information for release.
    b. Reassessment
        i. Reassessments are to determine change in the caregiver's status, client satisfaction, and the results of implementing the service plan.
        ii. Reassessments 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 should be noted on the assessment form.
            b. When the initial assessment indicates that the caregiver should be reassessed before six months, a determination of when reassessment should take place must be noted.
        iii. Reassessments must include a review of all required initial assessment items.

iv. When a reassessment determine the caregiver's identified needs have been adequately addressed or the caregiver's have been completed, the case should be closed.

c. Telephone Monitoring
    i. Case managers will ensure that a telephone contact is made to the caregiver at least monthly to monitor changes in the caregiver's circumstances and the continued need for services.
    ii. Telephone monitoring contact and outcome must be documented in the caregiver's file.
    iii. Telephone monitoring contacts and in-home personnel reports shall be used to determine if the reassessment must be conducted prior to the scheduled date.
d. Caregiver Service Plan
    i. A service plan must be developed in cooperation with and be approved by the caregiver.
    ii. The service plan must contain at a minimum the following:
        a. A statement of the caregiver's problems, needs, strength, and resources.
        b. Statement of the goals and objectives for meeting identified needs.
        c. Description of methods and/or approaches to be used in addressing needs.
        d. Identification of services and the frequency at which they are to be provided.
        e. Treatment orders of qualified health professionals, when applicable, such as a physician order for special diets.
        f. Dates that the service plan was reviewed with the caregiver.
e. Written policy and procedures
    i. Each provider must have a written policy and procedure for the development, implementation, and management of the service plans that includes, at a minimum, the following requirements:
        a. Service plans for caregivers must be updated and evaluated at all caregiver reassessments.
        b. 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. Written notations of such changes must be dated.
        c. 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.
        d. 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.

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

f. Caregiver Records
    i. CCM programs must maintain comprehensive and complete individual records.
g. All caregiver files must be kept confidential in controlled access files.
h. The individual caregiver record must contain, at a minimum, the following information:
    i. Details of the Caregiver's referral to the CCM program.
    ii. Completed intake and assessment forms.
    iii. Completed reassessment forms.
    iv. Service plan with updates and any notation of any revisions.
    v. Listing of all chronological and cumulative case notes.
    vi. Record of all releases of information about the caregiver 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.
    vii. Physician's orders for special modified diets.
i. Service providers must maintain chronological and cumulative case notes for each caregiver that include the following requirements:
    i. Dated, written entries
    ii. A column for the number of service units (Hour) for each contact
    iii. Details of the caregiver's referral to the program
    iv. Service plan reviews with the caregiver
    v. Documentation of assessment and reassessment visits
    vi. Documentation of any unusual circumstances or significant changes
    vii. Dated entry for other contacts such as telephone or correspondence with the caregiver, family, another agency, and/or the outcome of the contact
    viii. Notation of the purpose of the contact and the indication of the units (Hour)
    ix. Comments verifying caregiver's receipt of services from other providers and whether service adequately addressed caregiver's need
j. Each caregiver's file must be assigned status in one of the following categories:
    i. Open status- must be dated
        a. Initial referral
        b. Reassessment or inactive case
        c. Current activity in implementing a service plan
    ii. Closed status- must be dated
        a. Caregiver decides to discontinue service
        b. Caregiver's needs have been met

c. Another program o agency has assumed responsibility for the caregiver
d. Caregiver is unable to be served and referral of case is not possible
e. Caregiver or care recipient has died

6. 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.
7. Activity Log
    a. CCM direct service staff must maintain a daily activity log.
        i. Service staff time must be recorded and categorized as either:
            a. CCM Functions
            b. Other acceptable activities
            c. Other administrative activities
    b. CCM Functions
        i. Intake
        ii. Assessments
        iii. Reassessments
        iv. Development of service plan
        v. Monitoring of service plan through telephone contacts with caregiver provider agency
        vi. Arranging for service for a caregiver through identification of and communication with agencies and information supports such as family, church, or neighbors.
        vii. Evaluation of a service to a caregiver or a particular arrangement.
        viii. Transportation to or from a caregiver in conjunction with the above activities.
    c. Other Acceptable Activities
        i. Group presentations that are intended to locate or inform seniors of available services and opportunities.
        ii. Identifying and contacting isolated Older Adults
        iii. Assistance with completion of forms.
        iv. Distribution of food commodities.
        v. Information and referral.
    d. Other Administrative Activities
        i. Vacation and sick leave
        ii. Paid holidays
        iii. Breaks
        iv. Staff meetings
        v. Training, in-services not caregiver specific, seminars, or workshops

vi. Time spent preparing reports that are not caregiver related such as fiscal, board reports, time, or travel sheets.
vii. Time spent supervising the staff or volunteers
viii. Time spent performing non-CCM activities for another service program.
ix. Travel time in conjunction with the above.

