

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES

Appendix A

Services Descriptions and Standards

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

Appendix A: Service Descriptions and Standards

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Appendix A: Service Descriptions and Standards

Section 1: General Information

PURPOSE:

Appendix A, Service Descriptions and Standards, of the Department of Elder Affairs (DOEA) Programs and Services Handbook, provides the following components:

- A.** A description of each program under the auspices of DOEA.
- B.** Delivery standards and special conditions.
- C.** Provider qualifications.
- D.** Record keeping and reporting requirements.

Listed next are the program names and abbreviations referred to in this chapter. For a detailed description of each program, please refer to the specific chapters in this Handbook.

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Section 1: General Information

PROGRAM ACRONYMS:

Name Acronyms

Alzheimer's Disease Initiative	ADI
AmeriCorps	AC
Community Care for the Elderly	CCE
Home Care for the Elderly	HCE
Local Services Program	LSP
Respite for Elders Living in Everyday Families	RELIEF
Senior Companion	SCP
Title I of the Older Americans Act	OAAI
Title III of the Older Americans Act	OAAIII
Title III of the Older Americans Act, Part B	OAAIIIB
Title III of the Older Americans Act, Part C	OAAIIIC
Title III of the Older Americans Act, Part C, Subpart 1, Subpart 2, Subpart 3	OAAIIICI, OAAIIIC2, OAAIIIC3
Title III of the Older Americans Act, Part D	OAAIIID
Title III of the Older Americans Act, Part E	OAAIIIE
Title VII of the Older Americans Act	OAAVII

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Section I: General Information

CHARACTERISTICS COMMON FOR PROGRAMS/SERVICES:

The following are characteristics common to all services and to the manner they should be provided:

- A. All client information is confidential. Procedures shall be established to protect confidentiality of records.
- B. Each service performed shall be recorded as specified in the Client Information and Registration Tracking System (CIRTS) guidelines. Supporting documentation of services provided must be adequate to permit fiscal and programmatic evaluation and ensure internal management.
- C. The cost for every service includes CIRTS data entry, invoicing, and other necessary administrative activities related to service provision.
- D. Unless otherwise noted, units of service for group events shall be counted as the amount of time delivering the service, regardless of the number of attendees.
 - 1. The definition of “completer” for all Stanford University Self-Management Resource Center (SMRC) interventions is an individual who attends four out of six sessions.
- E. Travel time to and from the client's home is not counted in units of service unless travel time is specifically included as part of the service. Travel time may be included for services provided by volunteers who receive a stipend or living allowance.
- F. One hour of direct service with or on behalf of a client is accumulated daily. The cumulative amount of time per service is totaled for the day and minutes are rounded up to the nearest quarter of a unit as follows:

<u>Minutes</u>	<u>Units</u>	<u>Hours</u>
1-15	$\frac{1}{4}$	$\frac{1}{4}$
16-30	$\frac{1}{2}$	$\frac{1}{2}$
31-45	$\frac{3}{4}$	$\frac{3}{4}$
46-60	1	1

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- G.** Persons and/or agencies providing services shall meet the following criteria, as appropriate:
1. Have appropriate training for the program and service being delivered;
 2. Comply with licensure requirements;
 3. Comply with registration requirements;
 4. Comply with background screening requirements (Pursuant to Chapter 435, F.S. and Section 430.0402 (1) (a), F.S.;
 5. Comply with continuing education requirements;
 6. Obtain all required state or local permits;
 7. Comply with building codes and standards; and
 8. Obtain required insurance.
- H.** All persons in direct contact with clients are required to:
1. Handle the client's money only if permitted by the service provided;
 2. Not disclose confidential information; and
 3. Not accept monetary or tangible gifts from clients or their family members.
- I.** Providers shall incorporate volunteers and other community resources prior to accessing DOEA-funded services. The providers are responsible for ensuring coordination of services among agencies to avoid duplication of efforts.
- J.** Before providing services on a regular basis, paid staff and volunteers who have direct contact with clients shall receive basic orientation covering, but not limited to, the following topics:
1. Overview of the aging process;
 2. Overview of the aging network;
 3. Communication techniques with elders;

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Section I: General Information

4. Abuse, neglect, exploitation, and unusual incident reporting;
 5. Local agency procedures and protocols;
 6. Client confidentiality; and
 7. Client grievance procedures.
- K.** Procedures shall be established to recruit, train and schedule paid and volunteer staff. Procedures will include an annual evaluation of paid staff and documentation maintained in agency or personnel files.
- L.** Providers shall update and provide in-service training, as needed. Documented pre-service training may be substituted for all or part of required annual training for specified staff.
- M.** Unless stated otherwise in law, rule or in this Handbook, the number of hours, training methods, and training materials are determined by the provider.
- N.** All services should be provided in a manner accessible to those in need.
- O.** Services should be tailored to elder clients and their specific needs, including hearing, vision, mobility, memory, language, cultural, and other considerations.
- P.** Accurate, legible and complete client files shall be maintained for all clients receiving case management services. When case management is not offered, the provider shall determine service needs, document service activities and client participation, and report service activity.
- Q.** Procedures shall be established to respond to service complaints and objectively evaluate the quality of service and the level of client satisfaction. Service providers shall have procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in accordance with Appendix D—Minimum Guidelines for Recipient Grievance Procedures.
- R.** Procedures shall be established to report to supervisory staff and the Area Agency on Aging (AAA), as appropriate, unusual incidents related to clients and service delivery. Unusual incident reports shall be kept on file at provider agencies.

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- S.** Direct payment is a reimbursement made directly to the client, caregiver, and/or designee for services or supplies purchased. To be eligible for reimbursement, purchases must be based upon documented preauthorization by the case manager or program coordinator and approved by the case manager supervisor or designee. Preauthorized, approved services purchased from friends, family, or neighbors, and arranged by clients or caregivers may not be subject to the service standards contained in the Handbook. Original receipts shall be presented to the case manager or program coordinator within 30 days of purchase. Reimbursements shall be made within 60 days of submission and approval of original receipts.
- T.** Procurement procedures shall be developed for all services purchased in accordance with state and federal regulations to encourage competition and promote a diversity of contractors for services for the elder consumers.

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Section I: General Information

TABLE OF SERVICES BY PROGRAM:

The following pages include a table of services provided under each program. The legal authority for each program is cited specifically in “Section 2: Services” of this Appendix. The date of issuance for all pages is listed at the bottom of this page.

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Appendix A: Service Descriptions and Standards

TABLE OF SERVICES BY PROGRAM														
Key + : A Service in the Program ◆ : Requires Licensure ▲ : Requires AHCA REGISTRATION ▽ : Volunteers providing services in the AmeriCorps, Relief, and Senior Companion Programs must meet those program specifications (R) : OAA Registered Service Services listed under HCE can be purchased with special subsidy funds.														
Services	AC	ADI	CCE	HCE	LSP	OAA IIIB	OAA IIIC	OAA IIID	OAA IIIE	OAA IIIES	OAA IIIEG	OAA VII	Relief	SCP
Adult Day Care (R)			+	+	+	+			+					
Adult Day Health Care (R)			+	+	+	+			+					
Basic Subsidy				+										
Caregiver Training/Support		+	+	+	+	+			+		+	+		
Case Aide		+	+	+	+	+								
Case Management		+	+	+	+	+								
Child Day Care											+			
Chore (R)	+		+	+	+	+				+				
Chore (Enhanced) (R)	+		+	+	+	+				+				
Companionship			+		+	+								+
Congregate Meals (R)					+		+	C1						
Congregate Meals (Screening)					+		+	C1						
Counseling (Gerontological)		+	+	+	+	+		+	+		+			
Counseling (Mental Health/Screening)		+	+	+	+	+		+	+		+			
Education/Training		+			+	+			+		+	+		

C1 = Congregate meals

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Services	AC	ADI	CCE	HCE	LSP	OAA IIIB	OAA IIIC	OAA IIID	OAA IIIE	OAA IIIES	OAA IIIEG	OAA VII	Relief	SCP
Emergency Alert Response			+		+	+								
Escort (R)			+		+	+								+ ▽
Financial Risk Reduction (Assessment)			+						+					
Financial Risk Reduction (Maintenance)			+						+					
Health Support			+		+	+								
Home and Community Disaster Preparedness	+													
Home Delivered Meals (R)			+	+	+		+ C2							
Home Health Aide Service (R)			+ ◆	+ ◆	+ ◆	+ ◆								
Homemaker (R)			+ ▲	+ ▲	+ ▲	+ ▲								
Housing Improvement	+		+	+	+	+				+				
Information					+	+			+					

C2 = Home delivered meals

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TABLE OF SERVICES BY PROGRAM

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▽ : Volunteers providing services in the AmeriCorps, Relief, and Senior Companion Programs must meet those program specifications
(R): OAA Registered Service Services listed under HCE can be purchased with special subsidy funds.

Services	AC	ADI	CCE	HCE	LSP	OAA IIIB	OAA IIIC	OAA IIID	OAA IIIE	OAA IIIES	OAA IIIEG	OAA VII	RELIEF	SCP
Intake		+	+	+	+	+			+					
Interpreter/Translating					+	+								
Legal Assistance			+	◆	+	◆				+	◆			
Material Aid			+	+	+	+				+				
Medication Management			+		+			+						
Nutrition Counseling (R)			+	◆	+	◆	+	◆						
Nutrition Education					+		+							
Occupational Therapy			+	◆	+	◆	+	◆						
Other			+	+	+									
Outreach	+				+	+	+		+		+			
Personal Care (R)			+	+	+	+								
Pest Control (Enhanced Initiation)			+	◆										
Pest Control (Initiation)			+	◆										
Pest Control (Maintenance)			+	◆										
Pest Control (Rodent)			+	◆										

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TABLE OF SERVICES BY PROGRAM

Key **+** : A Service in the Program **◆** : Requires Licensure **▲** : Requires AHCA REGISTRATION
▽ : Volunteers providing services in the AmeriCorps, Relief, and Senior Companion Programs must meet those program specifications
(R): OAA Registered Service Services listed under HCE can be purchased with special subsidy funds.

Services	AC	ADI	CCE	HCE	LSP	OAA IIIB	OAA IIIC	OAA IIID	OAA IIIE	OAA IIIES	OAA IIIEG	OAA VII	Relief	SCP
Physical Therapy			+ ◆	+ ◆	+ ◆	+ ◆								
Recreation					+	+								
Referral/Assistance					+	+			+		+			
Respite (Facility Based) (R)		+ ▲	+ ▲	+ ▲	+ ▲◆	+ ▲			+ ▲					+ ▽
Respite (In-Home) (R)	+ ▽	+	+ ▲	+ ▲	+ ▲	+ ▲			+ ▲				+ ▽	+ ▽
Screening/Assessment (R)					+	+	+ C2		+		+			
Shopping Assistance			+	+	+	+								
Sitter											+			
Skilled Nursing Services			+ ◆	+ ◆	+ ◆	+ ◆								
Specialized Medical Equipment, Services and Supplies		+	+	+	+	+				+				
Specialized Adult Day Care		+ ◆												
Speech Therapy			+ ◆	+ ◆	+ ◆	+ ◆								
Telephone Reassurance					+	+								
Transportation		+	+	+	+	+			+		+			

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TABLE OF SERVICES BY PROGRAM (IIID)

Key **+** : A Service in the Program **◆** : Requires Licensure **▲**: Requires AHCA REGISTRATION

▽ : Volunteers providing services in the AmeriCorps, Relief, and Senior Companion Programs must meet those program specifications

(R): OAA Registered Service Services listed under HCE can be purchased with special subsidy funds.

Services	AC	ADI	CCE	HCE	LSP	OAA IIIB	OAA IIIC	OAA IIID	OAA IIIE	OAA IIIES	OAA IIIEG	OAA VII	Relief	SC
A Matter of Balance (MOB) and Un Asunto de Equilibrio								+◆						
Active Living Every Day								+◆						
Arthritis Foundation Exercise Program								+◆						
Arthritis Foundation Tai Chi Program (Tai Chi for Arthritis)								+◆						
Arthritis Self-Management Program and Program de Manejo Personal de la Artritis								+◆						
Applied Suicide Intervention Skills Training (ASIST)								+						
Brief Intervention and Treatment for Elders (BRITE)								+						
Chronic Disease Self-Management								+◆						
Chronic Pain Self-Management								+◆						
Diabetes Empowerment Education Program (DEEP)								+◆						
Diabetes Self-Management Program and Program de Manejo Personal de la Diabetes								+◆						
Enhance Fitness (EF)								+◆						
Enhance Wellness								+◆						

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Key + : A Service in the Program ◆ : Requires Licensure ▲: Requires AHCA REGISTRATION ▽ : Volunteers providing services in the AmeriCorps, Relief, and Senior Companion Programs must meet those program specifications (R): OAA Registered Service Services listed under HCE can be purchased with special subsidy funds.														
Fit & Strong								+◆						
Healthy Eating Every Day								+◆						
Healthy Ideas								+						
Health Moves for Aging Well								+						
HomeMeds								+◆						
Physical Fitness								+						
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)								+						
Stepping On								+◆						
Stay Active and Independent for Life (SAIL)								+						
Tai Chi/Tai Ji Quan: Moving for Better Balance								+						
Tomando Control de su Salud								+◆						
Walk with Ease								+◆						

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APPENDIX A: Service Descriptions and Standards

Section II: Services

The following pages include detailed descriptions of the services provided through the Department of Elder Affairs program components.

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Section II: Services

Adult Day Care

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB, OAAIIIE

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E, Section 373 (b)(4)

A. DESCRIPTION: Adult day care is a program of therapeutic social and health activities and services provided to elders who have functional impairments. Services are provided in a protective, community-based environment.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. There shall be one (1) staff member for every six (6) clients. Volunteers can be included in the 1 to 6 staff/client ratio, if they perform the same functions as paid staff and comply with training and background check requirements.
2. At least two staff members, one of which has CPR training, shall be on the premises all the time during the center's hours of operation.
3. Transportation shall be a function of the program. If the center does not provide transportation directly, arrangements for day care participants needing transportation shall be established.
4. Adult day care workers who have direct contact with clients shall have a screening in compliance with requirements of DOEA process.

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Section II: Services

Adult Day Care

C. PROVIDER QUALIFICATIONS:

- 1.** Adult day care centers shall be licensed by the Agency for Health Care Administration in accordance with Chapter 429, Part III, Florida Statutes, and Chapter 58A-6, Florida Administrative Code.
- 2.** Adult day care centers shall be designated in the area plan as congregate dining sites, if meals are counted as congregate meals.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** Unit of Service: One hour of actual client attendance at the day care center is one unit of adult day care service. Actual client attendance is defined as the time between the time of arrival at the day care center and the time of departure from the day care center.
- 2.** Hours of daily attendance shall exclude time in transit to and from the center. The cost of travel time shall be reported separately. It is not to be included in the unit rate.
- 3.** Meals cannot be counted as congregate meal units, if they are funded through any other payor source including but not on limited to the cost of the service (Private Pay or Service Rate), Adult Care Food Program, or Statewide Medicaid Managed Care Programs. Each meal shall at minimum meet requirements as defined in 58A-6.009(2)(d4-3)
- 4.** A daily attendance log with time in and time out shall be maintained.
- 5.** CIRTS reporting requirements are below on the next page. ↓

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Section II: Services

Adult Day Care

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	ADC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
HCE	ADC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
HCE	ADCV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
LSP	ADC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	ADC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3E	ADC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	310

For HCE, the client file shall document why the caregiver is unable to perform the service.

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Adult Day Health Care

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB, OAAIIE

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E, Section 373 (b)(4)

A. DESCRIPTION: Adult day health care is a program of therapeutic activities, encompassing both health and social services, to ensure the optimal functioning of the client. Services are provided in an outpatient setting four (4) or more hours per day, one or more days per week.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

- 1.** All adult day care standards apply. Physical, occupational and speech therapies indicated in the client's plan of care must be furnished as component parts of this service. Adult day health care centers shall comply with Chapter 58A-6.010(6), Florida Administrative Code.
- 2.** Nursing services are required for adult day health care and include, but are not limited to, screening procedures for chronic disease (e.g., hypertension, or diabetes; observation, assessment, and monitoring of participant's health needs and daily functioning levels; administration or supervision of medications or treatments; counseling of participant, family or caregiver in matters relating to health and prevention of illness; and referral to other community resources with follow-up of suspected physical, mental or social problems requiring definitive resolution).

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Adult Day Health Care

- C.** PROVIDER QUALIFICATIONS: Adult day care centers shall be licensed by the Agency for Health Care Administration in accordance with Chapter 429, Part III, Florida Statutes, and Chapter 58A-6, Florida Administrative Code.
- D.** RECORD KEEPING AND REPORTING REQUIREMENTS:
- 1.** Unit of Service: One hour of actual client attendance at the day care center is one unit of adult day health care service. Actual client attendance is defined as the time between the time of arrival and the time of departure from the day care center.
 - 2.** Hours of daily attendance shall exclude transportation time to and from the center. The cost of transportation shall be included in the unit rate. The cost of physical, occupational and speech therapies may be included in the unit rate; however, other funding sources such as Medicare, Medicaid and private insurance must be exhausted first.
 - 3.** Meals cannot be counted as congregate meal units, if they are funded through any other payor source including but not limited to the cost of the service (Private Pay or Service Rate), Adult Care Food Program, or Statewide Medicaid Managed Care Programs. Each meal shall at a minimum, meet requirements as defined in 58A-6.009(2)(614-e).

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Section II: Services

Adult Day Health Care

4. CIRTS reporting requirements are below.

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	ADHC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
HCE	ADHC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
HCE	ADHV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310
LSP	ADHC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	ADHC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3E	ADHC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	310

For HCE, the client file shall document why the caregiver is unable to perform the service.

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Basic Subsidy

PROGRAM FUNDING SOURCE (S): HCE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

HCE

Sections 430.601-608, F.S.

- A.** DESCRIPTION: Basic subsidy is a fixed cash payment made to approved caregivers each month to offset some of their expenses for providing support and maintenance of the elder care recipient. This may include medical costs not covered by Medicaid, Medicare or other insurance.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS:
- 1.** Clients must be at risk of nursing home placement, living with an approved caregiver, and meet financial eligibility.
 - 2.** Payments are made in accordance with a schedule developed by the Department and is based on the client's chargeable income and assets. If both husband and wife are clients, their income and assets are added together and compared to the standard for couples. The basic subsidy is not considered income by the Internal Revenue Service (IRS).
 - 3.** The basic subsidy is paid to the caregiver when the client is in the home for any part of the reporting period (16th thru the 15th of the month). If the client is hospitalized or in any other temporary institution but was in the home at any point during the reporting period, the basic subsidy check will be sent to the caregiver.
- C.** PROVIDER QUALIFICATIONS: The caregiver must:
- 1.** Be an adult at least 18 years of age, capable of providing a family-type living environment and willing to accept responsibility for the social, physical and emotional needs of the care recipient;
 - 2.** Be accepted or designated by the recipient as a caregiver;

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Basic Subsidy

3. Be physically present always to provide supervision and assist in arrangement of services for the care recipient or have alternative arrangements for care to be assumed by another adult;
4. Maintain the residential dwelling free of conditions that pose an immediate threat to the life, safety, health or well-being of the care recipient; and
5. Demonstrate evidence of an established positive personal relationship with the care recipient.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One unit equals one month.
2. The case manager or case aide must confirm that the caregiver provided care to the client during the month. The caregiver may sign a form attesting to eligibility each month and submit it to the case manager, or confirmation may be made by a telephone contact with the caregiver. The confirmation shall be documented in the case narrative of the client's file.
3. **CIRTS reporting requirements are below.** ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
HCE	BASI	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	1

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Caregiver Training and Support

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB, OAAIIIE, OAAIIIEG, OAAVII

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

ADI

Sections 430.501-504, F.S.

CCE

Sections 430.201-207, F.S.

HCE

Sections 430.601-608, F.S.

LSP

Specific Appropriations

OAAIIIB

Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C. 3030d

OAAIIIE

Older Americans Act, Title III, Part E, Section 373 (b)(4)

OAAVII

Older Americans Act, Title VII

- A.** DESCRIPTION: Caregiver training and support is defined as the training of caregivers, individually or in group settings to reduce stress, increase coping skills, provide strategies for effective management of caregiving tasks, and enable them to provide high quality care to recipients within the home. Caregiver training and support may be provided through forums, which include community workshops, seminars, support groups and other organized local, regional or statewide events.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: To receive caregiver training and support services, the caregiver shall be 18 years of age or older.
- C.** PROVIDER QUALIFICATIONS: Providers of caregiver training and support events shall be qualified by training or experience in the area on which training is being conducted.

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D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** Unit of Service - Individual: A unit of service is one hour with a client.
- 2.** Unit of Service - Group: A unit is one hour with clients, regardless of the number who participate.
- 3.** A direct payment reimbursement can be provided to facilitate caregiver attendance at caregiver forums with prior authorization from the program coordinator or designee. Respite services and reimbursement of travel expenses, registration and fees, etc., may be provided to enable the caregiver to attend caregiver training and support events. Travel expenses, registration and fees must be included in the unit rate. The cost of respite services is not to be included in the unit rate. It shall be reported separately.
- 4.** CIRTS reporting requirements are included on the next page.

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Caregiver Training and Support

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
ADI	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
CCE	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
HCE	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CTSV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3E	DPCTSI (DIRECT PAY)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3EG	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG	DPCTSI (DIRECT PAY)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OAA7	CTSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OAA7	CTSI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Case Aide

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u> Rulemaking	Section 430.08, F.S.
ADI	Sections 430.501-504, F.S.	
CCE	Sections 430.201-207, F.S.	
HCE	Sections 430.601-608, F.S.	
LSP	Specific Appropriations	
OAAIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5)(A) 42 U.S.C. 3030d	

A. DESCRIPTION: Case aide services are adjunctive and supplemental to case management services and are provided by paraprofessionals under the direction of case managers or designated supervisory staff. These services include the following:

1. Assist with implementing care plans;
2. Assist with accessing medical and other appointments;
3. Perform follow-up contacts. This may include the monthly contact with the HCE caregiver;
4. Oversee quality of provider services;
5. Delivery of supplies and equipment;
6. Assist with paying bills;
7. Assist the client or caregiver in compiling information and completing applications for other services and public assistance;
8. Facilitate linkages of providers with recipients via telephone contacts and visits;
9. Determine client satisfaction with services provided;

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10. Determine client satisfaction with services provided;
 11. Arrange, schedule and maintain scheduled services;
 12. Document activities in the case record;
 13. Reconcile and voucher activities;
 14. Assist with HCE monthly contact to confirm caregiver eligibility; and
 15. Record telephone and travel time associated with billable case aide activities.
- B. NON-BILLABLE ACTIVITIES:** The following activities cannot be billed as case management, because the time associated with these activities is already included in the unit rate:
1. Community organizing not specific to a client including informing clients of events and meetings;
 2. Staffing or group discussion not associated with single client;
 3. Recruiting/training staff and volunteers;
 4. Attending training;
 5. Conducting workshops;
 6. Entering data into CIRTS;
 7. General program administration functions which include routine supervision of case managers or other program direct service staff or volunteers;
 8. Reviews or home visits conducted because of AAA, DOEA, or OAA monitoring activities;
 9. Home visits and telephone calls made but not received by client/caregiver; and
 10. "Advocacy" or legal-related tasks such as working with officials of DCF Adult Protective Services, lawyers, and other court officials, and various investigators not specific to an individual client.

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- C. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Training and certification on the DOEA assessment instrument and care plan forms are required for case aides. All staff conducting assessments must complete the DOEA web-based training and receive a certificate of completion before being eligible to conduct an assessment. To receive a certificate of completion, a score of 90 percent or above on the multiple-choice test is required. Care plan training is conducted by AAAs and case aides must score at least 80 percent on the post training test.
- D. PROVIDER QUALIFICATIONS:** Case aide services shall be provided by the designated lead agency, or as otherwise approved by the AAA. Minimum requirements for case aides include a high school diploma or GED. Job-related experience may be substituted for a high school diploma or GED upon approval of the AAA.
- E. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service with or on behalf of a client accumulated daily. This may include travel time and time spent with caregivers, when it is related to the client's situation.
 2. The case aide shall document and sign-off on activities performed on behalf of the client in the client's case record.
 3. Activities shall be billed as case aide, not case management.
 4. CIRTS reporting requirements are below:

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	CA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	CA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CAV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	CA	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3B	CA	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100

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Case Management

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S
ADI	Section 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5)(A) 42 U.S.C. 303d

A. DESCRIPTION: Case Management is a client-centered service that assists clients in identifying physical and emotional needs and problems through an interview and assessment process; discussing and developing a plan for services which addresses these needs; arranging and coordinating agreed upon services; and monitoring the quality and effectiveness of the services. Case management is a service for actively enrolled clients that provides continuing support and addresses the changing needs of clients.

- 1.** Case management shall be delivered in accordance with the following understanding:
 - a.** The case manager's role is that of "gatekeeper" in the community care system. Therefore, the case manager must be knowledgeable about the array of community-based services and resources available to address the needs of clients and their caregivers.
 - b.** Assessments and care plan reviews shall be conducted to identify, evaluate and address the client's continuing and changing needs.

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- c. Case management is client-centered. Every effort shall be made to link clients with appropriate formal and/or informal support system regardless of the agency or organization offering the services. Service arrangements shall not be limited to those services offered by the agency for which the case manager works.
 - d. Case managers shall ensure full coordination of services provided by various agencies and clients and ensure appropriate use of funding sources.
 - e. Case managers provide linkage between health care and social service delivery systems. This requires involvement with physicians, hospitals, health maintenance organizations (HMOs), nursing homes and health services.
 - f. Case managers shall actively pursue the development of informal resources to help meet the client's needs.
 - g. Case managers shall help the families of clients to resolve concrete and emotional problems and to relieve temporary stresses encountered because of their caregiving efforts. With the client's consent, family involvement in decisions related to a client's plan of care shall be pursued.
 - h. Case managers shall arrange training for family members, relatives and friends in methods of caregiving.
 - i. Case managers shall monitor services to ensure they are having a positive impact on the problems that necessitated the service.
 - j. Scheduled home visits and telephone calls made but not received by client/caregiver, through no fault of the case manager.
2. **NON-BILLABLE ACTIVITIES:** The following activities cannot be billed as case management, because the time associated with these activities is already included in the unit rate.
- a. Community organizing not specific to a client, including informing clients of events and meetings;
 - b. Staffing or group discussion not associated with single client;

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- c. Recruiting/training staff and volunteers;
- d. Attending training;
- e. Conducting workshops;
- f. Billing, filing, vouchering, entering data into CIRTS and reconciling case narratives and time sheets to billing hours;
- g. General program administration functions which include routine supervision of case managers or other program direct service staff or volunteers;
- h. Reviews or home visits conducted because of AAA, DOEA, or OAA monitoring activities; and
- i. "Advocacy" or legal-related tasks such as working with officials of DCF Adult Protective Services, lawyers, and other court officials, and various investigators not specific to an individual client

- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Training and certification on the DOEA assessment instrument and care plan forms are required for case managers. All staff conducting assessments must complete the DOEA web-based training and receive a certificate of completion before being eligible to conduct an assessment. To receive a certificate of completion, a score of 90 percent or above on the multiple-choice test is required. Care plan training is conducted by AAAs, and case managers must score at least 80 percent on the post training test to complete care plans independently. New employees who have not been certified, or who have not passed the examination for the care plan certification shall have care plans approved by the review and signature of a certified case manager.

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C. PROVIDER QUALIFICATIONS:

- 1.** Case management services are provided by the designated lead agency, or as otherwise approved by the AAA. Minimum requirements for new case managers are a bachelor's degree in social work, psychology, sociology, nursing, gerontology or related field. Year-for-year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA.
- 2.** Caseloads include clients who have been determined eligible and are receiving case management services. DOEA suggests maintaining a caseload of 60 to 70 clients. Caseloads exceeding 100 clients require a waiver from the AAA.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** Unit of Service: One hour of direct service with or on behalf of a client accumulated daily. This may include travel time and time spent with caregivers when it is related to the client's situation.
- 2.** The case manager shall document and sign-off on case management activities in the client's case record.
- 3.** Case Management may be billed prior to client enrollment, as long as case notes detail why services were provided prior to enrollment. This can include case management for APS high-risk referrals. This can also include activities conducted for clients to arrange and/or complete an assessment and the client chooses not to complete an assessment, is found not eligible, or chooses not to enroll.

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4. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	CM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	CM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CMV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	CM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	9999
OA3B	CM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Child Day Care

PROGRAM FUNDING SOURCE(S): OAAIIIEG

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIIE

Older Americans Act, Title III, Part E, Section 372 (b)

- A.** DESCRIPTION: Child day care services are provided to a minor child, not more than 18 years old, or a child who is an individual with a disability residing with an age 55+ grandparent or other age 55+ related caregiver.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: Services shall be delivered as respite for caregivers to be temporarily relieved of their responsibility. Child day care services cannot replace other funding available, unless all other funding sources are exhausted. Child day care services can be provided for a caregiver to work at a maximum of twenty (20) hours per week.
- C.** PROVIDER QUALIFICATIONS: Child day care services for minor children shall be provided in a facility licensed in accordance with Chapters 402.26 - 402.319, Florida Statutes, and Chapter 65C, Florida Administrative Code. Child day care services for a disabled individual shall be provided in a facility and environment suitable to the disabled person's needs. Standards and licensing requirements to the type of facility apply, i.e., adult day care, etc.
- D.** RECORD KEEPING AND REPORTING REQUIREMENTS:
 - 1.** Unit of Service: One hour of actual client attendance at a facility is one unit of child day care service. Actual client attendance is defined as the time between the time of arrival and the time of departure from the facility.
 - 2.** A direct payment will be provided to the caregiver or vendor in accordance with the agency's direct payment policies. Prior authorization from the Title IIIE Coordinator or other designated staff is required.

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3. CIRT reporting requirements are included in the chart below:

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3EG (GRANDPARENT)	DCC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Chore

PROGRAM FUNDING SOURCE(S): AC, CCE, HCE, LSP, OAAIIB, OAAIIIES

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
AC	AmeriCorps Provisions
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C., 3030d
OAAIIIE	Older Americans Act, Title III, Part E, Section 373 (f)

- A.** DESCRIPTION: Chore is defined as the performance of routine house or yard tasks, including such jobs as seasonal cleaning; yard work; lifting and moving furniture, appliances or heavy objects; household repairs which do not require a permit or specialist; and household maintenance. Pest control may be included, when not performed as a distinct activity.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: Chore services may be provided only when there is no other means to accomplish the required tasks.
- C.** PROVIDER QUALIFICATIONS: Providers of chore services may be licensed home health and hospice agencies. Providers may also be independent vendors qualified to provide such service in accordance with all local ordinances that may apply. Home health agencies shall be licensed by the Agency for Health Care Administration in accordance with Chapter 400 Part IV, Florida Statutes. If the service is provided through the AmeriCorps program, volunteers must meet the AmeriCorps® program requirements.

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D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One worker hour, beginning at the time of arrival and concluding at the time of departure from client contact. Chore service does not include travel time to nor from the client's residence, except as appropriate for performing essential errands (such as picking up materials) as approved by the job order.
2. For AmeriCorps, one worker hour may include travel time.
3. If services are provided to a couple, units cannot be counted twice.
4. The service may include the cost of cleaning material or personal protective supplies. Materials used for repair or improvement, such as locks, doors, screens or grab rails, are not included in the unit rate of this service. Such materials should be donated, sponsored or purchased under the service "Material Aid."
5. The provider must maintain a service log.

CIRTS reporting requirements are below.

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ACP	CHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
CCE	CHO	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CHO	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	CHOV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	CHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	CHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3ES (SUPPLEMENTAL)	CHO	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

For HCE, the client file shall document why the caregiver is unable to perform the service.

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Chore (Enhanced)

PROGRAM FUNDING SOURCE(S): AC, CCE, HCE, LSP, OAAIIIB, OAAIIIES

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
AC	AmeriCorps Volunteer Program
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E, Section 373 (f)

- A. DESCRIPTION:** Enhanced chore is the performance of any house or yard task necessary to provide a clean, sanitary and safe living environment. This service is beyond the scope of chore due to the level of service needed. The service includes a more intensified, thorough cleaning to address more demanding circumstances. Pest control may be included when not performed as a distinct activity.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Enhanced chore services may be provided only when there is no other means to accomplish the required tasks.
- C. PROVIDER QUALIFICATIONS:** Enhanced chore services providers may be licensed home health or hospice agencies. Providers may also be independent vendors qualified to provide such service in accordance with local ordinances that may apply. Home health and hospice agencies shall be licensed by the Agency for Health Care Administration in accordance with Chapter 400 Parts IV and VI, Florida Statutes, respectively. If the service is provided through the AmeriCorps program, volunteers must meet the AmeriCorps program requirements.

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Chore (Enhanced)

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One worker hour, beginning at time of arrival and concluding at time of departure from client contact. Enhanced chore service does not include travel time to nor from the client's residence, except as appropriate for performing essential errands (such as picking up materials or dumping debris) as approved by the job order. For AmeriCorps, one worker hour may include travel time.
2. If services are provided to a couple, units cannot be counted twice.
3. The service may include cost of cleaning materials, personal protective supplies, or equipment rental. Materials used for repair or improvement, such as locks, doors, screens or grab rails are not included in the unit rate of this service. Such materials should be donated, sponsored or purchased under the service "Material Aid."
4. The provider must maintain a service log.
5. CIRT reporting requirements are below

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
AC	ECHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
CCE	ECHO	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	ECHO	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	ECHV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	ECHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	ECHO	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3ES (SUPPLEMENTAL)	ECHO	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

For HCE, the client file shall document why the caregiver is unable to perform the service.

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Companionship

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIB, SCP

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321 (a)(5)(c) 42 U.S.C. 3030d
SCP	Corporation for National and Community Service Senior Companion Program

A. DESCRIPTION: Companionship is visiting a client who is socially and/or geographically isolated, to relieve loneliness and provide continuing social contact with the community. This service includes activities such as engaging the client in casual conversation, helping with reading, writing letters, escorting a client to a medical appointment and diversional activities such as playing games, going to the movies, the mall, the library or grocery shopping.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Companionship services consist of non-hands-on, non-medical care, supervision and socialization activities provided on a one-on-one basis. A companion may assist the client with such tasks as meal preparation, laundry and shopping; however, these activities shall not be performed as discrete services.
2. This service does not include hands-on personal or medical care.
3. Companionship services shall be provided in direct relation to the achievement of the client's specific outcomes or goals in the care plan.
4. Companionship services may include transportation, but transportation services are not permitted to be the sole activity provided for a reported unit. Companionship services may be used if the client requires assistance and supervision to attend therapy, dental or medical appointments. Clients shall not receive this service in the provider's home.

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Companionship

C. PROVIDER QUALIFICATIONS:

1. The service shall be provided in accordance with the regulation of Home Health Agencies in Chapter 400, Part IV, Florida Statutes, and Chapter 59A-8, Florida Administrative Code. Companions shall meet background screening and training requirements, and provide services in accordance with Chapter 400.512, Florida Statutes, and Chapters 59A-8.004 (10) and (11) and 59A-8.0095(12) Florida Administrative Code.
2. An agency or individual that provides companionship services shall be licensed in accordance with Chapter 400.464, Florida Statutes. Agencies or organizations providing companionship services that do not provide home health service are exempt from licensure but shall be registered in accordance with Chapters 400.464 and 400.509, Florida Statutes.
3. If this service is provided through the Senior Companion Program, volunteers shall meet the Corporation for National and Community Service Senior Companion Program guidelines.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct client contact. Companionship services involve one-on-one contact with the client. If the individual chooses to bring a "friend", only the services provided to the one individual are to be billed.
2. A companion may not bill for services to two clients for the same period.
3. Companions shall maintain a chronological written record of services and report any unusual incidents or changes in the client's behavior to their supervisor.

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Companionship

4. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	COMP	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	COMP	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	COMP	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
SCP	COMP	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
CCES*	COMP	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

*** Special Senior Companion Program to Capture Agency Dollar Match**

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Counseling (Gerontological)

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB, OAAIIID, OAAIIIE, OAAIIIEG

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAI	Older Americans Act, Title I, Section 102, (14) 42 U.S.C. 3001
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a) (1), (23) 42 U.S.C. 3030d
OAAIIID	Older Americans Act, Title III, Part D
OAAIIIE	Older Americans Act, Title III, Part E

- A. DESCRIPTION:** Gerontological counseling provides emotional support, information and guidance through a variety of modalities including mutual support groups for older adults who are having mental, emotional or social adjustment problems that have arisen because of the process of aging.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** There shall be access to adequate, private working space to conduct either individual or group counseling sessions. These services may be provided in the provider's office, client's residence, or other appropriate locations in the community.

For OAAIIID, this service must meet ACL's Definition of Evidence-Based. Approval from the DOEA contract manager is required prior to using this service description under OAA IIID.

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Counseling (Gerontological)

C. PROVIDER QUALIFICATIONS: This service may be provided by the designated lead agency or as otherwise approved by the AAA. Minimum requirements for persons providing counseling are a bachelor's degree in social work, psychology, sociology, nursing, gerontology, or a related field. Year-for-year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA. Gerontological counseling may be conducted by paid, donated and volunteer staff. Volunteer staff shall meet comparable standards as paid staff.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service Individual: One hour of direct service with or on behalf of a client accumulated daily.
2. Unit of Service Group: One hour of direct service with or on behalf of clients regardless of the numbers of participants.
3. The provider shall maintain a summary note for each contact, copy of the assessment, and the treatment plan.
4. For OAAIID Program:
 - The provider must have a sign-in sheet for the evidence-based program, which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating.
 - The contractor must submit ACL's criteria documents proving that the service provided is an evidence-based program.
 - The contractor must verify and maintain documentation of provider qualifications for service.

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Gerontological Counseling

5. CIRT reporting requirements are below.

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
ADI	GECI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
CCE	GECI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
HCE	GECI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	GECV (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	GECO GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	GECI INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	GECI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	GECI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	GECI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG (GRANDPARENT)	GECI INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG (GRANDPARENT)	GECO (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Counseling (Mental Health/Screening)

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIB, OAAIID, OAAIIE, OAAIIEG

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAI	Older Americans Act, Title I, Section 102, (14) 42 U.S.C. 3001
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(1), (23) 42 U.S.C. 3030d
OAAIID	Older Americans Act, Title III, Part D, Sections 361 and 362 42 U.S.C. 3030m and 3030n
OAAIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION:

1. Mental health counseling services focus on the unique treatment of psychiatric disorders and rehabilitation for impairments of persons suffering from a mental illness, including depression and anxiety. These services include specialized individual, group, and family therapy provided to clients using techniques appropriate to this population.
2. Specialized mental health services include information gathering and assessment, diagnosis and development of a treatment plan in coordination with the client's care plan. This specialized treatment will integrate the mental health interventions with the overall service and supports to enhance emotional and behavioral functions. This may be done on a one-to-one or group basis.

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Counseling (Mental Health/Screening)

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. These services may be provided in the provider's office, the client's place of residence, or other appropriate locations in the community.
2. All other funding sources shall be exhausted prior to the use of DOEA funded mental health counseling.
3. For OAAIID, this service must meet ACL's Definition of Evidence- Based. Approval from DOEA contract manager is required prior to using this service description under OAA IIID.

C. PROVIDER QUALIFICATIONS: Providers of specialized mental health services shall be:

1. Psychologists or psychiatrists licensed by the Department of Health in accordance with Chapter 490, Florida Statutes; or
2. Clinical social workers, marriage and family therapists or mental health counselors licensed by the Department of Health in accordance with Chapter 491, Florida Statutes.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service Individual: One hour of direct service with or on behalf of a client accumulated daily.
2. Unit of Service Group: One hour of direct service with or on behalf of clients regardless of the number of participants.
3. The provider shall maintain a summary note, copy of the assessment, and the treatment plan.
4. For OAA IIID Program:
 - The provider must have a sign-in sheet for the evidence-based program, which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating.
 - The contractor must submit ACL's criteria documents proving that the service provided is an evidence-based program.

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Counseling (Mental Health/Screening)

- The contractor must verify and maintain documentation of provider qualifications for service.

5. CIRT reporting requirements are below

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
ADI	MHSI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
CCE	MHSI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
HCE	MHSI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	MHSV (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	MHSI (INDV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	MHSI (INDV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	MHSI (INDV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	MHSI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG (GRANDPARENT)	MHSI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3EG (GRANDPARENT)	MHSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Section II: Services

Education/Training

PROGRAM FUNDING SOURCE(S): ADI, LSP, OAAIIB, OAAIIE, OAAIIIEG, OAA7

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
	Rulemaking Section 430.08, F.S.
ADI	Sections 430.501-504, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(1) 42 U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E
OAAVII	Older Americans Act, Title VII

A. DESCRIPTION: Education/Training is defined as:

1. Speaking to groups or distributing materials to individuals at public gatherings about services and opportunities available to them within their communities;
2. Providing formal or informal opportunities for individuals or groups to acquire knowledge, experience or skills; to increase awareness in such areas as crime or accident prevention; promoting personal enrichment; and to increase or gain skills in a specific craft, trade, job or occupation. Training individuals or groups in guardianship proceedings of older individuals if other adequate representation is unavailable can also be done; and
3. Training conducted by memory disorder clinics funded under the Alzheimer's Disease Initiative designated to increase understanding of the disease and facilitate management of persons with Alzheimer's disease by their caregivers and health professionals.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: There are no age requirements for receiving education/training.

C. PROVIDER QUALIFICATIONS: A person qualified by training or experience shall be designated to provide the service.

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Education/Training

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** Unit of Service—Individual: An episode of direct service with a client, regardless of the amount of education/training provided.
- 2.** Unit of Service—Group: An episode, regardless of the number of persons educated. Examples of one unit of service are:
 - a.** One presentation, regardless of number of attendees;
 - b.** One training presentation;
 - c.** One program-wide distribution of information;
 - d.** One article prepared and printed in a newsletter or newspaper;
 - e.** One radio or television presentation; or
 - f.** One exhibit at a health fair or other public event, whose audience or attendees are known to include older adults or caregivers.
 - g.** CIRTTS reporting requirements are included on the next page.