e. Activity Log Minimum Entry
   i. Activities completed in less than 15 minutes should be grouped together so that a single entry on the log represents no less than ¼ hour= 0.25 (unit).
   ii. To facilitate unit tallying each entry should be made in multiples of ¼ hour= .25 (unit), such as 0.25, 0.50, 0.75, 1.0, 1.25).

f. Use of Activity Log for Reporting
   i. 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.
   ii. Time recorded in the Other Administrative column must not be included in the tally of CCS units report.
   iii. 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.
   iv. During the assessment, the Region VII AAA will verify reported CCS units through a review of the Activity Logs.

8. Staff Requirements
   a. Service providers shall employ case managers who have a minimum of a bachelor's degree in a human service field.
      i. 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.
      ii. 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. CCM staff must receive in-service training at least twice each fiscal year.
      i. 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.
      ii. An individualized in-service training plan should be developed for a staff person when performance evaluations indicate a need.
   c. Only one CCAM Coordinator may be currently assigned to each individual caregiver case.
9. 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.

10. Service providers are responsible for maintaining updated information on eligibility criteria and other application requirements for persons age 60 and older. CCM service components may be delivered in-person, telephonically, virtually, or hybrid.

VOLUME III:	Specific Service Requirements
POLICY:	Supplemental Nutrition Services C-25 **FOR FY2025 ONLY**
PURPOSE:	This policy outlines the definitions, and policy positions of Region VII AAA with respect to The ACLS Bureau Standards for Supplemental Nutrition Services.
AUTHORITY:	Bureau of Aging, Community Living, and Supports (ACLS Bureau) Operating Standards for Service Programs
DEFINITION:	A nutrition service provided that does not fall into the previously defined service categories (B-5) Home Delivered Meals, (B-12) Carry – out Meals, (C-3) Congregate Meals, (C-4) Nutrition Counseling, and (C-5) Nutrition Education.
UNIT OF SERVICE:	One good or service

I. Minimum Standards

A. The Supplemental Nutrition Services Operating Standard allows for additional nutrition services eligible participants that meets the purposes of the nutrition program as defined by the Older Americans Act (OAA).

B. Supplemental Nutrition Services may include, but are not limited to, oral nutrition supplements (ONS), groceries, food boxes, and meal kits.

1. These items are not considered prepared meals but rather supplemental nutrition support to existing nutrition services for individuals identified at high nutritional risk.

C. OAA funds may be used for the provision of Supplemental Nutrition Services provided that services comply with all relevant ACLS Bureau policies. Nutrition Services Incentive Program (NSIP) funds may not be used to pay for Supplemental Nutrition Services, as these do not constitute a meal.

D. Refer to the General Requirements for All Service Programs, the General Requirements for Nutrition Service Standards, and relevant nutrition operating standards for additional requirements.

VOLUME III: Specific Service Requirements

POLICY NAME: Slip/Fall/Safety Program

PURPOSE: Providing adaptations to the home environment of an older adult in order to prevent or minimize the occurrence of injuries.

Home injury control does not include any structural or restorative home repair, chore or homemaker activities. and to maintain safety in the home. The program does not include any structural or restorative home repair, chore, or homemaker activities.

AUTHORITY: Region VII AAA

I. Service Definition

A. Slip/Fall/Safety Program reduces the risk of fall-related injuries to the older adults and assists in providing a safe home.

B. Allowable tasks include installation or maintenance of:

1. Enhanced lighting
2. Ramps for improved and/or barrier-free access
3. Bathroom chairs and grab bars
4. Non-slip treatments
5. Vision or hearing adaptive devices
6. Stairway and/or hallway handrails
7. Smoke and/or gas alarms
8. Tub mats
9. Night-lights
10. Raised toilet seats with rails
11. Non-slip treatment for steps
12. Carbon monoxide detectors

13. Exit alarms

14. Security bolts

15. Locks
16. Outdoor security lights

17. Other items that can be identified as needed to prevent slipping/falling and to promote safety in the home.

II. Minimum Requirements Standards

A. Prior to initiating service, it must be each program must determine whether a potential Client is eligible to receive services available through a program supported by other funding sources, particularly programs funded through the Social Security Act.