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Education/Training

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
ADI	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE	9999
OA3EG (GRANDPARENT)	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3EG (GRANDPARENT)	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OAA7	EDUCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OAA7	EDUCI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Emergency Alert Response

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

CCE

Sections 430.201-207, F.S.

LSP

Specific Appropriations

OAAIIB

Older Americans Act, Title III, Part B, Section 321, (a)(5)
42 U.S.C. 3030d

A. DESCRIPTION: Emergency alert/response service is a community-based electronic surveillance system, which monitors the frail homebound elder by means of an electronic communication link with a response center. The service consists of:

1. Surveillance of a client from a remote location, 24 hours a day, seven days a week, actuated by a wireless signal, waterproof portable button;
2. Response to the client actuated emergency signal by the surveillance/response center; and
3. An emergency telephone communication from the response center to a local emergency team such as 911, police, fire department, ambulance, friends and/or neighbors directing emergency services to the client's home.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Components: The home communicator requires a landline or cellular service telephone service.
2. Button: The client may activate the system by a wireless waterproof portable button unit.
3. The client must have, or be willing to arrange for, a landline or cellular phone, and be mentally and physically able to use the equipment appropriately.

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Emergency Alert Response

4. All equipment shall be approved by the Federal Communications Commission (FCC) and both the button and communicator shall have proper identification numbers. The portable button sends a wireless signal, no less than 200 feet, to a receiver located in the communicator.
5. The communicator is designed to receive a wireless signal using a manual button for signaling a need for help. It also has a digital dialer to transmit the signal to the central receiving station. It shall provide an audible and visual indication of system operation for visual and hearing-impaired persons. It shall have a rechargeable battery with ten (10) hours backup in case of a power outage.
6. The communicator is attached and does not interfere with normal use of the telephone. It has the capability of automatically seizing the telephone line, even if the phone is off the hook, dialing the number of the central station and giving identifying information about the person. Where there are multiple phones or devices on one telephone line, it will be necessary to install an alarm jack, e.g., a RJ31X.
7. The communicator shall continually check for no-power conditions and indicate such conditions to the client and monitor. The communicator shall check for an active telephone line at least once every 24 hours. If no signal is received, the central station will contact the client to test the unit. If no test signal is received, the service provider shall investigate and resolve.

C. 24-Hour Monitoring Equipment Specifications:

1. The emergency response center equipment consists of a primary receiver, a backup receiver, a clock printer, a backup power supply and a primary and backup telephone line monitor. A single element can fail without causing a loss of signal;
2. The printer prints out the time and date of the emergency signal, the client identification code, and emergency codes indicating active or passive alarm or responder reset;
3. The backup power supply provides for an excess of ten hours of emergency response center operation in the event of a power failure;
4. The telephone line monitor gives visual and audible signals if the incoming telephone line is disconnected for more than ten (10) seconds; and

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Emergency Alert Response

5. The provider agency shall arrange monthly phone calls to each client's home to test the system operation, update records and provide direct client contact.
- D. PROVIDER QUALIFICATIONS:** Alarm system manufacturers shall comply with Chapter 489.503(15), Florida Statutes. Alarm system contractors shall be certified under Chapter 489, Part II, Florida Statutes. Lead agencies shall operate in accordance with Chapter 489.503(15), Florida Statutes. Hospitals shall be licensed under Chapter 395, Florida Statutes.
- E. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One day. Installation may be reported separately as one episode.
 2. A log must be kept of all signals received and reports filed for each active emergency. Verification of daily self-checks must be available.
 3. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	EAR	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	EARI (INSTALL)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	1
LSP	EAR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	EARI (INSTALL)	MONTHLY AGGREGATE REPORTING BY CLIENT	NO REQUIREMENT	1
OA3B	EAR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	EARI (INSTALL)	MONTHLY AGGREGATE REPORTING BY CLIENT	NO REQUIREMENT	1

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Escort

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIB, SCP

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u> Rulemaking	Section 430.08, F.S.

CCE	Sections 430.201-207, F.S.	

LSP	Specific Appropriations	

OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(5) 42 U.S.C. 3030d	

SCP	Corporation for National and Community Service Senior Companion Program	

- A.** DESCRIPTION: Escort is personal accompaniment and assistance to a person who has difficulties (physical or cognitive) using regular vehicular transportation. The accompaniment and assistance is provided to clients to or from service providers, medical appointments or other destinations needed by the client. Escort is essential during travel to provide safety, security and support.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: Escorts may also provide language interpretation to persons with hearing/speech impairments or who speak a foreign language.
- C.** PROVIDER QUALIFICATIONS:
1. Providers of escort services shall have equipment available to assist in mobility of persons with disabilities such as steps, walkers, wheelchairs and sliding guards and have the capacity to operate the equipment Providers shall also be certified in first aid.
 2. If this service is provided through the Senior Companion Program, volunteers shall meet the Corporation for National and Community Service Senior Companion Program guidelines.

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Escort

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

Unit of Service: One hour of direct service with a client accumulated daily per person escorted.

a. Effective 7/1/2020

1. Escort units may not be counted in addition to the transportation unit if the escort service is provided by the vehicle driver.
2. CIRTS reporting requirements are below. ↓

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	ESC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	ESC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	ESC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
SCP	ESC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
CCES*	ESC	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999

*** Special Senior Companion Program to Capture Agency Dollar Match.**

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APPENDIX A: Service Descriptions and Standards

Section II: Services Evidence-Based Arthritis Foundation Tai Chi Program (Tai Chi for Arthritis)

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: The Arthritis Foundation Tai Chi Program, (also known as Tai Chi for Arthritis) offered in community settings, has been proven to improve movement, balance, strength, flexibility, and relaxation. Other benefits associated with this program include decrease in pain and falls. Fidelity and training information is found through the Tai Chi for Health Institute based in Australia.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This program is targeted for older adults 60 or older with chronic pain.
2. Participants are led by a certified Tai Chi For Health Institute board trainer.
3. Other requirements of the program include:
 - a. Class schedule: 6-8 weeks (twice per week).
 - b. Session length: 45-60 minutes per class.

C. PROVIDER QUALIFICATIONS:

1. Trainers must complete a two-day Arthritis Foundation instructor training workshop; recertification training is every two years (one-day training); trainers must be CPR certified and must carry professional liability insurance.
2. For Tai Chi AZ, Trainers must complete the Tai Chi for Health Institute or Arthritis foundation instructor training for the Tai Chi for Arthritis Part II Program
3. Provider must maintain program fidelity to the original program design by The Arthritis Foundation through Tai Chi for Health Institute.

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Section II: Services Evidence-Based Arthritis Foundation Tai Chi Program (Tai Chi for Arthritis)

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. Unit of Service Group: One episode of direct service with or on behalf of clients regardless of the numbers of participants for the entire 6-8-week period.
3. The contractor must verify and maintain documentation of provider qualifications for service.
4. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	AFTCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<http://taichiforhealthinstitute.org/programs/tai-chi-for-arthritis/>

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Evidence-Based Arthritis Self-Management (Self Help) Program and Evidenced-Based Programa de Manejo Personal de la Artritis

PROGRAM FUNDING SOURCE(S): OAAIIID PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** The Arthritis Self-Management (Self-Help) Program and Programa de Manejo Personal de la Artritis were developed by Stanford University; the division has been renamed as the Self- Management Resource Center (SMRC). People with different types of rheumatic diseases, such as osteoarthritis, rheumatoid arthritis, fibromyalgia, and lupus attend workshops in a community setting. Subjects covered include the following: 1) techniques to deal with problems such as pain, fatigue, frustration and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) healthy eating, 6) making informed treatment decisions, 7) disease related problem solving, and 8) getting a good night's sleep.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service must maintain fidelity of the program in accordance with Stanford University / SMRC fidelity and administrative/implementation manuals.
2. Other requirements of the program include:
 - a. Number of weeks: Six weeks (once a week)
 - b. Workshop participant size:
 - i. Minimum 10 participants (8 in rural and low- populated areas)
 - ii. Maximum 16 participants
 - c. Session length: 2.5 hours a session
 - d. Workshops are facilitated from a highly-detailed manual by two trained SMRC Leaders, one SMRC Master Trainer, or one SMRC T-Trainer.

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3. Any deviation of this program as set forth by Stanford University/SMRC is a violation of the license and may result in revocation of the Stanford/SMRC license.

C. PROVIDER QUALIFICATIONS:

1. An SMRC Leader must have successfully completed four-day/24-hour training as required for the SMRC Leader designation.
2. To remain active as an SMRC Leader, they must facilitate at least one six-week workshop every 12 months.
3. If SMRC Leaders are unable to facilitate a workshop within a given 12 months, they may attend a refresher training, though not to be used during the first 12 months after completing training, nor two years in a row.
4. If SMRC Leaders are unable to facilitate a workshop and the option of a refresher training is not available, or more than two years have passed without facilitating, they must attend a new four-day/24-hour training.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 10 participants and a maximum of 16 participants (minimum 8 in rural and low populated areas) on the first session. The same participants would continue through the six-week course. One episode equals a six-week course. The entire six-weeks needs to be completed prior to submitting a request for payment.

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4. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	ASMPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	SASMPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<https://www.selfmanagementresource.com/programs/>

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Diabetes Empowerment Education Program (DEEP)

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** The Diabetes Empowerment Education Program (DEEP) was designed to provide residents in the community with tools to better manage their diabetes. The content components include nutrition, prevention of both chronic and acute complications, blood glucose monitoring, insulin pump program, and individual goals which include quality and length of life.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** The Diabetes Empowerment Education Program is divided into eight modules covering diabetes related topics such as nutrition, complications, medications, and risk factors. The curriculum is based on national medical care and diabetes self-care education guidelines. It is hoped that professionals, community educators or promoters, and other educators will use the curriculum with adequate responsibility and achieve an impact in their communities. The curriculum has been divided into eight modules so that the facilitator can use them in any order during one to two-hour sessions for six weeks, based on the needs of the participants and the level of their knowledge of diabetes.
- C. PROVIDER QUALIFICATIONS:** There are three levels of DEEP trainers: Senior Trainers, Lead Trainers, and Peer Educators. Senior Trainers, train Lead Trainers, Peer Educators, and patients or clients. Lead Trainers, train Peer Educators, and patients or clients. Eligibility to attend the Senior and/or Lead Training requires professional experience and/or an academic background in allied health professions. Senior Trainers must have extensive experience using DEEP. Lead Trainers include nurses, dietitians, pharmacists, doctors, social workers, and community health workers or other professionals with experience in diabetes education. Peer Educators train patients or clients. Peer Educators can be diabetes patients or community members who want to help other residents understand how to manage their diabetes and avoid complications. Every patient, community health worker, or health professional who wants to teach DEEP must be certified. Individuals who wish to become certified must be trained by a certified DEEP Senior Trainer or Lead Trainer. Provider must maintain program fidelity to the original program design by The Institute for Health Research and Policy at UIC.

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Diabetes Empowerment Education Program (DEEP)

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Individual: One episode of direct service with or on behalf of a client for a six-week workshop.
4. Unit of Service Group: One episode of direct service with or on behalf of clients regardless of the numbers of participants, for the entire six-week workshop.
5. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	DEEPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	DEEPI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://mwlatino.uic.edu/deep-program>

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Section II: Services

Evidence-Based Diabetes Self-Management Program and Programa de Manejo Personal de la Diabetes

PROGRAM FUNDING SOURCE(S): OAAIIID PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: The Diabetes Self-Management Program and Programa de Manejo Personal de la Diabetes were developed by Stanford University; the division has been renamed as the Self-Management Resource Center (SMRC). Individuals managing Type 2 diabetes make weekly action plans, share experiences, and help one another create and carry out these plans while they are taught (through workshops) techniques, appropriate exercises, healthy eating, appropriate use of medications, and ways to work more effectively with health care providers.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service must maintain fidelity of the program in accordance with Stanford University/SMRC fidelity and administrative/implementation manuals.
2. Other requirements of the program include:
 - i. Number of weeks: Six weeks (once a week)
 - ii. Workshop participant size:
 - a. Minimum 10 participants (8 in rural and low populated areas)
 - b. Maximum 16 participants
 - iii. Session length: 2.5 hours a session
 - iv. Workshops are facilitated from a highly-detailed manual by two trained SMRC Leaders, one SMRC Master Trainer, or one SMRC T- Trainer.

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Evidence-Based Diabetes Self-Management Program and Programa de Manejo Personal de la Diabetes

3. Any deviation of this program as set forth by Stanford University/SMRC is a violation of the license and may result in revocation of the Stanford University/SMRC license.

C. PROVIDER QUALIFICATIONS:

1. An SMRC Leader must have successfully completed four-day/24-hour training as required for the SMRC Leader designation.
2. To remain active as an SMRC Leader, they must facilitate at least one six- week workshop every 12 months.
3. If SMRC Leaders are unable to facilitate a workshop within a given 12 months, they may attend a refresher training, though not to be used during the first 12 months after completing training, nor two years in a row.
4. If SMRC Leaders are unable to facilitate a workshop and the option of a refresher training is not available, or more than two years have passed without facilitating, they must attend a new four-day/24-hour training.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 10 participants and a maximum of 16 participants (minimum 8/maximum 16 in rural and low populated areas) on the first session. The same participants would continue through the six-week course. One episode equals six-week session. The entire six weeks needs to be completed prior to submitting request for payment.

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4. CIRT reporting requirements are below

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	DSMPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	PMPDG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/>

<https://www.selfmanagementresource.com/programs/small-group-spanish/programa-de-manejo-personal-de-la-diabetes/>

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Evidence-Based A Matter of Balance and Programa Un Asunto de Equilibrio

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** A Matter of Balance Program and Programa Un Asunto de Equilibrio were adapted from Boston University Roybal Center by MaineHealth's Partnership for Healthy Aging. A Matter of Balance uses practical coping strategies to reduce fear of falling and to diminish the risk of falling, including group discussions, mutual problem solving, exercises to improve strength, coordination and balance, and home safety evaluation.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:**
- 1.** This program is targeted for older adults 60 or over. Sessions should be held in a facility that is ADA accessible with enough space for participants to move around comfortably. Materials needed for the classes include a DVD player, participant workbooks, and DVD set, A Fear of Falling: It's a Matter of Balance and Exercise: It's Never Too Late.
 - 2.** Other program requirements include:
 - a.** Number of weeks: Eight weeks (once a week) or four weeks (twice a week)
 - b.** Workshop participant size:
 - i.** Minimum 8 participants; and
 - ii.** Maximum 12 participants
 - c.** Session length: 2 hours a session
 - d.** Two coaches are required to facilitate sessions. Master Trainers are not required to facilitate workshops in pairs however it is recommended to ensure fidelity of program.

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Evidence-Based A Matter of Balance and Programa Un Asunto de Equilibrio

3. A completer is an individual who has attended five out of the eight sessions.

C. PROVIDER QUALIFICATIONS:

1. This evidence-based program is facilitated by either Master Trainers or coaches. Master Trainers are trained by individuals from MaineHealth's Partnership for Healthy Aging (PFHA).
2. Coaches are trained by Master Trainers.
3. The Master Trainer receives a license agreement and is responsible for and providing technical assistance to the coaches.
4. Provider must maintain program fidelity to the original program design by Boston University Roybal Center.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 8 participants and maximum of 12 participants on the first session. The same participants would continue through the four-week (2 times weekly) or eight-week (one time weekly) course. One episode equals either a four-week or eight-week session. The entire eight weeks needs to be completed prior to submitting for payment.

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4. CIRTS reporting requirements are below.

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	MOBG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	ASEQG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training
information:

<http://www.mainehealth.org/mob/>

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Evidence-Based Stepping On

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** Stepping On is a program with training and technical support provided by the Wisconsin Institute for Healthy Aging. It empowers older adults to carry out health behaviors that reduce the risks of falls, improve self- management, and increase quality of life. Participants of this program should be older adults who are 65 or over, at risk of falling, have a fear of falling, or who have fallen one or more times. Topics covered in this workshop include: Simple and fun balance and strength training, the role vision plays in keeping your balance, how medication can contribute to falls, ways to stay safe when out and about in your community, what to look for in safe footwear, and how to check your home for safety.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** The Stepping On workshop meets for two hours a week for seven-weeks led by a professional leader and a peer leader. There is a minimum of 8 and a maximum of 12 participants per workshop allowed. A participant of this program must attend five out of seven sessions to be a completer. Two weeks after the last session the leader meets with the participants in their homes or by phone, and three months after the last workshop there is a class booster session.
- C. PROVIDER QUALIFICATIONS:** To lead a workshop, organizations must send potential workshop leader to a 3- day training and purchase a license.

Stepping On Leader Qualifications: Professional (RN, NP, LPN, PA, OT, PT, PTA, COTA, Social Worker, Fitness Expert, Health Educator) with professional training related to older adults, who has facilitated an evidence-based group program based on adult learning or self-efficacy principles, and worked with older adults in a professional setting. They must also have completed 3-day training, conducted by Wisconsin Institute for Healthy Aging, its licensees or Master Trainers.

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Evidence-Based Stepping On

Stepping On Peer Leader Qualifications: Older adult who has experience with falls or falls prevention, and/or participated in or facilitated a Stepping On workshop or another evidence-based group program based on adult learning of self-efficacy principles, and has strong desire to lead by example and can participate in doing the strength and balance exercises that are part of the program.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provide a yearly report to WIHA under the oversight of Master Trainer that contains: (a) the number of Stepping On workshops given by Licensee; (b) the dates of those workshops; (c) the number of attendees at each workshop; and (d) the names and addresses of the leaders of each workshop. In addition, if Licensee has offered leader training, Licensee will submit to WIHA (i) the number of leader trainings given by the Licensee; (ii) the dates of each of those trainings; (iii) the number of leaders trained at each training course; (iv) the names and addresses of the organizations receiving such training; and (v) the names of the leaders who have undergone fidelity checks and the dates that all such fidelity checks are completed.
2. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information
3. The contractor must verify and maintain documentation of provider qualifications for service.
4. Unit of Service Individual: One episode of direct service with or on behalf of a client accumulated daily for entire seven-week period.
5. Unit of Service Group: One episode of direct service with or on behalf of clients regardless of the numbers of participants for entire seven-week period.
6. The provider shall maintain a summary note for each contact, copy of the assessment, and the treatment plan.

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Evidence-Based Stepping On

7. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	STONG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	STONI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

**Website for updated fidelity and training
information:**

<https://www.ncoa.org/resources/program-summary-stepping-on/>

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Evidence-Based Tai Chi/Tai Ji Quan Moving for Better Balance

PROGRAM FUNDING SOURCE(S): OAAIIID PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: Developed out of the Oregon Research Institute, this simplified, 8-form version of Tai Chi/Tai Ji Quan, offered in community settings, has been proven to decrease the number of falls and risk of falling in older adults. Other benefits associated with this program include social and mental well-being, balance and daily physical functioning, self-confidence in performing daily activities, personal independence and quality of life and overall health.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS

1. Tai Chi/Tai Ji Quan: Moving for Better Balance workshops are offered to adults aged 60 or older.
2. Participants are led by a certified trainer.
3. There are several options for frequency and duration of the program.

	Hours Per Class	Classes Per Week	At Home Practice Per Week for 45 Minutes	Total Weeks
Option 1	1	3	0	12
Option 2	1	2	1	12
Option 3	1.5	2	0	12

The course length has many options:

- 12 weeks – minimum
 - 16 weeks
 - 24 weeks (six months) – preferred length showing best results for fewer incidences of falls especially if continued program after the 6 months.
4. A completer is an individual who completes 75 percent of the total number of sessions.

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Evidence-Based Tai Chi/Tai Ji Quan Moving for Better Balance

5. Workshop participant size is a minimum of 8 and a maximum of 15 participants. It is expected that the sessions will take place in a spacious and sufficiently private area that can adequately accommodate all participants and the instructor.
6. Materials required for the workshop include the instructor's manual. DVDs are optional.
7. Instructor is responsible for maintaining fidelity to the program by teaching each session as it was designed by the Oregon Research Institute.

C. PROVIDER QUALIFICATIONS:

1. To become certified, instructors should have some knowledge about working with older adults and experience in Tai Chi/Tai Ji Quan or other fitness programs such as yoga, dance, qigong, etc. prior to completing a Tai Chi: Moving for Better Balance training that lasts two days.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 8 participants and a maximum of 15 participants for the first session. The same participants would continue through 12 weeks, 16 weeks, or 24 weeks, whichever is desired by the certified Tai Chi/Tai Ji Quan, Moving for Better Balance Instructor. One episode equals the selected number of weeks' session. The entire selected number of weeks the program needs to be completed prior to submitting payment.

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Evidence-Based Tai Chi/Tai Ji Quan Moving for Better Balance

4. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	TCMBBG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://tjgmbb.org/>

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Section II: Services Evidence-Based Chronic Disease Self-Management Program

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>

Rulemaking	Section 430.08, F.S.