1. When it is apparent If it appears that an individual cannot be served through other resources, an appropriate referral should be made.

B. Funds awarded for the program home injury control may be used to purchase materials and/or for labor costs and to purchase safety devices to be installed. used to complete the tasks that increase the safety of the individual.

1. The program must establish a limit on the amount to be spent on any one residence in a 12-month period.

2. Each program must seek contributions of labor and supplies from the private sector and volunteer organizations, as may be feasible.

3. Equipment or tools needed to perform home injury control tasks may be purchased or rented with grant funds up to an aggregate amount equal to 10% of total grant funds.

4. No more than $350 may be spent on materials and/or labor for any one household per fiscal year.

C. Develop a working relationship with chore, homemaker, home care assistance, and home repair service providers available within the program area to ensure effective coordination of efforts.

D. Utilize a home environment assessment tool to evaluate to formally evaluate the circumstances and needs of each Client.

E. The program may utilize the MI Choice assessment for initiating service if the Client is referred by either a care management or HCBS/ED program.

F. Maintain a record of safety improvements made at each residence including dates, tasks performed, materials used, and cost.

G. All safety devices installed must conform to local building codes and meet respective UL(R) safety standards.

H. Seek contributions of labor and supplies from the private sector and volunteer organizations, as may be feasible.

I. Service providers must receive prior authorization for the purchase of services by filling out a request form and submitting it to Region VII AAA on an approved form.

III. Eligibility

A. Care Management and CCS Clients 60 or older.

1. Priority must be given to eligible persons with the greatest social and/or economic need.

B. Caregivers

1. Caregivers 60 or older who care for care recipient 60 or older

2. Caregivers 60 or older who care for a recipient under 60

3. Caregivers under 60 who care for a recipient 60 or older

C. Region VII AAA Waiver Clients

1. 65 and older

2. 18 years of age or older and disabled

D. There will be no means testing.

IV. Intake Procedure

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

1. The intake process must document the Client's unmet need for program services.

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

    1. For every subsequent fiscal year the Client requests services, the service provider must re-establish the unmet need.

    2. The list of tasks to be performed must be updated.

VOLUME III: Specific Service Requirements

POLICY NAME: Unmet Needs Program

PURPOSE: Services that are defined as non-category services that can be provided to address the needs of the Older Adults that cannot be met through traditional funding streams.

AUTHORITY: Region VII AAA

I. Service Definition

A. Funds can be used to provide non-categorical services, one-time per fiscal year, to meet individual needs that cannot be met through traditional funding streams.

1. Examples of unmet needs would include such items as window air conditioners, special shoes, or paid transportation.

B. Service providers will be paid directly by Region VII AAA after the billing has been received.

II. Minimum Requirements

A. Prior to initiating service, it must be determined whether a potential Client is eligible to receive services available through a program supported by other funding sources, including supplemental funds.

1. When it is apparent that an individual cannot be served through other resources, an appropriate referral should be made.

B. There will be no means testing.

C. The service can only be used by one eligible individual per household.

D. The service will be allowed one time per fiscal year per eligible individual.

E. Service providers must receive prior authorization for the purchase of services by filling out a request form and submitting it to Region VII AAA on an approved form.

III. Eligibility

A. Persons 60 or older

Approved March 2006

1. Priority must be given to eligible persons with the greatest social and/or economic need.

B. Caregivers

1. Caregivers 60 or older who care for care recipient 60 or older

2. Caregivers 60 or older who care for a recipient under 60

3. Caregivers under 60 who care for a recipient 60 or older.

C. Unmet needs services will be provided to persons served by the Region VII AAA Waiver, Care Management program, and CCS.

IV. Intake Procedure

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

1. The intake process must document the Client's unmet need for program services.

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

1. For every subsequent fiscal year the Client requests services, the service provider must re-establish the unmet need.

2. The list of tasks to be performed must be updated.

VOLUME III: Specific Service Requirements

POLICY NAME: Unmet Needs Home Repair Program

PURPOSE: To help Older Adults homeowners who have a special need to make modifications to their homes in order to enable them to continue living in an independent, yet safe and functional environment

XIX. Home Repair Services

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.

1. Persons 60 years of age or older shall be eligible for services.

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

1.There will be no means testing.

C. Before beginning services, the service provider must determine whether a Client is eligible for home repair services provided through other funding sources, including supplemental funding.