OAAIIID	Older Americans Act, Title III, Part D

A. DESCRIPTION: The Chronic Disease Self-Management Program was developed by Stanford University; the division has been renamed as the Self- Management Resource Center (SMRC). People with different chronic health problems attend workshops in a community setting. Subjects covered include:

1. Techniques to deal with problems such as frustration, fatigue, pain and isolation;
2. Appropriate exercise for maintaining and improving strength, flexibility, and endurance;
3. Appropriate use of medications,
4. Communicating effectively with family, friends, and health professionals,
- 5 Nutrition, and
6. how to evaluate new treatments.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service must maintain fidelity of the program in accordance with Stanford University/SMRC fidelity and administrative/implementation manuals.
2. Other requirements of the program include:
 - a. Number of weeks: Six-weeks (once a week)

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- b. Workshop participant size:
 - i. Minimum 10 participants (8 in rural and low populated areas)
 - ii. and Maximum 16 participants
 - c. Session length: 2.5 hours a session
 - d. Workshops are facilitated from a highly-detailed manual by two trained SMRC Leaders, one SMRC Master Trainer, or one SMRC T- Trainer.
3. Any deviation of this program as set forth by Stanford University/SMRC is a violation of the license and may result in revocation of the Stanford University/SMRC license.

C. PROVIDER QUALIFICATIONS:

- 1. An SMRC Leader must have successfully completed four-day/24-hour training as required for the SMRC Leader designation.
- 2. To remain active as an SMRC Leader, they must facilitate at least one six-week workshop every 12 months.
- 3. If SMRC Leaders are unable to facilitate a workshop within a given 12 months, they may attend a refresher training, though not to be used during the first 12 months after completing training, nor two years in a row.
- 4. If SMRC Leaders are unable to facilitate a workshop and the option of a refresher training is not available, or more than two years have passed without facilitating, they must attend a new four-day/24-hour training.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1. The provider shall maintain all appropriate documentation as set forth by the program (i.e., participant data, sign-in sheets (which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, workshop information, etc.).
- 2. The contractor must verify and maintain documentation of provider qualification for service.

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Evidence-Based Chronic Disease Self-Management Program

3. The provider must enter data into NCOA force online database system.
4. Unit of Service Group: One episode of direct service with a minimum of 10 participants and a maximum of 16 participants (minimum 8/maximum 16 in rural and low populated areas) on the first session. The same participants would continue through the six-week course. One episode equals six-week session. The entire six weeks needs to be completed prior to submitting for payment.
5. CIRT reporting requirements are below. ↓

CIRTREPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	CDSMPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

[https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self- management/](https://www.selfmanagementresource.com/programs/small-group/chronic-disease-self-management/)

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Section II: Services Evidence-Based Chronic Pain Self-Management Program

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>

Rulemaking	Section 430.08, F.S.

OAAIIID	Older Americans Act, Title III, Part D

A. DESCRIPTION: The Chronic Pain Self-Management Program was developed by Stanford University; the division has been renamed as the Self-Management Resource Center (SMRC). The Chronic Pain Self-Management Program provides information and teaches practical skills for managing the challenge of living with chronic pain. This program is for adults age 60 or older who have a primary or secondary diagnosis of chronic pain (pain that lasts longer than 3-6 months, or that lasts longer than the normal healing time of an injury).

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service must maintain fidelity of the program in accordance with Stanford University/SMRC fidelity and administrative/implementation manuals.
2. Other requirements of the program include:
 - a. Number of weeks: Six weeks (once a week)
 - b. Workshop participant size:
 - i. Minimum 10 participants (8 in rural and low populated areas)
 - ii. Maximum 16 participants.
 - c. Session length: 2.5 hours per session.
 - d. Workshops are facilitated from a highly-detailed manual by two trained SMRC Leaders, one SMRC Master Trainer, or one SMRC T- Trainer.
3. Any deviation of this program as set forth by Stanford University/SMRC is a violation of the license and may result in revocation of the Stanford University/SMRC license.

Section II: Services Evidence-Based Chronic Pain Self-Management Program

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C. PROVIDER QUALIFICATIONS:

1. An SMRC Leader must have successfully completed four-day/24-hour training as required for the SMRC Leader designation.
2. To remain active as an SMRC Leader, they must facilitate at least one 6-week workshop every 12 months.
3. If SMRC Leaders are unable to facilitate a workshop within a given 12 months, they may attend a refresher training, though not to be used during the first 12 months after completing training, nor two years in a row.
4. If SMRC Leaders are unable to facilitate a workshop and the option of a refresher training is not available, or more than two years have passed without facilitating, they must attend a new four-day/24-hour training.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 10 participants and a maximum of 16 participants (minimum 8/maximum 16 in rural and low populated areas) would continue through the six-week course. One episode equals a six-week session. The entire six weeks need to be completed prior to submitting for payment.

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[**Section II: Services Evidence-Based Chronic Pain Self-Management Program**

4. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	CPSMPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
[https://www.selfmanagementresource.com/programs/small-group/chronic-pain-self- management/](https://www.selfmanagementresource.com/programs/small-group/chronic-pain-self-management/)

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Evidence-Based Tomando Control de su Salud

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: Tomando Control de su Salud was developed at Stanford University; the division has been renamed as the Self-Management Resource Center (SMRC). It is designed to teach a range of skills in managing chronic conditions for the Spanish speaking population. The program is not a translation of the Chronic Disease Self-Management Program, but developed separately in Spanish. Subjects covered are similar, but they are presented in ways that are culturally appropriate. Subjects include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation, 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance, 3) appropriate use of medications, 4) communicating effectively with family, friends, and health professionals, 5) healthy eating, 6) appropriate use of the health care system, and, 7) how to evaluate new treatments.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service must maintain fidelity of the program in accordance with Stanford University/SMRC fidelity and administrative/implementation manuals.
2. Other requirements include:
 - a. Number of weeks: Six weeks (once a week)
 - b. Workshop participant size:
 - i. Minimum 10 participants (8 in rural and low populated areas)
 - ii. Maximum 16 participants
 - c. Session length: 2.5 hours a session

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Evidence-Based Tomando Control de su Salud

- d. Workshops are facilitated from a highly-detailed manual by two trained SMRC Leaders, one SMRC Master Trainer, or one SMRC T-Trainer.
 - 3. Any deviation of this program as set forth by Stanford University/SMRC is a violation of the license and may result in revocation of the Stanford/SMRC license.
- C. PROVIDER QUALIFICATIONS:**
- 1. An SMRC Leader must have successfully completed four-day/24-hour training as required for the SMRC Leader designation.
 - 2. To remain active as an SMRC Leader, they must facilitate at least one 6-week workshop every 12 months.
 - 3. If SMRC Leaders are unable to facilitate a workshop within a given 12 months, they may attend a refresher training, though not to be used during the first 12 months after completing training, nor two years in a row.
 - 4. If SMRC Leaders are unable to facilitate a workshop and the option of a refresher training is not available, or more than two years have passed without facilitating, they must attend a new four-day/24-hour training.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
- 1. The provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
 - 2. The contractor must verify and maintain documentation of provider qualifications for service.
 - 3. The provider must enter data into NCOA force online database system.
 - 4. Unit of Service Group: One episode of direct service with a minimum of 10 participants and a maximum of 16 participants (minimum 8/maximum 16 in rural and low populated areas) on the first session. The same participants would continue through the six-week course. One episode equals six-week course. The entire six weeks must be completed prior to submitting for payment.

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Evidence-Based Tomando Control de su Salud

5. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	TCSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.selfmanagementresource.com/programs/small-group-spanish/tomando-control-de-su-salud/>

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Section II: Services

Evidence-Based EnhanceWellness

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: EnhanceWellness was developed by the University of Washington in collaboration with Senior Services. EnhanceWellness is an evidence-based program that shows participants how to lower the need for drugs that affect thinking or emotions, lessen symptoms of depression and other mood problems, and develop a sense of greater self-reliance.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Class timeframe: minimum of six months
2. EnhanceWellness (EW) is a one-on-one, health-behavior-change coaching program. A participant works with EW clinicians to identify and develop goals about changing specific health behaviors, such as increasing physical activity, improving disease self-management, losing weight or improving nutrition, quitting smoking or drinking, managing depression and increasing socialization.
3. Participants complete a comprehensive survey at enrollment. The clinician enters the survey along with participant demographic data into a web-based software application called WellWare. WellWare scores the questionnaire, identifying the participant's strengths and areas of possible improvement. The participant works with the clinician to develop a personalized Health Action Plan around whatever area(s) they choose to work on. WellWare provides a template for building the customized Health Action Plans. The participant then continues to meet with the clinician, or is referred to other resources as necessary to achieve the steps in their plan. These resources depend on what is available at the site, but typically include support groups, exercise classes, educational classes, socialization opportunities, etc. After about six months in the program, the questionnaire is administered and scored again.

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Evidence-Based EnhanceWellness

The change in scores from baseline to follow-up is evaluated and progress or lack of progress toward the participant's goal is noted. The participant has the option to continue to work on the same goal or create a new one, or to graduate from the program

C. PROVIDER QUALIFICATIONS: This service can be delivered by a team comprised of a registered nurse or social workers, but it can be provided by a solo clinician as well. The provider must attend EnhanceWellness training.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider must maintain program fidelity to the original program design by University of Washington.
2. The provider shall maintain all appropriate documentation as set forth by the program (i.e., summary notes for each contact, copy of the assessment, and the treatment plan).
3. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
4. The contractor must verify and maintain documentation of provider qualifications for service.
5. Unit of Service Individual: One hour of direct service with or on behalf of a client accumulated daily.
6. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	EWELI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://projectenhance.org/enhancewellness/>

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Evidence-Based Healthy Eating Every Day

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: Healthy Eating Every Day was designed by The Copper Institute. This program helps individuals establish healthy eating habits. Participants will learn how to identify reason for their poor eating choices learn management skills and improve their eating habits. Healthy Eating Every Day follows the USDA Nutrition Guidelines.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Healthy Eating Every Day can be delivered in a classroom/workshop setting, or by one-on-one coaching or online formats. Each week participants will meet for one session, lasting one hour.
2. There is no minimum number of participants required to start the number of participants required to start the workshop; however, number of participants must not exceed 20.
3. A completer for this program is a participant who attends 70% of the workshop sessions.

C. PROVIDER QUALIFICATIONS:

1. To become a facilitator for the Healthy Eating Every Day program, an individual must become a partner of the organization, Active Living Partner. Individuals/organizations must do the following:
 - a. Contact Active Living Partners (information below).
 - b. Sign a license agreement. This allows you to offer Active Living Partners courses and to use our name, logo, and materials.

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Evidence-Based Healthy Eating Every Day

- c. Complete an in-person or web-based training workshop and pass an online exam. The program provider does not have to be a health care professional. Anyone interested in helping others improve their health can be trained to be a facilitator.
 - d. Start offering courses – Active Living Partners will provide lesson plans, marketing materials, guidance on working with groups, and support from Active Living Partners staff when needed.
2. Provider must maintain program fidelity to the original program design by The Cooper Institute.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program (i.e., summary notes for each contact, copy of the assessment, and the treatment plan).
2. Unit of Service Individual: One episode equals the full 14-week course regardless of the number of completers. Direct service with a participant in the entire 14-week course.
3. Unit of Service Group: One episode equals the full 14-week course regardless of the number of completers. Direct service with no more than the maximum of 20 participants in the entire 14-week course.
4. CIRT reporting requirements are below.↓

CIRTREPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	HEEDG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	HEEDI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<http://www.activeliving.info/training-support.cfm>

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Evidence-Based HomeMeds

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** HomeMeds, previously known as Medication Management Improvement System (MMIS) was adapted from the Vanderbilt University Medication Management Model by the Partners in Care Foundation in California. This intervention was designed to identify, assess and resolve medication problems that are common among frail older adults. The medication errors that are specifically targeted by HomeMeds this MMIS are: unnecessary therapeutic duplication, cardiovascular medication problems, falls, confusion, and inappropriate use of non-steroidal anti-inflammatory drugs.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Core components include screening, assessment, consultation, and follow-up for high risk older adults – all conducted by the care manager in consultation with a consulting pharmacist. The intervention includes a computerized risk assessment screening algorithm and alert system to assist care managers in identifying potential medication problems. Because care managers already dedicate time to collect medication lists, adding the intervention to identify and correct medication problems is cost-effective, relatively simple to implement, and can have a powerful positive impact on clients' health and quality of life.
- C. PROVIDER QUALIFICATIONS:**
1. To become a site for this evidence-based program, your participation in the NCOA Diffusion of Innovation Readiness survey is required. Please visit the link below to access the survey. After completion, you will be contacted by Partners in Care Foundation with more information on software and required training to implement the program:
 2. Provider must maintain program fidelity to the original program design by Vanderbilt University.

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Evidence-Based HomeMeds

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. This program requires accurate reporting of medications into an online database system which requires a site license for software. The software then creates any alerts which are then reviewed by a pharmacist who will then notify the client's physician. The provider will then follow up with the client annually unless the client addresses a concern to the case manager.
2. The provider shall maintain a summary note for each contact, copy of the assessment, and the treatment plan.
3. The provider shall maintain all appropriate documentation as set for by the program.
4. The contractor must verify and maintain documentation of provider qualifications for service.
5. Unit of Service Individual: One hour of direct service with or on behalf of a client.
6. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	MMISI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.picf.org/homemeds/>

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Applied Suicide Intervention Skills Training (ASIST)

PROGRAM FUNDING SOURCES (S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: The Applied Suicide Intervention Skills Training (ASIST) program was developed in 1983. ASIST is a 2-day training program aimed at developing “suicide first aid” skills and competencies. The program is available to anyone seeking to increase the immediate safety of persons at risk of suicide. Since people at risk are often inclined to reach out first to family and friends, ASIST fulfills a “gatekeeper” role that seeks to build and empower a broad network of community helpers. ASIST also provides those in more formal helping roles with professional development to ensure that they are prepared to provide suicide first aid help as part of the care they provide.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This program is targeted for older adults 60 or over. Sessions should be held in a facility that is ADA accessible with enough space for participants to move around comfortably.
2. Participants will receive one participant training kit per session. The kit includes a workbook, reminder card stickers, and a certificate of attendance.
3. ASIST workshops are facilitated by a minimum of two registered trainers, per 15-30 participants, who have completed a five-day Training for Trainers (T4T) course.
4. A minimum of three trainers will be required for workshops with 30-45 participants.
5. Workshops over 45 participants are not recommended and should be split into two separate sessions instead.

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Applied Suicide Intervention Skills Training (ASIST)

C. PROVIDER QUALIFICATIONS:

1. Provider must complete a five-day T4T ASIST Training; registration is maintained thereafter by presenting at least one workshop per year.
2. Provider must maintain program fidelity to the original program designed by Living Works.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with a minimum of 15 participants and maximum of 45 participants on the first session. The same participants would complete the two-day training. One episode equals one two-day training. The entire two-day training needs to be completed prior to submitting for payment. *

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	ASIST	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.livingworks.net/asist>

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Evidence-Based Healthy Ideas

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) is designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. It was developed by the Huffington Center on Aging at Baylor College of Medicine, Sheltering Arms and the Care for Elders Partnership in Houston.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** The program is delivered as part of routine case management services over a period of three to six months. Typically, the program involves at least three face-to-face visits and at least three telephone contacts; although clients with more severe depression symptoms may require more contacts or attention beyond an initial intervention period. Agencies with only short-term relationships (less than 3-6 months) with their older adult clients are not able to implement the program.
- C. PROVIDER QUALIFICATIONS**
1. Case Managers must be trained to use the Healthy IDEAS curriculum. Healthy IDEAS Case Managers use problem-solving skills in working with their clients. Healthy IDEAS model incorporates the expertise of licensed mental health providers in a manner more in keeping with the resources of the community.
- D. PROVIDER QUALIFICATIONS:**
1. Case Managers must be trained to use the Healthy IDEAS curriculum. Healthy IDEAS Case Managers use problem-solving skills in working with their clients. Healthy IDEAS model incorporates the expertise of licensed mental health providers in a manner more in keeping with the resources of a community agency. Case Managers should have prior experience in mental health and be familiar with some of the barriers exhibited by the clients. The instructor must complete a 14-20-hour Healthy IDEAS training curriculum, which is delivered by a trained mental health or behavioral health specialist in

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Evidence-Based Healthy Ideas

an interactive group format, using a training DVD and local client scenarios

2. Provider must maintain program fidelity to the original program design by Huffington Center on Aging at Baylor College of Medicine.

E. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Individual: One hour of direct service with or on behalf of a client accumulated daily.
4. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	HEIDI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<http://careforelders.org/healthyideas>

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Evidence-Based Brief Intervention and Treatment for Elders (BRITE)

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: The Brief Intervention and Treatment for Elders (BRITE) was developed by the Florida Mental Health Institute, University of South Florida and the Florida Department of Children and Families (DCF). The mission of BRITE is to identify non-dependent substance use or prescription medication issues and to provide effective service strategies prior to their need for more extensive or specialized substance abuse treatment. BRITE offers screening, brief intervention, and referral for professional assessment by trained BRITE health educators. BRITE began as a DCF-funded pilot project in four Florida Counties and later expanded to 70 sites in 18 counties under a \$14 million five-year (2006- 2011) federal grant funded by the Substance Abuse and Mental Health Services (SAMHSA) Center for Substance Abuse Treatment to the state of Florida under the national initiative known as SBIRT (Screening, Brief Intervention, and Referral to Treatment). BRITE is the only SBIRT specific to older adults.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service may be provided in the provider's office, the client's place of residence, or other appropriate locations in the community.
2. This service consists of:
 - Prescreening
 - Screening
 - Brief Intervention
 - Referral for professional assessment (previously labeled as "referral to treatment")
3. Screening instruments and educational materials for this program are available using the website provided.

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Evidence-Based Brief Intervention and Treatment for Elders (BRITE)

C: PROVIDER QUALIFICATIONS: Outreach, screening and services need to be conducted by BRITE “health educators.” This category illustrates that this is a wellness, educational, and public health approach. As the education and training of staff members and volunteers vary widely, agencies implementing BRITE must ensure individuals who serve as BRITE health educators meet the following criteria:

- Received BRITE training and is certified (process to be established); and
- Job function allows for at least 20 minutes up to one hour on each visit with the client.

This approach can be delivered by aging services’ case managers, nurses, social workers, other professionals familiar with the aging population. These may be ideal personnel to deliver the protocol, although these titles are not indicative of required job functions.

The BRITE health educators shall include certified addictions specialists, nurses, licensed social workers, case managers, licensed psychologists, and licensed mental health counselors. These licensed professionals must be trained to deliver the BRITE program.

The BRITE health educator training consists of the use of screening techniques, brief intervention with the Health Promotion Workbook, referral for professional assessment, and data collection.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program, i.e. summary notes for each contact, copy of the completed baseline (ASSIST) and three-month follow-up assessments, a copy of the completed Health Promotion Workbook or similar documentation, and a copy of the service plan.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service—Individual: An episode is an activity with one client served, regardless of the number of screening questions or the information provided.

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Section II: Services Evidence-Based Brief Intervention and Treatment for Elders (BRITE)

4. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	BRITEI (IND IV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<http://brite.fmhi.usf.edu/BRITE.htm>

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Evidence-Based Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>

Rulemaking	Section 430.08, F.S.

OAAIIID	Older Americans Act, Title III, Part D

- A. DESCRIPTION:** The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) was designed to reduce depressive symptoms and improve quality of life in older adults. The depression intervention takes place in the client's home over a six-month period, and includes problem-solving treatment, behavioral activation, and pleasant activities scheduling. Throughout the intervention, there is ongoing clinical supervision provided by a psychiatrist. PEARLS is designed to be deliverable by staff typically available in an Area Agency on Aging or in senior centers.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Program to Encourage Active Rewarding Lives for Seniors (PEARLS) is conducted over six to eight sessions during a six-month period at the client's home. Before regular counseling sessions can begin, a process of recruiting and screening prospective clients for depressive disorders must take place first. During the PEARLS treatment, the counselor must pay attention to different ways of conducting sessions depending whether it is a first, middle or last session. Clinical supervision must be conducted on a weekly or biweekly basis.

The PEARLS program consists of the following 11 distinct components (each component is billed separately):

- Screening (PEARLS): This involves recruiting clients from referral sources and screening these clients to determine eligibility for the program.
- Enrollment (PEARLE): After determining eligibility enroll client in the program.
- Session 1 (PEARL1): The first session is meant to establish rapport and trust and incorporate problem-solving treatment, behavioral activation, and pleasurable activity scheduling.

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- Session 2 (PEARL2): The second session is meant to incorporate problem- solving treatment, behavioral activation, and pleasurable activity scheduling.
- Session 3 (PEARL3): The third session is meant to incorporate problem- solving treatment, behavioral activation, and pleasurable activity scheduling.
- Session 4 (PEARL4): The fourth session is meant to incorporate problem- solving treatment, behavioral activation, and pleasurable activity scheduling.
- Sessions 5 (PEARL5): The fifth session is to continue to incorporate problem-solving treatment, behavioral activation, and pleasurable activity scheduling in addition to consolidating the skills the client has learned during the program and transitioning the client to a self-directed approach to depression management.
- Session 6 (PEARL6): The sixth session is to continue to incorporate problem-solving treatment, behavioral activation, and pleasurable activity scheduling in addition to consolidating the skills the client has learned during the program and transitioning the client to a self-directed approach to depression management.
- Session 7 (PEARL7): The seventh session is to continue to incorporate problem-solving treatment, behavioral activation, and pleasurable activity scheduling in addition to consolidating the skills the client has learned during the program and transitioning the client to a self-directed approach to depression management.
- Session 8 (or last session) (PEARL8): The eighth session is to continue to incorporate problem-solving treatment, behavioral activation, and pleasurable activity scheduling in addition to consolidating the skills the client has learned during the program and transitioning the client to a self-directed approach to depression management. This final session will include a summary of **the client's achievements**.
- Follow-up/Disenrollment (PEARLD): After completing all of the client sessions, there is a series of follow-up and wrap up of the program to include one phone call per month for three or four months before the client is discharged from the program.

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C. PROVIDER QUALIFICATIONS:

1. The PEARLS program requires a collaborative effort among several key roles, starting with an organizational leader who will provide and support an infrastructure for implementation. The organizational leader will also supervise the work done by the PEARLS manager, the clinical supervisor, Data Coordinator, and Pearls counselor. Below is a brief description of each role
 - a. PEARLS Manager: The person in charge of managing the PEARLS program may be a project manager, a planner, a case manager, a case management supervisor, or another appropriate staff member. The specific duties of the PEARLS manager may vary in different organizations or locations, but may include supervising PEARLS staff members, assigning eligible PEARLS clients to counselors who will deliver the program, and managing the activities and results of the data coordinator. In some cases, the PEARLS manager will also handle recruitment.
 - b. Clinical Supervisor: The person providing clinical supervision to the counselor(s). The supervisor meets regularly with the PEARLS counselor in person or on the phone to review client cases and provide guidance on the sessions.
 - c. Data Coordinator: The data coordinator is responsible for managing the data that comes from the PEARLS sessions, as well as from the program evaluation instruments (Baseline and Follow- up Questionnaires). Duties also include tracking and reporting the number of clients who are eligible, enrolled, and completed.
 - d. PEARLS Counselor: The PEARLS counselor is the heart of PEARLS, as this individual works directly with clients to implement the program. This role includes recruitment and screening, conducting the sessions and follow-up activities, and providing data (for screening, baseline and follow-up) to the data coordinator.
2. Provider must maintain program fidelity to the original program design by The University of Washington PRC.

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D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** As stated in the implementation requirements, the data coordinator is responsible for managing the data pertaining to the PEARLS sessions, and the program evaluations instruments. Templates and Samples of the forms needed to collect this data are provided in the PEARLS toolkit. Website to access this toolkit is provided under the program description above. It is the responsibility of the provider to implement the program as it was designed and to collect all the appropriate data requested.
- 2.** The provider shall maintain all appropriate documentation as set forth by the program.
- 3.** The contractor must verify and maintain documentation of provider qualifications for service.
- 4.** Unit of Service Individual: One episode of direct service with or hone behalf of a client. Each component (Screening, Enrollment, Sessions 1-8, and Discharge) equals one episode, and may be billed upon successful completion of the component.
- 5.** CIRTTS reporting requirements are on the next page. ↓

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Evidence-Based Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	PEARLS – SCREENING	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARLE – ENROLLMENT	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL1 - SESSION 1	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL2 - SESSION 2	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL3 - SESSION 3	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL4 - SESSION 4	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL5 - SESSION 5	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL6 - SESSION 6	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL7 - SESSION 7	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARL8 - SESSION 8	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	PEARLD – DISCHARGE/ FOLLOWUP	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

Website for updated fidelity and training information:
<https://depts.washington.edu/hprc/evidence-based-programs/pearls-program/>

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Active Living Every Day

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: Active Living Every Day (ALED) is a step-by-step behavior change program that helps individuals overcome their barriers to physical activity. This program was developed by the Cooper Institute and Human Kinetics. ALED offers alternatives to more traditional, structured exercise programs. Participants choose their own activities and create their own plans based on their lifestyle and personal preferences, focusing on moderate-intensity activities that can be easily added to their daily routines. The course text and online tools offer structure and support as participants explore their options and begin to realize how enjoyable physical activity can be. As participants work through the course, they learn lifestyle management skills and build on small successes with methods that have proven effective in producing lasting change.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. It is a 12-week course, and it can be offered in a group or one-on-one format, and focuses on behavior change to help sedentary adults adopt and maintain physically active lifestyles.
2. It is recommended that group participant workshops start out with a minimum of five individuals and maximum of 20. To gain the full benefit of the program, it is recommended that participants attend at least 70 percent of the sessions (8 out of 12 sessions).
3. Instructor may choose to have additional sessions if needed; however, unit of service is based on the 12-week format.

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Section II: Services

Evidence-Based Active Living Every Day

C. PROVIDER QUALIFICATIONS:

1. To become an Active Living Partner, you must:
 - a. Contact Active Living Partners (the contact information is located under program description above).
 - b. Sign a license agreement. This allows you to offer Active Living Partners courses and to use our name, logo, and materials.
 - c. Complete facilitator training. Providers must complete an online facilitator course, participate in either an in-person or Web-based training workshop, and pass an online exam. Individual does not have to be a health care professional to complete the facilitator training.
 - d. Start offering courses – Active Living Partners will provide lesson plans, marketing materials, guidance on working with groups, and support from our staff when you need it.
2. Provider must maintain program fidelity to the original program design by The Cooper Institute.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program (i.e., summary notes for each contact, copy of the assessment, and the treatment plan).
2. The provider shall maintain all appropriate documentation as set forth by the program (i.e., participant data, sign-in sheets, which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, workshop information, etc.)
3. The contractor must verify and maintain documentation of provider qualifications for service.
4. Unit of Service Individual: One episode equals the full 12-week course, regardless of the number of weeks the course is offered. Direct service with a participant for the entire 12-week course. The same participant would continue through the 12-week course.

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Section II: Services

Evidence-Based Active Living Every Day

5. Unit of Service Group: One episode equals one full 12-week course, regardless of the number of completers. Direct service with no more than the maximum of 20 participants in the first session course regardless of the number of participants for the entire 12-week course. The same participants would continue through the 12-week course.
6. CIRT reporting requirements are included below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	ALEDG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	ALEDI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<http://www.activeliving.info/training-support.cfm>

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APPENDIX A: Service Descriptions and Standards

Section II: Services Evidence-Based Arthritis Foundation Exercise Program (AFEP)

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
OAAIID	Older Americans Act, Title III, Part D

A. DESCRIPTION: The Arthritis Foundation Exercise Program (AFEP) is a group recreational exercise program designed specifically for people with arthritis and related diseases. The Arthritis Foundation now partners with the Athletics and Fitness Association of America for program fidelity. The program uses gentle activities to help increase joint flexibility and range of motion, maintain muscle strength, and to increase overall stamina. Other reported benefits include increased functional ability, increased self-care behaviors, decreased pain and decreased depression. The exercises learned in the program, however, should not replace therapeutic exercises prescribed for the participant by their therapist.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. AFEP classes meet for one hour, one to three times per week, for eight weeks. Instructors select from a total of over 70 exercises, performed while sitting, standing, or lying on the floor. Also included are a variety of endurance-building activities, games, relaxation techniques, and health education topics. Because there are many types of arthritis, two different levels of the AFEP program are available: basic and advanced.
2. The host sites in which Arthritis Foundation Exercise Program classes are conducted must be an accessible site consistent with the Americans with Disabilities Act, and the exercise room must set-up in a way that facilitates safe, comfortable, effective group interaction and activity.
3. Per the program developer, there is no specified minimum or maximum number of participants for this class. However, provider must monitor and maintain records of monitoring the program to ensure participant safety and program fidelity.

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APPENDIX A: Service Descriptions and Standards

Section II: Services Evidence-Based Arthritis Foundation Exercise Program (AFEP)

C. PROVIDER QUALIFICATIONS:

1. Certification as an Arthritis Foundation Exercise Program Instructor requires:
 - a. Successful completion of an Arthritis Foundation Exercise Program Leader Training Course
 - b. Proof of CPR/AED certification
 - c. Recertification every two years

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Unit of Service Group: One episode of direct service with or on behalf of clients regardless of the numbers of participants for the entire eight-week period.
4. CIRT reporting requirements below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	AFEPG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://aeawave.org/Arthritis/Arthritis-Foundation-Programs>

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Section II: Services

Evidence-Based EnhanceFitness

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A.** DESCRIPTION: EnhanceFitness, developed by the University of Washington in collaboration with Senior Services, is a group exercise program that focuses on stretching, flexibility, balance, low impact aerobics, and strength training exercises.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: EnhanceFitness sessions are held for one hour, three times a week. There is a minimum of 10 and a maximum of 25 participants per session. Each session consists of a 5-minute warm-up, a 20-minute aerobic workout, a 5-minute cool-down, a 20-minute strength training workout with soft ankle and wrist weights (0 up to 20 pounds), a 10-minute stretch, as well as balance exercises throughout the class.
- C.** PROVIDER QUALIFICATIONS:
- 1.** To lead an EnhanceFitness course, the instructor must attend the 12-hour EnhanceFitness New Instructor Training course. To qualify for the New Instructor Training Course certification as a fitness instructor is required, as well as a current CPR certification.
 - 2.** Provider must maintain program fidelity to the original program design by University of Washington.
- D.** RECORD KEEPING AND REPORTING REQUIREMENTS: The provider shall follow guidelines of Project Enhance for the EnhanceFitness Program. This includes gathering and collecting individual client files with the following information:

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Section II: Services

Evidence-Based EnhanceFitness

1. At enrollment
 - a. Participant demographics.
 - b. Baseline Fitness Checks (a set of three functional fitness tests and a few survey questions about self-rating of health and fitness).
2. Four months after enrollment, Fitness Checks are repeated.
3. Every four months after that, or annually (at site's discretion), Fitness Checks are repeated.
4. Attendance is recorded for each participant at each class.
5. There are also anonymous satisfaction surveys, which are collected annually.
6. The provider shall maintain all appropriate documentation as set forth by the program (i.e., participant data, sign-in sheets (which includes the time started, time ending, date, location, funding source, title of evidence-based program and signature of individuals participating), evaluations, workshop information, etc.).
7. The contractor must verify and maintain documentation of provider qualifications for service.
8. Unit of Service Group: One hour of direct service with or on behalf of clients regardless of the numbers of participants per session.
9. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	ENFIG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<https://projectenhance.org/enhancefitness/>

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Evidence-Based Fit and Strong!

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S

OAAIIID

Older Americans Act, Title III, Part D

A. DESCRIPTION: Fit and Strong! is an evidence-based physical activity program for older adults. This program targets older adults with osteoarthritis. This program was designed by the Midwest Roybal Center for Health Promotion & Behavior Change. Participants will learn to perform safe stretching, balance, aerobic and strengthening exercises which gradually increase frequency, duration, and intensity over time.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Other program requirements include:

a. Number of weeks: Eight weeks (three days a week)

b. Workshop participant size:

i. Minimum 10 participants

ii. Maximum 25 participants

c. Session length: 1.5 hours a session

2. There shall be access to adequate, private working space to conduct group exercise sessions. Contractors who utilize the Fit & Strong! service will follow and maintain fidelity of program by following all guidelines of the University of Illinois at Chicago, Institute for Health Research and Policy.

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Section II: Services

Evidence-Based Fit and Strong!

C. PROVIDER QUALIFICATIONS:

3. This instructor for this program must be either a certified exercise instructor or licensed physical therapist. The individual must have experience working with older adults and/or individuals with arthritis is beneficial however, Fit and Strong! certification can provide skills needed with no prior experience. Individuals must be trained and certified by the University of Illinois at Chicago, Institute for Health Research and Policy staff. To be trained individuals must participate in an 8-hour full day training.
4. Fit and Strong! providers need to:
 - a. Register to offer Fit & Strong! with a Fit & Strong staff member.
 - b. Recruit participants
 - c. Enroll participants in workshop (minimum 10; maximum 25)
 - d. Recruit a certified exercise instructor who is trained in Fit & Strong!
 - e. Obtain Fit & Strong! exercise equipment
 - f. Schedule workshop
 - g. Collect data (attendance forms, participant data, evaluation forms, etc.)

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program (i.e., participant data, sign-in sheets (which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, workshop information, etc.).
2. The contractor must verify and maintain documentation of provider qualifications for service.
3. Provider must enter data into Fit and Strong! Online database.

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Section II: Services

Evidence-Based Fit and Strong!

4. Unit of Service Group: One episode of direct service with or on behalf of clients regardless of the numbers of participants. One episode equals eight-week session. The entire eight weeks needs to be completed prior to submitting for payment.
5. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	FITSG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.fitandstrong.org/>

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Healthy Moves for Aging Well

PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** Healthy Moves for Aging Well was developed and tested by the Partners in Care Foundation in collaboration with other Southern California organizations. This physical activity program enhances the activity level of frail, high-risk sedentary older adults and is supported by case managers as an additional service of their community-based case management program. The goal of Healthy Moves is to help older adults gain independence and reduce their risk of falls.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Healthy Moves for Aging Well is performed in the homes of seniors. Care managers from community-based care management agencies teach the program's exercises to older adults in their home. Guidelines concerning the number of repetitions per movement are distributed to all participating clients and they are encouraged by their care managers and motivational phone coaches to do the movements three to five days per week, multiple times. Care managers are required to spend 15 minutes with each client to identify their personal goals and incorporate the necessary movements into their daily activities. Motivational phone coaches contact their clients on a weekly or biweekly basis for a three-month period to reinforce new behavior change.
- C. PROVIDER QUALIFICATIONS:**
1. Care managers partner with motivational volunteer coaches from the community and/or local universities to assess the physical condition of their clients, engage them to participate, teach a variety of safe exercises, and encourage continuation by monitoring their progress.
 2. Provider must maintain program fidelity to the original program design by Partners in Care Foundation.

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Healthy Moves for Aging Well

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Care managers measure changes in the level of pain, depression, fear of falling, number of falls, and fall injuries. The clients verbalize how ready they are to increase their physical activity and choose a goal they would like to achieve by becoming more active.
2. After three months of participation with regular monitoring by phone via volunteer coaches, the clients are reassessed. The new data is compared to the baseline data to measure goal achievement and any improvement in the client's mental and physical well-being because of their involvement in the exercise program. Six months from baseline, clients are asked if they are still performing the exercises regularly and progress is documented.
3. The provider shall maintain a summary note for each contact, a copy of the assessment and the treatment plan, and other appropriate documentation as set forth by the program.
4. The contractor must verify and maintain documentation of provider qualifications for service.
5. Unit of Service Individual: One hour of direct service with or on behalf of a client accumulated daily.
6. CIRT reporting requirements are below.

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	HMAWI (INDIV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.ncoa.org/resources/program-summary-healthy-moves-for-aging-well/>

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Physical Fitness

PROGRAM FUNDING SOURCE: OAAIIID

PROGRAM AUTHORITY:

Program Funding:

Specific Authority

OAAIIID:

Older Americans Act, Title III, Part D
Sections 361, 362, 42 U.S.C. 3030m, n

OAAI

Older Americans Act, Title I, Section 102, (14)

A. DESCRIPTION: Physical fitness services are defined as activities for elders to improve their strength, flexibility, endurance, muscle tone, range of motion, reflexes, cardiovascular health and/or other aspects of physical functioning.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: Activities shall be geared to all levels of fitness including frail clients and those in wheelchairs.

For OAAIIID, this service must meet ACL's Definition of Evidence-Based. Approval from DOEA contract manager is required prior to using this service description under OAA IIID.

C. PROVIDER QUALIFICATIONS: Physical fitness activities shall be provided by a certified trainer, for example personal fitness trainers or physical therapists. Other provider qualifications shall be approved by the AAA or designee before being used in any physical fitness service.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1.** Unit of Service - Group: One hour of physical fitness activity, regardless of the number of clients in attendance.
- 2.** Documentation of the number of clients attending and evaluation of the service shall be maintained.
- 3.** Providers are encouraged to keep a physician's certification or a client waiver on file for participants.

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Section II: Services

Evidence-Based Physical Fitness

4. For OAA IIID, note the following:
- The provider must have a sign-in sheet for the evidence-based program, which includes the time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating.
 - The contractor must submit ACL's criteria documents proving that the service provided is an evidence-based program.
 - The contractor must verify and maintain documentation of provider qualifications for service.
5. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	PHFG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:

<https://www.ncoa.org/center-for-healthy-aging/physical-activity/physical-activity-programs-for-older-adults/>

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Stay Active and Independent for Life

PROGRAM FUNDING SOURCE (S): OAAIID

Program Authority:

Program Funding:

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID:

Older Americans Act, Title III, Part D

A. DESCRIPTION: Stay Active and Independent for Life (SAIL) is a strength, balance, and fitness class for adults 65 and older. This SAIL Class Exercise Guide was developed because of the Washington State Department of Health's Senior Falls Prevention Study, which was funded by the Centers for Disease Control and Prevention. The goal of the SAIL Program is to increase strength, balance, and mobility while decreasing the likelihood of falls.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. SAIL classes are one hour long, three times each week. Each class includes warm-up aerobics, balance activities, strengthening and stretching exercises that can be done seated or standing, and educational components. Periodic Fitness Checks assess general mobility, arm strength, and leg strength. SAIL Guides supplement class activities by providing written education information to prevent falls by addressing fall risk factors.

There is a maximum of 20 participants allowed per class. The class site should provide sufficient space for instructor and participants to perform the exercises comfortably.

C. PROVIDER QUALIFICATIONS:

1. Providers must complete an 8-hour one-day SAIL Program Leader Training, or complete a 10-week online class through Pierce College with Continuing Education Units awarded upon course completion.
2. Providers must have background in fitness or exercise science, such as personal fitness trainers or physical therapists. Providers must be CPR certified.
3. Provider must maintain program fidelity to the original program design.

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Section II: Services Evidence-Based Stay Active and Independent for Life

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. The provider shall maintain all appropriate documentation as set forth by the program i.e., participant data, sign in sheets, evaluations, workshop information, etc.
2. Unit of Service Group: One hour of service with or on behalf of clients regardless of the numbers of participants per session.
3. CIRTTS reporting requirements are below. ↓

CIRTTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	SAILG (Group)	Monthly Aggregate Reporting	No Requirement	9999

Website for updated fidelity and training information:

<http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/OlderAdultFalls/StayActiveandIndependentforLifeSAIL>

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Section II: Services

Evidence-Based Walk with Ease

PROGRAM FUNDING SOURCE (S): OAAIIID

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIIID

Older Americans Act, Title III, Part D

- A. DESCRIPTION:** Walk with Ease is a program developed by the Arthritis Foundation intended for individuals with arthritis and other ongoing health conditions to increase the level of physical activity. Research supporting this program has shown to reduce disability, pain, fatigue, and stiffness, as well as improve balance, strength, walking pace. The program also helps build confidence to be physically active and manage ongoing health conditions.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** To participate in Walk with Ease, participants must be able to stand for 10 minutes without increased pain. Classes meet three times a week for six weeks (18 sessions). Each session must be at least 45 minutes during the beginning weeks, but may increase to an hour or more as the group improves its fitness level. A certified leader will conduct a class with a group of 12 to 15 participants. Additional leaders may be used if needed. The essential components to the program are walking, health education information, stretching and strengthening exercises (during warm-up and cool-down periods) and motivational tips and tools (including participant workbook).

Program site must be safe and accessible, following the American with Disability Act standards. Site must have adequate general liability insurance.

C: PROVIDER QUALIFICATIONS:

1. Individuals interested in becoming Walk with Ease leaders must have current certification in cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED). Certification in first aid is strongly recommended.
2. Leaders must be certified by the Athletics and Fitness Association of America (AFAA), (a partner of the Arthritis Foundation), a certification that is renewable every two years.
3. Providers must maintain program fidelity to the original program design by the Arthritis Foundation / through the Athletics and Fitness Association of America.

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Evidence-Based Walk with Ease

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Organizations must submit participant consent forms and program information form to the Arthritis Foundation within two weeks of finishing a workshop (six-week class).
2. Provider shall maintain all appropriate documentation as set forth by the program (i.e., participant data, sign-in sheets (which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, workshop information, etc.)
3. The contractor must verify and maintain documentation of provider qualifications for service.
4. Unit of Service Individual: One episode of direct service with a client equals the six-week workshop.
5. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	WWEG (Group)	Monthly Aggregate Reporting	No Requirement	9999

Website for updated fidelity and training information:

<http://www.afaa.com/courses/arthritis-foundation-walk-with-ease>

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Section II: Services

Evidence-Based Powerful Tools for Caregivers

PROGRAM FUNDING SOURCE(S): OAAIID, OAAIIIE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

OAAIID

Older Americans Act, Title III, Part D

OAAIIIE

Older Americans Act, Title III, Part E

- A. DESCRIPTION:** Powerful Tools for Caregivers (PTC) is an evidence-based education program offering a unique combination of elements. This is a self-care education program for family caregivers to improve: self-care behaviors, management of emotions, self-efficacy, and use of community resources. The program utilizes a train-the-trainer method of dissemination. Powerful Tools for Caregivers provides individuals strategies to handle unique caregiver challenges.

Caregivers develop a wealth of self-care tools to: reduce personal stress; change negative self-talk; communicate their needs to family members and healthcare or service providers; communicate more effectively in challenging situations; recognize the messages in their emotions, deal with difficult feels; and make tough caregiving decisions.