D. Home Repair service offer permanent restoration and/or renovation to extend the life of the home and may involve structural changes. related to safety, security, and health.

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

E. Allowable home repair tasks may include for consideration the following:

1. Minor roof repair/replacement

2. Siding repair/replacement

3. Door and window repair/replacement

4. Foundation repair/replacement

5. Floor repair/replacement

6. Interior wall repair

7. Plumbing and drain repair/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/replacement

10. Heating system repair/replacement

11. Ensuring safe and adequate water supply

12. Electrical wiring repair/replacement

13. Obtaining building permits when required

14. Painting to prevent deterioration in conjunction with repairs

15. Replacing fuses, light bulbs, electric plugs, frayed cords

16. Installing weather stripping around doors

17. Caulking windows

18. Installing window shades and curtain rods that assist in the home climate control

19. Securing carpets and rugs

F. Service Providers will be paid directly by Region VII AAA after the billing has been received.

XX. Minimum Requirements Standards

A. Each service provider must program shall establish and utilize written criteria for prioritizing homes to be repaired which address the following: condition of the home, Client need and appropriateness of the requested repairs.

1. Client need and appropriateness of requested repairs

2. 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.

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

C. Each home repair program, prior to initiating service, shall determine whether a potential Client is eligible to receive services through a program supported by other funding sources, particularly program funded through the Social Security Act.

1. If it appears that an individual can be served through other resources, an appropriate referral should be made.

D. Each program shall develop working relationships with weatherization, chore and housing assistance serve providers, as available, in the program area to ensure effective coordination of efforts.

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

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

2. Equipment or tools needed to perform home repair tasks may be purchased or rented with funds from OSA up to an amount equal to 10% of total grant funds.

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

G. The program shall check each home to be repaired for compliance with local building codes.

1. No repairs may be made to a condemned structure.

H. Each program shall utilize a job completion procedure which includes:

1. Verification that work is complete and correct.

2. Verification by a local building inspector(s) that the work satisfies building codes.

3. Acknowledgement by the home owner that the work is acceptable, within ten days of completion.

I. The program shall utilize a written agreement with the owner (purchaser) of each home to be repaired which includes at a minimum:

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

2. A statement that in the event that 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.

J. Service providers shall outline the parameters of their program, including the circumstances in which the program will complete potentially high demand activities.
1. When it is apparent that an individual cannot be served through other resources, an appropriate referral should be made.

K. Service providers must receive prior authorization for the home repair by filling out a request form and submitting it to Region VII AAA on an approved form.

L. To ensure effective coordination of effort each service provider must develop a working relationship with the home repair and weatherization service providers available in the project area.

XXI. Restrictions and Limitations in the Scope of Service

A. Funds can be used to provide non-categorical services one-time per fiscal year to meet individual needs that cannot be met through traditional funding streams.

B. Funds awarded for home repair may be used to purchase materials, services, and supplies used to complete the tasks.

1. No more than $600 may be spent on materials, supplies, services, and/or labor per household per fiscal year regardless of the activities undertaken when funds are available.

a. A minimum of two quotes are required with each funding request.

b. Quotes are not required by Region VII AAA contracted service providers that uses their employed staff to make repairs.

2. Volunteers should be used when possible.

C. 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.

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

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

F. The service provider must assure that each home repair complies with local building codes.

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

H. The service can only be used once per year per household per fiscal year.

I. Each program must utilize a job completion procedure that includes the following and sent with payment request.

1. Verification that work is completed and correct

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

3. Acknowledgement by homeowner that work is acceptable, and a statement to be obtained within 10 days of completion

XXII. 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 home improvement services.

1. A list of the home repair 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.

2. The list of tasks to be performed must be updated.

XXIII. Staff Requirements

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

VOLUME III: Specific Service Requirements

POLICY NAME: Utility Assistance Program

PURPOSE: To assist elderly homeowners who are unable to pay for heating, water, and electrical bills.

I. Eligibility

A. Persons 60 years of age or older shall be eligible for services.

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

1. There will be no means testing.

C. Clients must attempt to access all other available community utility assistance programs before access will be available through this program.

1. Community Assistance includes:

a. Salvation Army

b. Community Action Agencies

c. Department of Human Services

d. American Red Cross

e. Veterans Councils

f. Thaw Agencies

II. Program Requirements

A. Service providers must receive prior authorization by submitting a request form to Region VII Area Agency on Aging on an approved form.

B. Up to $400 in funding can be used to provide services one-time per fiscal year.