The six-week program consists of weekly, 90-minute sessions or 2.5 hours per week. The scripted curriculum provides tools that can be individualized to meet the challenges of caregiving in a supportive and interactive environment.

Target Audience: Family caregivers of adults with chronic conditions.

- B: DELIVERY STANDARDS/SPECIAL CONDITIONS:** Caregivers develop a wealth of self-care tools to: reduce personal stress; change negative self-talk; communicate their needs to family members and healthcare or service providers; communicate more effectively in challenging situations; recognize the messages in their emotions, deal with difficult feels; and make tough caregiving decisions.

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Evidence-Based Powerful Tools for Caregivers

Program requirements include:

1. Class schedule: Six weeks/ one session per week.
2. Class length: 1.5 hour – 2.5 hours per session, depending upon the needs of the local family caregivers and trained Powerful Tools Caregiver Leader availability.
3. Number of participants: no fewer than 6 participants and no more than 15 participants. The recommended class size is 8-12 participants. Special considerations are made at the discretion of the national office, particularly for rural areas where class sizes may be small. However, the AAA, must consult the contract manager prior to delivery of service to have these special considerations approved by the national Powerful Tools for Caregivers program.
4. Facility setting: The location should allow for caregivers to feel comfortable to discuss confidential information among the group. The setting should be closed off to avoid distractions in the class. Ideally a classroom or small conference room.
5. Facilitators: 2 group facilitators trained in Powerful Tools for Caregivers

C. PROVIDER QUALIFICATIONS:

1. Group facilitation experience.
2. Personal caregiving experience is recommended but not required
3. Trained in Powerful Tools for Caregivers – two-day PTC class Leader Training.
4. Have a trained PTC co-leader with whom to work.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Provider shall maintain all appropriate documentation as set forth by the program including participant data, sign-in sheets (showing time started, time ended, date, location, funding source, title of evidence-based program, and signature of individuals participating), evaluations, and workshop information.

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APPENDIX A: Service Descriptions and Standards

Section II: Services

Evidence-Based Powerful Tools for Caregivers

2. Unit of Service Group: One episode equals a complete six-week course regardless of the number of participants.
3. The contractor must verify and maintain documentation of provider qualifications for service; and
4. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3D	PTCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	PTCG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

Website for updated fidelity and training information:
<https://www.powerfultoolsforcaregivers.org/>

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Financial Risk Reduction (Assessment)

PROGRAM FUNDING SOURCE(S): CCE, OAAIIIIE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

CCE

Sections 430.201-207, F.S.

OAAIIIIE

Older Americans Act, Title III, Part E

- A. DESCRIPTION:** Financial risk reduction services provide assessment of problem area(s) or coaching and guidance for managing income, assets, liabilities and expenditures. The service may include the establishment of checking accounts and direct deposits that reduce the risk of financial exploitation of the recipient.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** This service is provided to persons who are at risk of financial exploitation, or unable or unwilling to manage their own financial affairs.
- C. PROVIDER QUALIFICATIONS:** The provider shall have knowledge, skills and abilities commensurate with the service being provided.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
- 1. Unit of Service:** One hour of direct service with or on behalf of a client accumulated daily.
 - 2. CIRTS reporting requirements are below. ↓**

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	RRFA ASSMT	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
OA3E	RRFA ASSMT	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE	9999

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Financial Risk Reduction (Maintenance)

PROGRAM FUNDING SOURCE(S): CCE, OAAIIIE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

CCE

Sections 430.201- 207, F.S.

OAAIIIE

Older Americans Act, Title III, Part E

- A. DESCRIPTION:** Financial risk reduction maintenance services provide ongoing assessment of problem area(s) or coaching and guidance for managing income, assets, liabilities and expenditures.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** This service is provided to persons who are at risk of financial exploitation or unable or are unwilling to manage their own financial affairs.
- C. PROVIDER QUALIFICATIONS:** The provider shall have knowledge, skills and abilities commensurate with the service being provided.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service with or on behalf of a client accumulated daily.
 2. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	RRFM MAINTAIN	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
OA3E	RRFM MAINTAIN	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Health Support

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAA IIIB

PROGRAM AUTHORITY:

Program Funding	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(17) 42 U.S.C. 3030d

- A.** DESCRIPTION: Health support activities assist persons to secure and utilize necessary medical treatment as well as preventive, emergency and health maintenance services. Examples of health support activities are:
1. Physical activities, including regular exercise programs, weight control emphasis, and activities to reduce mental fatigue, stress and boredom;
 2. Special programs, such as hospice or Alzheimer's disease support groups, which focus on caring rather than curing, for the impaired and terminally ill and their families;
 3. Prevention and assistance activities such as obtaining appointments for treatment; locating health and medical facilities; and obtaining therapy;
 4. Obtaining clinic cards for clients; and
 5. Arranging hospice service for non-Medicaid or Medicare clients when all other resources have been exhausted.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: For case-managed clients, this service is appropriate only for group activity or if the activity is beyond the scope of case management.
- C.** PROVIDER QUALIFICATIONS: A person qualified by training or experience shall be designated to provide the service.

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Health Support

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service—Individual: One hour of direct service with or on behalf of a client, accumulated daily.
2. Unit of Service—Group: One hour of direct service with or on behalf of clients, regardless of the number of clients participating.
3. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	HSUG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
CCE	HSUI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	HSUG (GROUP)	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999
LSP	HSUI (INDV)	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999
OA3B	HSUG (GROUP)	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999
OA3B	HSUI (INDV)	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999

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Home Health Aide

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-201, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older American Act, Title III, Part B, Section 321, (a)(5)(C) 42 U.S.C. 3030d

A. DESCRIPTION: Home health aide service is the provision of hands on personal care services, the performance of simple procedures as an extension of therapy or nursing services, assistance in ambulation or exercises, and assistance with self-administered medication as defined by Chapter 400.488, Florida Statutes, and Chapter 59A-8.020, Florida Administrative Code. Services are performed by a trained home health aide or certified nursing assistant to a client in the home, as assigned by and under the supervision of a registered nurse or licensed therapist. Types of assistance provided with activities of daily living include: bathing, dressing, eating, personal hygiene, toileting, assistance with physical transfer, and other responsibilities as outlined in Chapter 59A-8, Florida Administrative Code.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: Any client who is receiving a skilled service (nursing or therapy) shall have a plan of care established in consultation with the physician in accordance with Chapter 400.487, Florida Statutes, and the home health agency staff involved in providing care and services. Clients receiving non-skilled care from a home health agency shall have a service provision plan or written agreement in accordance with Chapter 59A-8.020, Florida Administrative Code.

The service plan shall include specific goals and services to be provided, implementation plans, and any special activities permitted or prohibited, such as special diets, medications and treatments.

For HCE, the client file shall document why the caregiver is unable to perform the service.

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Home Health Aide

C. PROVIDER QUALIFICATIONS:

1. The service shall be provided in accordance with the regulation of home health agencies in Chapter 400, Part IV, Florida Statutes, and Chapter 59A-8, Florida Administrative Code.
2. These services are provided by persons employed by agencies licensed or exempt under Chapter 400.464, Florida Statutes, or by independent contractors acting within the definitions and standards of their occupation. Per Chapter 400.464(5)(b)(1), Florida Statutes, home health services provided by DOEA, either directly or through a contractor, are exempt from home health agency licensing.
3. Home health aides shall meet training, certification and background screening requirements of Chapters 400.497, 400.512, Florida Statutes, and Chapters 59A-8.004(10) and (11) and 59A-8.0095(5), Florida Administrative Code.
4. Certified nursing assistants shall have documented competency in the home health core curriculum and meet training, certification and background screening requirements of Chapters 400.512 and 464.203, Florida Statutes, and Chapters 59A-8.004(10) and (11) and 59A- 8.0095(5), Florida Administrative Code.
5. Supervision of the home health aide and certified nursing assistant by a registered nurse in the home will be in accordance with Chapter 400.487(3), Florida Statutes. Supervision is at the election and approval of the client.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with a client.
2. Travel time can be counted if the aide transports the client.
3. Providers shall maintain a written record of personal health care activities and report any unusual incidents or changes in the client's appearance or behavioral changes.

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4. CIRT reporting requirements are below ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	HHA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HHA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HHA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	HHA	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999
OA3B	HHA	MONTHLY AGGREGATE REPORTING	NOT REQUIRED	9999

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Homemaker

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(5)(C) 42 U.S.C. 3030d

- A. DESCRIPTION:** Homemaker service is defined as the accomplishment of specific home management duties by a trained homemaker. Duties may include, but are not limited to, housekeeping; laundry; cleaning refrigerators; clothing repair; minor home repairs; assistance with budgeting and paying bills; client transportation; meal planning and preparation; shopping assistance; and routine house-hold activities.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Homemaker services can be provided under the HCE program only when the caregiver is physically unable to provide the service.
- C. PROVIDER QUALIFICATIONS:**
- Homemaker service providers may be home health or hospice agencies licensed or exempt under Chapter 400.464, Florida Statutes. Providers may also be independent vendors or employees of agencies registered with the Agency for Health Care Administration. Homemaker services provided by DOEA, either directly or through a contractor, are exempt from this licensing requirement. Independent vendors do not have to be licensed or registered, if they bill for and are reimbursed only for services they personally render. An agency using more than one employee to provide services shall register as a homemaker/sitter/companion provider in accordance with Chapter 400.509, Florida Statutes.

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Homemaker

- Homemakers shall meet background screening requirements in accordance with Chapter 400.512, Florida Statutes, and Chapter 59A- 8.004(10) and (11), Florida Administrative Code.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- Unit of Service: One worker hour. Travel time can be counted if the homemaker transports the client or performs essential errands for the client as approved by the job order.
- Units of services provided to a couple represent one (1) unit for each hour of service. The units cannot be doubled.
- Clients (and/or their caregivers/designees) and homemakers shall be provided with copies of the tasks authorized by the case manager, service coordinator or homemaker supervisor.
- Providers shall maintain a written record of activities and report any unusual incidents or changes in the client's appearance or behavioral changes.
- For HCE, the client file shall document why the caregiver is unable to perform the service.
- CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	HMK	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HMK	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HMKV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	HMK	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	20000
OA3B	HMK	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999

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Housing Improvement

PROGRAM FUNDING SOURCE(S): AC, CCE, HCE, LSP, OAAIIIB, OAAIIIES

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
AC	AmeriCorps National Service Volunteer Programs
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(4)(B), (C) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: Housing improvement is defined as providing home repairs, environmental modifications, adaptive alterations or installing security devices.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Examples of housing improvement and modifications include installation of smoke detectors, vented heaters, ramps for access, and repairs or improvements to the client's bedroom area, installation of ramps and grab bars, widening doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which accommodate medical equipment.
2. Housing improvement may only be provided when there is no one else capable of or responsible to accomplish the task. The service shall be used to lower the environmental risk level and as funds are available.
3. All applicable federal, state and local building codes are to be followed in repair work and required licenses and instructions obtained.

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C. PROVIDER QUALIFICATIONS:

1. A person qualified by training or experience shall be designated to provide the service. Satisfactory procedures shall be established to develop volunteer staff sources to augment paid staff. Providers are encouraged to use trained volunteers for this service.
2. If the service is provided through the AmeriCorps program, volunteers shall meet the AmeriCorps program requirements.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One episode begins at time of arrival and concludes at time of departure from client contact. Housing improvement service does not include travel time to or from the client's residence except as appropriate for performing essential errands (such as picking up materials or dumping debris) as approved by the job order; .
2. For AmeriCorps, one worker hour may include travel time. If services are provided to a couple, units cannot be counted twice.
3. Materials for improvement, modification or repair such as smoke detectors, vented heaters, grab bars and wood are not included in the unit rate of this service. Such materials should be donated, sponsored or purchased under the service "Material Aid."
4. CIRTS reporting requirements are included on the next page. ↓

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CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
AC	HOIM	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
CCE	HOIM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HOIMH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HOIV (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	HOIM	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	HOIM	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3ES (SUPPLEMENTAL)	HOIM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3ES (SUPPLEMENTAL)	DPHOIM (DIRECT PAY)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Information

PROGRAM FUNDING SOURCE(S): LSP, OAAIIB, OAAIIE

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(1) 42 U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: Information is an “access” service and is defined as responding to an inquiry from a person, or on behalf of a person, regarding public and private resources and available services.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: This service is not limited to the elderly and may be provided in writing, by telephone, in person or via the Internet. Information must be accurate and pertinent to the request of the inquirer. At a minimum, the Elder Helpline must maintain business hours from 8:00 a.m. to 5:00 p.m., Monday through Friday, except for state and national holiday observances. If there is a planned office closure during normal business hours, the Elder Helpline manager must notify the Department of Elder Affairs Elder Helpline coordinator and the OAA/GR Program contract manager via email at least 24 hours before the office closure. After hours and weekend calls shall be covered by an answering device that informs the caller of emergency numbers.

If the Area Agency on Aging (AAA) plans to observe holidays that are not observed by the State of Florida, the AAA must notify the Department in writing and include the agency’s policy for handling calls during the office closures.

C. PROVIDER QUALIFICATIONS: Staff (paid and volunteer) shall meet the following requirements:

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1. Have pre-service and in-service training that includes, but is not limited to, listening skills, communication, proper telephone usage, information giving and referral procedures;
2. Understand the Alliance of Information and Referral Systems (AIRS) standards for professional information and referral services; and
3. Have knowledge of the community resources.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: An episode is providing information to one person regardless of the amount of information provided.
2. The provider shall keep records to assist the provider in identifying appropriate referrals and gaps in services.
3. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	INFO	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	20000
OA3B	INFO	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	20000
OA3E	INFO	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	20000

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Intake

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIB, OAAIIE

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB 42	Older Americans Act, Title III, Part B, Section 321, (a)(23) U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: Intake involves the administration of standard intake and screening instruments for gathering information about an applicant for services. It also encompasses the follow-up of clients waiting for services to review any changes in their situations and ensure prioritization for services.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Clients should be directed to other non-DOEA resources, as appropriate, to have their needs met.
2. All staff conducting assessments must complete the DOEA web-based training and receive a certificate of completion before being eligible to conduct an assessment. To receive a certificate of completion, a score of 90 percent or above on the multiple-choice test is required.
3. Intake service in ADI may only be assessed once the client is deemed eligible post screening.



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Intake

C. PROVIDER QUALIFICATIONS: This service shall be provided by the AAA, designated lead agency, or as otherwise approved by the AAA. Minimum education requirement for an intake worker is a high school diploma or GED. Job-related experience may be substituted for a high school diploma or GED upon approval of the AAA.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with or on behalf of a client accumulated daily.
2. Records shall be kept to assist the provider in identifying appropriate referrals and gaps in services.
3. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	INSV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	NO REQUIREMENT	9999
OA3B	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	NO REQUIREMENT	9999
OA3E	INSC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Interpreter/Translating

PROGRAM FUNDING SOURCE(S): LSP, OAAIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S

LSP

Specific Appropriations

OAAIIB

Older Americans Act, Title III, Part B, Section 321, (a)(3)
42 U.S.C. 3030d

- A. DESCRIPTION:** Interpreter/Translating is defined as explaining the meaning of oral and/or written communication to non-English speaking persons and persons with disabilities who require such assistance.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Interpreters shall possess high levels of knowledge and fluency in English and the non-English language, a level generally equivalent to that of an educated native speaker of the language.
- C. PROVIDER QUALIFICATIONS:** Sign language interpreters shall be certified by the National Registry of Interpreters for the Deaf under the Screening Program of Florida Registry of Interpreters for the Deaf, except in documented emergencies. Persons providing translation shall be proficient in the client's language.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service.
 2. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	INTE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	INTE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Legal Assistance

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIIB, OAAIIIEG, OAAIIIES

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(6), (16) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: The goal of the Older Floridians Legal Assistance Program is to build a collaborative and supportive network of key stakeholders in both the aging and legal services networks to ensure accessible, high impact, high quality legal services, which are targeted particularly to older Floridians in greatest economic or social need.

B. Definitions:

1. Legal Assistance:

- a. Means legal advice and representation provided by an attorney to older individuals with economic or social needs.
- b. Includes to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and may include counseling or representation by a non-lawyer where permitted by law.
- c. Legal Assistance does not include group legal education.



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C. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Target Groups: Recognizing that OAA III-B resources are inadequate to meet the legal needs of older persons, legal assistance must be particularly targeted to older persons in greatest economic and social need.
 - a. The OAA specifies target groups, with emphasis on low-income older persons, low-income minority older persons, older persons with limited English proficiency, and those residing in rural areas.
 - b. Consideration should be given at the local level to the necessity of prioritizing additional populations for legal assistance based on community need. Establishing additional target populations should be achieved by ongoing joint planning by the AAA and legal assistance providers and reflected in governing service provider agreement.
2. Priority Issue Areas:
 - a. AAAs and legal providers shall assure that the following broad categories of legal assistance specified in the OAA are available in each planning and services area. These include: Income; Health Care; Long-term Care; Nutrition; Housing and Utilities; Defense of Guardianship; Abuse, Neglect and Exploitation; Age Discrimination; Protective Services..
 - b. Consideration should be given at the local level to the necessity of prioritizing specific legal needs within each broad category, based on the needs of the target groups. Establishing priority issue areas should be achieved by ongoing joint planning by the AAA and legal assistance providers, as well as be reflected in governing service provider agreement.

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Legal Assistance

- D. PROVIDER QUALIFICATIONS:** To achieve the goal of a coordinated and collaborative legal assistance program, the roles and responsibilities of the state unit on aging, AAAs and legal assistance providers:
1. Department of Elder Affairs:
 - a. Assign personnel (legal services developer) to provide state leadership in developing legal assistance programs for individuals throughout the state.
 - b. Providing leadership and fostering communication and collaboration throughout the state among AAAs and legal assistance providers.
 - c. Develop statewide reporting requirements and formats to collect essential and meaningful data on legal services funded by Title IIIB, OAA
 2. AAAs are to:
 - a. Select as their legal assistance provider, the entity that is best able to provide the targeted legal services. If AAA contracts with same legal provider as another AAA, agencies should coordinate with each other to ensure uniform contract standards and reporting and engage in joint planning so that the legal provider is not burdened with conflicting requirements across multiple contracts.
 - b. If AAA does not contract directly for legal services, but subcontracts through local entities, AAA is responsible for a coordinated area wide approach to legal services that meets these standards.
 - c. Assure that legal programs are adequately funded in accordance with federal and state requirements and that legal assistance services are available in every county in the Planning and Service Area.
 - d. Engage in joint-planning and cross-training efforts with the legal assistance providers.
 - e. Ensure legal assistance providers are an integral part of the AAAs advocacy efforts.

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- f. Develop and maximize the use of other resources to expand the provision of legal assistance, with emphasis on partnering with the statewide Senior Legal Helpline.
- g. Collect aggregate, non-identifying data from legal providers in accordance with Department requirements.

3. Providers:

- a. Providers must be licensed in accordance with Chapter 454.021, Florida Statutes.
- b. If not a Legal Services Corporation (LSC) project grantee, coordinate services with existing LSC in the region.
- c. Engage in joint-planning and cross-training efforts with the aging network.
- d. Ensure high quality, cost-effective and high-impact services are delivered.
- e. Provide the full scope of services and limited representation as appropriate in applicable Florida and Federal courts and administrative forums.
- f. Report aggregate, non-identifying, client and case data in accordance with Department requirements.
- g. Demonstrate capacity and expertise in major priority categories or areas of law that affect the target populations.
- h. Develop and maximize the use of other resources to expand the provision of legal assistance, with emphasis on partnering with the statewide Senior Legal Helpline.

C. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1. Unit of Service: One hour of direct service with or on behalf of a client accumulated daily.

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Legal Assistance

2. Legal assistance providers will use the Older Floridians Legal Assistance Program Information System (OFLAP-IS) guidelines to collect and report client and case data, using definitions and specific instructions provided, to the AAA and the Department. The OFLAP client report, closed case report, and narrative report should be submitted to the Department annually.
3. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	LEG	MONTHLY AGGREGATE REPORTING	NO CLIENT RECORD	9999
LSP	LEG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	LEG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3EG (GRANDPARENT)	LEG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3ES (SUPPLEMENTAL)	LEG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Material Aid

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB, OAAIIIES

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(1), (4), (5) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: Material aid is defined as:

1. Goods or food such as direct distribution of commodities, surplus food, clothing, smoke detectors, eyeglasses, hearing aids, security devices, etc.;
2. Food item(s) necessary for the health, safety or welfare. This may include condiments or paper products necessary for food consumption and delivery charges. Alcohol, drugs and tobacco products are excluded;
3. Repair, purchase, delivery and installation of any household appliance to assist with household tasks necessary for the health, safety, or welfare of the person;
4. The purchase of materials necessary to perform chore or enhanced chore services (refer to chore and enhanced chore services); and
5. The purchase of construction materials necessary to perform housing improvements, alterations and repairs (refer to housing improvement service).

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Material Aid

- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Material aid may be provided only when there is no available alternative (e.g. other program fund source or community resource) to accomplish the service or supply the goods. Prior approval shall be obtained from the AAA for purchases of \$500.00 or more, unless the AAA has established a lower review threshold. Repair, purchase, delivery and installation of household appliances shall not be provided as direct payment (reimbursement) to a caregiver. The purchase of food items shall not be provided as a direct payment (reimbursement) to a caregiver. The distribution of commodities shall be done in cooperation with the Department of Agriculture contracted recipient agencies of The Emergency Food Assistance Program (TEFAP) commodities.
- C. PROVIDER QUALIFICATIONS:** Repair, purchase, delivery, or installation of any household appliance must be performed by a licensed professional, or a provider with qualifications commensurate with the products or services being provided. Quotes must be sought to ensure cost efficiency as well as quality.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: An episode is one contact where goods, food or assistance is given to a client.
 2. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	MATE	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	MATE	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	MATV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	MATE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	MATE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3ES (SUPPLEMENTAL)	MATE	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Medication Management

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIID

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
LSP	Specific Appropriations
OAAIIID	Older Americans Act, Title III, Part D, Sections 361, 362 42 U.S.C.3030m, n
OAAI	Older Americans Act, Title I, Section 102, (14)

- A. DESCRIPTION:** Medication management is one on one screening and education and is defined as counseling regarding the medication regime that a client is using, including prescription and over-the-counter medications, vitamins and home remedies. These services also help to identify any dietary factors that may interact with the medication regime. The combination of alcohol or tobacco with various medications and diets, along with the effects on specific conditions, would ideally be included in this service.

For OAAIIID, the service must be an evidence-based program that may be a group service.

- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** The service provider shall receive written consent from the elder before medication management counseling services are to be provided. All problems found during the counseling session should be noted in the client's file and discussed with the client during the time that services are provided. The service provider should make every effort to follow up with the elderly client later and/or with permission of the client, follow up with his/her primary care physician.

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Medication Management

For OAAIID, this service must meet ACL's Definition of Evidence-Based. Approval from DOEA contract manager is required prior to using this service description under OAA IID.

- C. PROVIDER QUALIFICATIONS:** Pharmacists or individuals trained in medication management shall be used to deliver the service.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service—Individual:

- a.** For CCE and LSP: An episode is one client who receives individual counseling.
- b.** For OAAIID: Individuals are measured in hourly units. An individual is one client directly served who receives individual counseling. (Hourly units are described in Section 1: General Information, Common Issues for Programs/Services.)

2. Unit of Service—Group:

- a.** For CCE and LSP: An episode is one lecture, workshop or seminar, regardless of the number of clients who attend and receive counseling.
- b.**
- c.** For OAAIID: Groups are measured in hourly units. A group is one lecture, workshop, or seminar, regardless of the number of clients who attend and receive counseling. (Hourly units are described in Section 1: General Information, Common Issues for Programs/Services.)
- d.** A record of the number of clients served shall be maintained. This may include sign-in sheets, registration logs, or other methods of documentation. Where appropriate, client files shall contain written consent and follow-up documentation.

3. OAAIID program, note the following:

- The provider must have a sign-in sheet for the evidence-based program, which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating.

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Medication Management

- The contractor must submit ACL's criteria documents proving that the service provided is an evidence-based program.
- The provider must verify and maintain documentation of provider qualifications for service.

4. CIRT reporting requirements are included below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE*	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	MMG (GROUP)	MONTHLY AGGREGATE REPORTING	N/A	100
CCE	MMI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	MMG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	MMI (INDV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	MEMAG (GROUP)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3D	MEMAI (INDV)	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

***The MM and MEMA are two codes for Medication Management. The code MM has a unit measure of EPISODES and MEMA codes are measured in HOURS.**

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Nutrition Services

PROGRAM FUNDING SOURCES: CCE, HCE, LSP, OAAIIC1, OAAIIC2, OAAIIC3,

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking	Section 430.08, F.S
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIC1	Older Americans Act, Title III, Part C 42 U.S.C. 3030e
OAAIIC2	Older Americans Act, Title III, Part C, Subpart 2, Sections 336, 337, 42 U.S.C. 3030f, g
OAAIIC3	Older Americans Act, Title III, Part C, Subpart 3, Section 339
OAAIID	Older Americans Act, Title III, Part D, Sections 361, 362 42 U.S.C. 3030m, n
OAAI	Older Americans Act, Title I, Section 102 (14)
Food Handling	Chapter 64E-11, Florida Administrative Code (F.A.C.)
Nutrition Counseling	Section 468.516, F.S. Chapter 64B8-44.007, F.A.C.
Dietary Guidelines	http://www.health.gov/dietaryguidelines/
Material Safety Data Sheets	Occupation Safety and Health Administration (OAHA) 1910.1200 (G)
Public Law 101-445 Research	The National Nutrition Monitoring and Related Act of 1990 http://uscode.house.gov

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Nutrition Services

- A. DESCRIPTION:** The purpose of the elderly nutrition program is to:
- 1.** Reduce hunger and food insecurity. (Food insecurity occurs when an individual has a limited or uncertain availability of nutritionally adequate and safe food or ability to acquire acceptable foods in socially acceptable ways.);
 - 2.** Promote socialization; and
 - 3.** Promote health and well-being of older individuals by assisting them in gaining access to nutrition and other disease prevention and health promotion services. The intent is to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.
 - 4.** Nutrition services to older clients at community dining centers or in their homes include the following:
 - a.** Procurement, preparation, transportation, and service of meals;
 - b.** Nutrition counseling; and
 - c.** Nutrition education.
 - 5.** Elderly nutrition programs objectives are to:
 - a.** Prevent malnutrition and promote good health behaviors through participant nutrition education, nutrition screening, and intervention;
 - b.** Serve wholesome and delicious meals that are safe and have good quality, through the promotion and maintenance of high food safety and sanitation standards;
 - c.** Promote or maintain coordination with other nutrition-related supportive services for older adults; and
 - d.** Target older adults who have the greatest economic or social need with attention to low-income minority and rural clients.

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Nutrition Services: Congregate Meals

PROGRAM FUNDING SOURCES: LSP, OAAIIC1

A. PROGRAM DESCRIPTION:

1. Congregate meals provide eligible persons with nutritionally sound meals, particularly those in greatest economic and social need, low-income minorities, and those at nutritional risk.
2. These meals are provided and served in strategically located centers such as schools, churches, community centers, senior centers, and other public or private facilities where persons may obtain other social and rehabilitative services. Center site selection should attempt to offer services to varying age groups to promote interaction between the ages.
3. In addition to promoting better health among elders through improved nutrition, the program's focus is to reduce the isolation of aging and offer elders the opportunity to live their lives with dignity.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Persons receiving congregate meals shall meet eligibility requirements established by the Older Americans Act, as amended.
2. Eligible persons include:
 - a. Individuals age 60 or older;
 - b. Any spouse who attends the dining center with his/her spouse who is age 60 or older;
 - c. Persons with a disability, regardless of age, who reside in a housing facility occupied primarily by older individuals where congregate nutrition services are provided;
 - d. Disabled persons who reside at home with and accompany an eligible person to the dining center; and
 - e. Volunteers, regardless of age, who provide essential services on a regular basis during meal hours.

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Nutrition Services: Congregate Meals

3. Each meal provided must meet the following criteria:

- a. Follow the procedures described in Chapter 4
- b.

C. PROVIDER QUALIFICATIONS:

- 1. Congregate meals shall be provided by organizations that have demonstrated the following:
 - a. Ability to provide meals efficiently and reasonably; and
 - b. Provide assurances that the organization will maintain efforts to solicit voluntary support and not supplant non-federal funds.
- 2. Providers shall be awarded congregate meal contracts through a competitive solicitation process that includes evaluation of experience in providing services to older persons.
- 3. Persons qualified by training and experience shall be designated to provide the services in accordance with federal, state, and local food handling and food safety requirements.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

- 1. Unit of Service: One meal.
- 2. Documentation: The provider shall maintain the following documents:
 - a. Locally required fire marshal safety inspection (if applicable);
 - b. Food permit if applicable, the current food permit and or inspection report issued by the Department of Health, the Department of Business and Professional Regulation or the Department of Agriculture and Consumer Services;
 - c. Meal site review forms. Meal site reviews must be conducted quarterly at each physical meal site location, using the 2016 NPCR form. Reviews must be conducted as detailed in Chapter 3.
 - d. Records on each participant that verifies eligibility;

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Nutrition Services: Congregate Meals

- e. Approved menus with appropriate documentation;
 - f. Daily food temperature logs;
 - g. Documentation, with justification, of all menu substitutions and comprehensive menu substitution policies and procedures;
 - h. Documentation of nutrition education provided;
 - i. Documentation of employee and volunteer training;
 - j. Sign-in logs or meal delivery sheets for congregate meal guest; and
 - k. Record of volunteer's attendance, work hours, and applicable background screening information for congregate meal site volunteers.
3. Meals served to participants shall be included in the Nutrition Services Incentive Program (NSIP) meal count according to NSIP requirements.
4. CIRTS reporting requirements are included on the next page. ↓

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Nutrition Services: Congregate Meals

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	CNML	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	50000
LSP	CNMLG	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	3
LSP	CNMLV	MONTHLY REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	360
LSP	CNMLS	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	50000
LSP	CNMLG	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	3
LSP	CNMLV	MONTHLY REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	360
LSP	EHDM	MONTHLY AGGREGARE REPORTING	MONTHLY AGGREGATE REPORTING	50,000
NDP*	CNML	MONTHLY REPORTING BY CLIENT	MONTHLY E REPORTING BY CLIENT	50000
O3C1	CNML	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	50000
O3C1	CNMLP (PRIVATE)	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	50000
O3C1	CNMLB	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	50000
O3C1	CNMLS	MONTHLY AGGREGATE REPORTING	MONTHLY AGGREGATE REPORTING	50000
O3C1	CNMLG	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	3
O3C1	CNMLM	MONTHLY REPORTING BY CLIENT	MONTHLY REPORTING BY CLIENT	5000
O3C1	CNMLV	MONTHLY REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	360
O3C1	EHDM	MONTHLY AGGREGATE REPORTING	MONTHLY AGGREGATE REPORTING	50,000

* Used to reconcile NSIP reimbursement when funding is provided by a non-DOEA means. An example would be the United Way

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Nutrition Services: Congregate Meals Screening

PROGRAM FUNDING SOURCES: LSP, OAAIIC1

- A. PROGRAM DESCRIPTION:** Screening is the completion of a DOEA 701C Congregate Meals Assessment for congregate meals, or nutrition counseling for applicants or recipients. This is for both new clients and for clients receiving an annual reassessment.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Anyone who is an applicant or eligible for congregate meals or nutrition counseling is eligible for this service.
- C. PROVIDER QUALIFICATIONS:** Meal site manager or designee who has received training on the DOEA 701C Congregate Meals Assessment.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service with or on behalf of a client accumulated daily.
 2. Records shall be kept which will assist the provider in identifying appropriate referrals and gaps in services.
 3. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OFSERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	NTSC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
O3C1	NTSC	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Nutrition Services: Home Delivered Meals

PROGRAM FUNDING SOURCES: CCE, OAAIIC2, HCE, LSP

A. PROGRAM DESCRIPTION: Home-delivered meals provide eligible persons with nutritionally sound meals in their homes. Emphasis is placed on serving elders who are at greatest economic and social need, low-income minorities, and those who are at nutritional risk.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Eligible persons include:
 - a. Individuals age 60 or older who are homebound due to illness, disability, or isolation;
 - b. The recipient's spouse of a homebound eligible individual, regardless of age, if the provision of the collateral meal supports maintaining the person at home;
 - c. Individuals with disabilities, regardless of age, who reside at home with eligible individuals and are dependent on them for care; and
 - d. Persons at nutritional risk who have physical, emotional, or behavioral conditions, which would make their presence at the congregate site inappropriate; and persons at nutritional risk who are socially or otherwise isolated and unable to attend a congregate nutrition site.
2. Each meal provided must meet menu development and safe and sanitary handling criteria as defined in Chapter 3.
3. Frozen Meals must meet criteria as described in Chapter 3.
4. Cold Meals must meet criteria as defined in Chapter 3:

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Nutrition Services: Home Delivered Meals

- C. PROVIDER QUALIFICATIONS:** Home-delivered meals shall be delivered by organizations that have demonstrated the following:
1. Ability to efficiently deliver meals to the participants' homes;
 2. Provide assurances that the organization shall maintain efforts to solicit voluntary support and not supplant non-federal funds;
 3. Providers shall be awarded home delivered meal agreements through a competitive solicitation process that includes evaluation of experience in providing services to older clients, and
 4. Persons qualified by training and experience shall be designated to provide the services in accordance with federal, state, and local food handling and food safety requirements.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One meal
 2. Temperature Checks must meet criteria as defined in Chapter 3.:
 3. Meals served to participants shall be included in the Nutrition Services Incentive Program (NSIP) meal count according to NSIP requirements.
 4. Documentation for meals served to guests includes meal delivery sheets signed by either the recipient or driver.
 5. If the AAA has a blended rate for home-delivered meals that reflects the cost of a hot meal and the cost of a frozen meal, the following codes are available to distinguish between the two: HDMH (hot) and HDMF (frozen). These codes were set up to avoid the use of "blended" rates when the same provider is authorized to provide meals that have different rates.

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Nutrition Services: Home Delivered Meals

6. To assist the Department in tracking expenditures for CCE-funded emergency shelf stable meals, it is necessary for AAAs to use the CIRTS code, CCE: EHDM - Emergency Home-Delivered Shelf Meals. This code should be used for aggregate reporting to record the number of meals distributed.

7. CCE clients who are not assessed a co-payment, the following codes should be used:

EHDMN Emergency Home Delivered Shelf Meals – Non-Co-Payment
HDMN Home Delivered Meals – Non-Co-Payment
HDMFN Home Delivered Meals – Frozen – Non-Co-Payment
HDMHN Home Delivered Meals – Hot – Non-Co-Payment

CCE client meals can be included in the NSIP meal count.

NOTE: For HCE program clients, the file must document why the caregiver cannot perform preparation of meals.

8. CIRTS reporting requirements are included on the next page. ↓

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Nutrition Services: Home Delivered Meals

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	HDM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100000
CCE	HDMF	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100000
CCE	HDMH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100000
CCE	EHDM	MONTHLY AGGREGATE REPORTING	N/A	50,000
HCE	HDM	MONTHLY AGGREGATE REPORTING BY CLIENT	/A	100
HCE	HDMV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100000
LSP	HDM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100000
LSP	HDMF	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100000
LSP	HDMH	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100000
LSP	HDMG	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	3
NDP*	HDM	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	100000
O3C1	EHDM	MONTHLY AGGREGATE REPORTING	MONTHLY AGGREGATE REPORTING	100000
O3C2	HDM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	10000
O3C2	HDMP (PRIVATE PAY)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	10000
O3C2	HDMF	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100000
O3C2	HDMH	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100000
O3C2	HDMG	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	3
O3C2	EHDM	MONTHLY AGGREGATE REPORTING	MONTHLY AGGREGATE REPORTING	100000

*Used to reconcile NSIP reimbursement when funding is provided by non-DOEA means. An example is the United Way.

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Nutrition Services: Nutrition Counseling

PROGRAM FUNDING SOURCES: CCE, LSP, OAAIIC1, OAAIIC2, OAAIID

A. PROGRAM DESCRIPTION: Nutrition counseling provides one-on-one individualized advice and guidance to persons, who are at nutritional risk because of their poor health, nutritional history, current dietary intake, medication, use or chronic illness. Nutrition counseling includes options and methods for improving a client's nutritional status.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: Standards must meet criteria as defined in Chapter 3

For OAAIID: This service must meet ACL's Definition of Evidence- Based. Approval from DOEA contract manager is required prior to using this service description under OAA IID.

C. PROVIDER QUALIFICATIONS: A Florida licensed dietitian and/or licensed registered dietitian, or a registered dietetic technician (RDT) under the supervision of a Florida licensed dietitian and/or licensed registered dietitian shall evaluate the participant's nutritional needs, conduct a comprehensive nutrition assessment, and develop a nutrition care plan in accordance with Chapter 64B8- 43, Florida Administrative Code. It is recommended that any dietitian providing nutrition counseling be covered by malpractice insurance.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with or on behalf of a client.
2. Documentation: Licensed dietitians and/or licensed registered dietitians shall keep documentation of the nutrition assessment, the nutrition counseling plan, dietary orders, nutrition advice, progress notes, and recommendations related to the participant's health or the participant's food or supplement intake, and any participant examination or test results in accordance with Chapter 64B8-44, Florida Administrative Code.
3. For OAAIID program:
 - a. The provider must have a sign-in sheet for the evidence-based program, which includes the time started, time ending, date, location, funding source, title of evidence-based program, and signature of individuals participating.
 - b. The contractor must submit ACL's criteria documents proving that the service provided is an evidence-based program.

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Nutrition Services: Nutrition Counseling

- c. The contractor must verify and maintain documentation of provider qualifications for service.

4. CIRTS reporting requirements are below. ↓

Section II: Services

Nutrition Services: Nutrition Counseling

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	NUCOI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	n/a	100
LSP	NUCOI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
O3C1	NUCOI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
O3C2	NUCOI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3D	NUCOI (INDV)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Nutrition Services: Nutrition Education

PROGRAM FUNDING SOURCES: LSP, OAAIIC1, OAAIIC2

A. PROGRAM DESCRIPTION:

Nutrition education provides accurate and culturally sensitive information regarding the following topics:

1. Food;
2. Nutrients;
3. Diets;
4. Lifestyle factors;
5. Physical fitness and health (as it relates to nutrition); and
6. Community nutrition resources and services to participants and caregivers to improve their nutritional status.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS MUST MEET CRITERIA AS DEFINED IN CHAPTER 3

C. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: Each nutrition education session participant counts as a unit of service.
2. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	NTED	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
O3C1	NTED	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
O3C2	NTED	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Occupational Therapy

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

CCE

Sections 430.201-207, F.S.

HCE

Sections 430.601-608, F.S.

LSP

Specific Appropriations

OAAIIB

Older Americans Act, Title III, Part B, Section 321, (a)(11), (23)
42 U.S.C. 3030d

A. DESCRIPTION: Occupational therapy services are provided to produce specific functional outcomes in self-help, adaptive and sensory motor skill areas, and assist the client to control and maneuver within the environment. The service shall be prescribed by a physician. It may include an occupational therapy assessment that does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those clients to ensure they are carrying out therapy goals correctly.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. These services may be provided in the therapist's office, in the residence, or other appropriate locations in the community.
2. A registered occupational therapist and occupational assistant practitioner shall abide by American Occupational Therapy Association (AOTA) standards of practice for occupational therapy.

C. PROVIDER QUALIFICATIONS: The occupational therapist and occupational therapist assistant shall be currently licensed in the state pursuant to Chapter 468, Florida Statutes, with one year of experience. Duties of the occupational therapist assistant shall be directed by the licensed occupational therapist and shall not exceed those outlined in the Chapter 59A-8.0185, Florida Administrative Code.

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Occupational Therapy

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with or on behalf of a client.
2. The registered occupational therapist shall develop and document an intervention plan that is based on the results of the evaluation and the desires and expectations of the client and/or the client's caregiver or representative.
3. A clinical record shall be kept for each client. CIRTS reporting requirements are below. ↓

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	OCTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	OCTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	OCTV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	OCTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	OCTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Other Services

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
Rulemaking	Section 430.08, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations

- A. DESCRIPTION:** Other services is a miscellaneous category for goods or services not defined elsewhere, necessary for the health, safety or welfare of the person.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Other services may be provided only when there is no available alternative to accomplish the service or supply the goods. Prior approval shall be obtained from the AAA.
- C. PROVIDER QUALIFICATIONS:**
1. The provider qualifications are commensurate with the products or services being provided.
 2. CIRTTS reporting requirements are included on the next page. ↓

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Other Services

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	OTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	OTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	OTHV (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	OTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
NDP	OTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100

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Outreach

PROGRAM FUNDING SOURCE(S): AC, LSP, OAAIIB, OAAIIC1, OAAIIC2, OAAIIE, OAAIIEG

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
AC	AmeriCorps National Service Volunteer Program
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (c) 42 U.S.C. 3030d
OAAIIC1	Older Americans Act, Title III, Part C, Subpart 1, Section 331 42 U.S.C. 3030e
OAAIIC2	Older Americans Act, Title III, Part C, Subpart 2, Sections 336, 337 42 U.S.C. 3030m, n
OAAIIE	Older Americans Act, Title III, Part E

A. DESCRIPTION: Outreach is an access service and is a required service or function in Title IIB and Title IIC. Outreach is defined as a face-to-face, one-to- one intervention with clients initiated by the agency for the purpose of identifying potential clients or caregivers and encouraging their use of existing and available resources.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Group contact is not outreach. Outreach efforts shall take place in highly visible public locations or in neighborhoods identified for visiting or canvassing. Title III of the Older Americans Act requires outreach to older clients with greatest economic and social need, with attention to low- income minority and older clients residing in rural areas.
2. Outreach activities cannot be counted for clients already receiving any Older Americans Act services or other DOEA funded services. Contact shall be initiated by the outreach worker, not by the client.

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Outreach

C. PROVIDER QUALIFICATIONS:

1. Outreach services are provided by paid or volunteer staff of the designated lead agency, or as otherwise approved by the AAA. Minimum education requirements for outreach workers include a high school diploma or GED. Job-related experience may be substituted for a high school diploma or GED upon approval of the AAA. Outreach staff shall be knowledgeable about local resources.
2. If the service is provided through the AmeriCorps program, volunteers must meet the AmeriCorps program requirements.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: An episode of outreach is one-on-one, face-to-face, contact with an older individual who is not receiving any DOEAF funded services.
2. CIRTS reporting requirements are included on the table below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
AC	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
LSP	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
O3C1	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
O3C2	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3EG (GRANDPARENT)	OTR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Personal Care

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(5) 42 U.S.C. 3030d

A. DESCRIPTION:

1. Personal care is primarily the provision of assistance with eating, dressing, personal hygiene and other activities of daily living. This service may also include other tasks that are incidental to the care provided. Assistance with meal preparation and housekeeping chores, such as bed making, dusting and vacuuming are examples of these secondary services.
2. Personal care can include accompanying the client to clinics, physician office visits, or trips for health care, provided the client does not require special medical transportation. Personal care can also include shopping assistance to purchase food, clothing and other items needed for the client's personal care needs.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. For the Home Care for the Elderly program, personal care shall be provided only when the caregiver is unable to provide the service.
2. Personal care may be provided by home health aides or certified nursing assistants (refer to home health aide services) but does not substitute for the medical care usually provided by a registered or licensed practical nurse or therapist, home health aide or certified nursing assistant. Personal care does not include the performance of simple procedures as an extension of therapy or nursing services and assistance with self- administered medication. Services provided shall be specified in a written service agreement and essential to the needs of the client rather than the client's family.

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Personal Care

C. PROVIDER QUALIFICATIONS:

1. This service shall be provided in compliance with the regulation of the home health agencies in Chapter 400, Part IV, Florida Statutes, and Chapter 59A-8, Florida Administrative Code. Services are provided by persons employed by agencies licensed or exempt under Chapter 400.464, Florida Statutes, or independent vendors in compliance with Chapter 400, Part IV Florida Statutes, and Chapter 59A-8, Florida Administrative Code. Per Chapter 400.464(5)(b)(1), Florida Statutes, home health services provided by DOEA either directly or through a contractor, are exempt from home health agency licensing.
2. Personal care assistants shall meet background screening requirements in accordance with Chapter 400.512, Florida Statutes, and Chapter 59A-8.004(10) and (11), Florida Administrative Code.
3. Supervision by a registered nurse in the home shall be in accordance with Chapter 400.487(3), Florida Statutes. Supervision is at the election and approval of the client.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with a client.
2. Personal care providers shall maintain a chronological written record of services and report any unusual incidents or changes in the client's appearance or behavior.
3. For the Home Care for the Elderly program, the client file must document why the caregiver is unable to perform the service.

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4. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICE	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	PECA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	PECA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	PECV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	PECA	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	PECA	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999

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Pest Control (Enhanced Initiation)

PROGRAM FUNDING SOURCE(S): CCE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

CCE

Sections 430.201-207, F.S.

- A. DESCRIPTION:** Enhanced initial pest control services assists in ridding the environment of insects and other potential carriers of disease and enhances the safety, sanitation and cleanliness for recipients. Initiation covers start-up costs. This service is beyond the scope of pest control initiation due to the greater effort required.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** This service must be necessary to enhance the safety, sanitation and cleanliness of the elder's home.
- C. PROVIDER QUALIFICATIONS:** This service shall be provided by a licensed and insured company or individual in accordance with Chapter 482, Florida Statutes.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: An episode of enhanced initial treatment may consist of more than one application.
 2. CIRT reporting requirements are below. ↓

CIRTREPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	EPECI (INITIAL)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100

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Pest Control (Initial)

PROGRAM FUNDING SOURCE(S): CCE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

CCE

Sections 430.201-207, F.S.

- A.** DESCRIPTION: Initial pest control services assists in ridding the environment of insects and other potential carriers of disease and enhances the safety, sanitation and cleanliness for recipients. Initiation covers start-up costs.
- B.** DELIVERY STANDARDS/SPECIAL CONDITIONS: Pest control services must be necessary to enhance the safety, sanitation and cleanliness of the elder's home.
- C.** PROVIDER QUALIFICATIONS: This service shall be provided by a licensed and insured company or individual in accordance with Chapter 482, Florida Statutes.
- D.** RECORD KEEPING AND REPORTING REQUIREMENTS:
- 1.** Unit of Service: An episode of initial treatment may consist of more than one application.
 - 2.** CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	PECI (INITIAL)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100

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Pest Control Maintenance)

PROGRAM FUNDING SOURCE(S): CCE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

CCE

Sections 430.201-207, F.S.

- A. DESCRIPTION:** Pest control maintenance services assist in ridding and maintaining the environment free of insects and other potential carriers of disease, and enhances the safety, sanitation and cleanliness for recipients.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Pest control services must be necessary to enhance the safety, sanitation and cleanliness of the elder's home.
- C. PROVIDER QUALIFICATIONS:** This service shall be provided by a licensed and insured company or individual in accordance with Chapter 482, Florida Statutes.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: An episode of maintenance consists of a maximum of one application per month.
 2. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	PECM (MAINTAIN)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100

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Pest Control (Rodent Control)

PROGRAM FUNDING SOURCE(S): CCE

PROGRAM AUTHORITY:

Program Funding

Specific Authority

CCE

Sections 430.201-207, F.S.

- A. DESCRIPTION:** Pest control rodent services assist in ridding the environment of rodents; and other potential carriers of disease, and enhances the safety, sanitation and cleanliness for recipients. Rodent service consists of trapping, baiting, or other treatments or applications that result in the elimination of rodent(s).
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Rodent control services must be necessary to enhance the safety, sanitation and cleanliness of the elder's home.
- C. PROVIDER QUALIFICATIONS:** This service shall be provided by a licensed and insured company or individual in accordance with Chapter 482, Florida Statutes.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: An episode of rodent control may require more than one treatment.
 2. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	ROCI	MONTHLY AGGREGATE REPORTING BY CLIENT	NA	100

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Physical Therapy

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(11), (23) 42 U.S.C. 3030d

A. DESCRIPTION: Physical therapy is a service provided to produce specific functional outcomes in ambulation, muscle control and postural development, and prevent or reduce further physical disability. The service shall be prescribed by a physician. It may also include a physical therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those individuals to ensure they are carrying out therapy goals correctly.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service may be provided in the therapist's office, client's residence or other appropriate locations in the community.
2. A physical therapist assistant shall comply with the standards of ethical conduct for physical therapist assistant and with all the legal requirements of jurisdictions relating to the practice of physical therapy.

C. PROVIDER QUALIFICATIONS: The physical therapist and physical therapist assistant shall be currently licensed in the state in accordance with Chapter 486, Florida Statutes, and have one year of experience. Duties of the physical therapist assistant shall be directed by the licensed physical therapist and shall not exceed those outlined in the Chapter 59A-8.0095, Florida Administrative Code.

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Physical Therapy

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with or on behalf of a client.
2. A physical therapist shall develop and document a plan of care that is based on the results of the evaluation and the desires and expectations of the client and appropriate others about the outcome of the service.
3. A clinical record shall be kept for each client.
4. CIRTS reporting requirements are below. ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	PHTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	PHTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	PHTV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	PHTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	PHTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Recreation

PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

LSP

Specific Appropriations

OAAIIIB

Older Americans Act, Title III, Part B, Section 321, (a)(1), (7)
42 U.S.C. 3030d

- A. DESCRIPTION:** Recreation is defined as participation in or attendance at calendared (with date and time) events that are directed by a person that meets the provider qualifications below. The purpose is to offer activities of interest for participants, increase physical and mental stimulation, prevent isolation, and encourage socialization. The type of activities may include games, sports, arts and crafts, theater, trips and other social or physical activities.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Services shall be provided that include activities which appeal to all program participants and levels of functioning; increase physical stamina in older persons; provide mental stimulation; provide social interaction; and provide an appropriate mix of individual and group activities.
- C. PROVIDER QUALIFICATIONS:** A person qualified by training or experience shall be designated to provide the service. Training shall include the process of aging, interest of the elderly, and acquiring knowledge of community resources available for use in recreational activities.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of recreation activity regardless of the number of participants. Recreation cannot be counted as a separate unit of service, if delivered through adult day care services or adult day health care.
 2. Providers need to maintain sign-in sheets for all recreation activities provided.
 3. CIRTTS reporting requirements are included on the next page. ↓

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Recreation

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	RECR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	15000
OA3B	RECR	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	50000

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Referral/Assistance

PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB, OAAIIIE, OAAIIIEG

PROGRAM AUTHORITY:

Program Funding

Specific Authority

LSP

Specific Appropriations

OAAIIIB

Older Americans Act, Title III, Part B, Section 321, (a)(1), (14)
(B) 42 U.S.C. 3030d

OAAIIIE

Older Americans Act, Title III, Part E

A. DESCRIPTION:

1. Referral/assistance is an activity provided via telephone or one-on-one in person wherein information is obtained about the person's needs, and the person is directed to resources most capable of meeting the needs. Contact with the resource is made for the person, as needed. Follow-up is a mandatory part of referral/assistance and is conducted with the referred person and/or the resource to determine the outcome of the referral/assistance.
2. In referral/assistance, more in-depth interviewing and assessment may be required than in information-giving to assist a client in either determining his or her need, or linking him or her with an appropriate resource.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Follow-up shall be made within fourteen (14) business days of the referral/assistance. Agencies making referrals will need to obtain intake information from the client to be used as part of the referral/assistance process.
2. Providers are expected to assist the person being referred by planning for appointments, assistance with forms and paperwork requirements, and making arrangements for travel and escort services.

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Referral/Assistance

C. PROVIDER QUALIFICATIONS: Referral/assistance providers shall have:

1. Pre-service and in-service training that includes, but is not limited to, listening skills, communication, proper telephone usage, information giving and referral procedures;
2. An understanding of the Alliance of Information and Referral Systems (AIRS) standard for professional information and referral services; and
3. Knowledge of the community resources.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: An episode of referral is counted only after all follow-up, regardless of the number of contacts, has been completed.
2. Records shall be kept identifying organizations to which a referral has been made and of the follow-up results.
3. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	REFE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	REFE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3E	REFE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3EG (GRANDPARENT	REFE	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Respite Care (Facility-Based)

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIB, OAAIIIE, SCP

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201.207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(19) 42 U.S.C. 3030d
OAAIIIE	Older Americans Act, Title III, Part E, Sections 373(b)(4)
SCP	Corporation for National and Community Service Senior Companion Program

A. DESCRIPTION: Facility-based respite care is the provision of relief or rest for a primary caregiver from the constant, continued supervision and care of a functionally-impaired older person by providing care for the older person in an approved facility-based environment for a specified period of time.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. If respite care requires a home health aide due to the client's medical condition, a physician or medical professional shall prescribe the service. Respite care cannot substitute for care that a licensed nurse or therapist must provide. Respite care may include personal care, homemaker or companionship activities and may be provided by a home health aide. It shall be provided according to the standards for the service under which it is provided.
2. Respite care may be provided for caregivers who are employed regardless of program funding source. Caregivers who receive a stipend under the Home Care for the Elderly (HCE) program are eligible for respite services, if needed.

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Respite (Facility-Based)

C. PROVIDER QUALIFICATIONS:

1. This service can be provided in any safe environment suitable to the needs of the clients, or a licensed facility. If the service is provided in a licensed facility, the standards applicable to the type of facility apply, i.e., adult day care, assisted living facility, or nursing home. If the service is provided in a non-licensed facility, there shall be at least 2 staff for every 6 clients, 4 staff for every 12 clients and 1 staff for each additional 6 clients.
2. If this service is provided through the Senior Companion Program, volunteers shall meet the Corporation for National and Community Service Senior Companion Program guidelines.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

3. Unit of Service: One hour of actual client attendance at the facility is one unit of facility-based respite. Actual client attendance is defined as the time between the client's arrival at the facility and the time of departure from the facility. Time spent in transit to the facility is not counted in the daily attendance.
4. Unit of service for the Senior Companion Program: One worker hour.
5. A daily attendance log with time in and time out shall be maintained.
6. CIRTS reporting requirements are included on the next page.

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Respite (Facility-Based)

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	RESF	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	1000
CCE	RESF	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	1000
HCE	RESF	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	RESV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	RESFV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	RESF	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	1000
OA3B	RESF	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	1000
OA3E	RESF	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
SCP	RESF	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	1000
CCES*	RESF	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	1000

* Special Senior Companion Program to Capture Agency Dollar Match.

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Section II: Services

Respite Care (In-Home)

PROGRAM FUNDING SOURCE(S): AC, ADI, CCE, HCE, LSP, OAAIIB, OAAIIE, RELIEF, SCP

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
AC	AmeriCorps National Service Volunteer Program
ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(19) 42 U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E, Sections 373(b)(4)
RELIEF	Respite for Elders Living in Everyday Families
SCP	Corporation for National and Community Service Senior Companion Program

A. DESCRIPTION: In-home respite care is the provision of relief or rest for a primary caregiver from the constant, continued supervision and care of a functionally impaired older person by providing care for the person in the home for a specified period.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. If respite care requires a home health aide due to the client's medical condition, a physician or medical professional shall prescribe the service. Respite care cannot substitute for care that shall be provided by a licensed nurse or therapist. Respite may include personal care, homemaker or companionship activities and may be provided by a home health aide. It must be provided according to the standards for the service under which it is provided.

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2. Respite care shall meet the needs of the client and primary caregiver and be inclusive of the services that will allow the caregiver to leave the premises. The primary caregiver (relative or non-relative) shall be unpaid, and shall provide care on a 24-hour bases with little or no relief to receive DOEA funded respite care services. A primary caregiver is defined as any person who regularly can be depended on to provide or arrange help as needed with Activities of Daily Living (ADLs) and Instrumental activities of Daily Living (IADLs). Caregiver paid (salaried or hourly) by a state-funded program may not receive respite care. Caregivers who receive a basic subsidy payment under the Home Care for the Elderly (HCE) program are eligible for respite services, if needed.

C. PROVIDER QUALIFICATIONS:

1. This service can be provided in the home or a safe environment suitable to the needs of the client. Respite may include personal care, homemaker or companionship activities and may be provided by a home health aide. It shall be provided according to the standards for the service under which it is provided.
2. If the service is provided through the AmeriCorps program, volunteers shall meet the AmeriCorps program requirements.
3. If this service is provided through the Senior Companion Program, volunteers shall meet the Corporation for National and Community Service Senior Companion Program guidelines.
4. If this service is provided through the RELIEF Program, volunteers shall meet the Department's guidelines for volunteer service.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service.
2. Providers shall maintain a written record of activities and report any unusual incidents or changes in the client's appearance or behavior.

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Respite Care (In-Home)

3. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
AC	RESP	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
ADI	RESP	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	200
CCE	RESP	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	200
HCE	RESP	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	RESV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	RESP	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3B	RESP	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
OA3E	RESP	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3E	DPRESP (DIRECT PAY)	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
RELF	RESP	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	200
SCP	RESP	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999
CCES*	RESP	MONTHLY AGGREGATE REPORTING	ZERO UNIT ENTRY REQUIRED ANNUALLY	9999

*Special Senior Companion Program to Capture Agency Dollar Match.

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Screening/Assessment

PROGRAM FUNDING SOURCE(S): LSP, OAAIIB, OAAIIC2, OAAIIE, OAAIIEG

PROGRAM AUTHORITY:

Program Funding

Specific Authority

LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(5)(A) 42 U.S.C. 3030d
OAAIIC2	Older Americans Act, Title III, Part C, Subpart 2, Section 339, (2)(J)
OAAIIE	Older Americans Act, Title III, Part E

- A. DESCRIPTION:** Screening/assessment is defined as administering standard assessment instruments for gathering information about clients to determine need and eligibility for services and prioritizing them at the time of active enrollment or to reassess currently active clients.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** All staff conducting assessments must complete the DOEA web-based training and receive a certificate of completion before being eligible to conduct an assessment. To receive a certificate of completion, a score of 90 percent or above on the multiple-choice test is required.
- C. PROVIDER QUALIFICATIONS:** Screening/assessment is provided by the AAA, designated lead agency, or as otherwise approved by the AAA. Minimum education requirements for new staff are a bachelor's degree in social work, psychology, sociology, nursing, gerontology or related field. Year-for-year related job experience or any combination of and related experience may be substituted for a bachelor's degree upon approval of the AAA.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
- 1.** Unit of Service: One hour of direct service with or on behalf of a client accumulated daily. It can include travel time related to the client. The time may include time spent with caregivers when it is related to the client's situation.

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Screening/Assessment

2. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	SCAS	MONTHLY AGGREGATE REPORTING BY CLIENT	SERVICES REPORTED BY CLIENT	100
OA3B	SCAS	MONTHLY AGGREGATE REPORTING BY CLIENT	SERVICES REPORTED BY CLIENT	100
O3C2	SCAS	MONTHLY AGGREGATE REPORTING BY CLIENT	SERVICES REPORTED BY CLIENT	100
OA3E	SCAS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3EG (GRANDPARENT)	SCAS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100

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Shopping Assistance

PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

CCE

Sections 430.201-207, F.S.

LSP

Specific Appropriations

OAAIIB

Older Americans Act, Title III, Part B, Section 321, (a)(5)(C)
42 U.S.C. 3030d

- A. DESCRIPTION:** Shopping assistance is defined as assisting a client in getting to and from stores or shopping on behalf of a client, including the proper selection of items to purchase. The service also includes storing purchased items upon return to the client's home. An individual shopping aide may assist more than one client during a shopping trip.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Transportation, if provided to the client, shall include the trip to the shopping destination and the return trip to the client's home. This assistance may be provided individually or in groups.
- C. PROVIDER QUALIFICATIONS:** A person qualified by training or experience shall be designated to provide the service. Training should include nutritional needs of older persons, best seasonal buys for food and other products, selecting for quality and quantity, and selecting for economy.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: A one-way trip per person assisted.

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Shopping Assistance

2. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	SA	MONTHLY AGGREGATE REPORTING BY CLIENT	NA	200
LSP	SA	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	SA	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Sitter

PROGRAM FUNDING SOURCE(S): OAAIIIEG

PROGRAM AUTHORITY:

Program Funding

Specific Authority

OAAIIIE

Older Americans Act, Title III, Part E, Section 373 (b)(4)

- A. DESCRIPTION:** Sitter services are provided to a minor child, not more than 18 years old, or a child who is an individual with a disability residing with an age 55+ grandparent or other age 55+ related caregiver. Sitter services may be carried out in the home or in a facility during the day, at night or on weekends and are arranged by the caregiver for a specified period.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Services shall be delivered as a respite to enable caregivers to be temporarily relieved of caregiver responsibility.
- C. PROVIDER QUALIFICATIONS:** Determined by the relative caregiver.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service.
 2. A direct payment shall be provided to the relative caregiver or vendor in accordance with the agency's direct payment policies. Prior authorization from the Title IIIIE coordinator or designated staff is required.
 3. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
OA3EG (GRANDPARENT)	DPSIT	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Skilled Nursing Services

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B, Section 321, (a)(5) 42 U.S.C. 3030d

- A. DESCRIPTION:** Skilled nursing service is part-time or intermittent nursing care administered to a client by a licensed practical nurse, registered nurse or advanced registered nurse practitioner, in the client's place of residence, pursuant to a plan of care approved by a licensed physician.
- B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** A physician's prescription/plan of treatment is required to obtain skilled nursing services in the home, which is reviewed at 62-day intervals.
- C. PROVIDER QUALIFICATIONS:** This service shall be provided by persons currently licensed under Chapter 464, Florida Statutes, operating within their scope of practice, and pursuant to physician's plan of treatment.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: One hour of direct service.
 2. CIRTTS reporting requirements are included on the next page. ↓

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Skilled Nursing Services

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	HN	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HN	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	HN (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	HN	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	HN	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Specialized Medical Equipment, Services and Supplies

PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB, OAAIIIES

PROGRAM AUTHORITY:

Program Funding

Specific Authority

ADI	Sections 430.501-504, F.S.
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIIB	Older Americans Act, Title III, Part B
OAAIIIE	Older Americans Act, Title III, Part E, Section 373(b)(5)

A. DESCRIPTION: Specialized medical equipment, services and supplies include the following;

1. Adaptive devices, controls, appliances or services that enable clients to increase their ability to perform activities of daily living. This service also includes repair of such items as well as replacement parts;
2. Dentures, walkers, reachers, bedside commodes, telephone amplifiers, touch lamps, adaptive eating equipment, glasses, hearing aids, and other mechanical or non-mechanical, electronic, and non-electronic adaptive devices;
3. Supplies may include items such as adult briefs, bed pads, oxygen or nutritional supplements;
4. Medical services pay for doctor visits or dental visits; and
5. Pharmaceutical services payment for needed prescriptions.

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Specialized Medical Equipment, Services and Supplies

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service shall only be provided, if it cannot be purchased through Medicare, Medicaid or other third parties. If a Medicare co-payment is required for the purchase, it is permissible to pay it.
2. All items shall have direct medical or remedial benefit to the client and be related to the client's medical condition. A physician's verification of the need for any item or service may be requested.

C. PROVIDER QUALIFICATIONS: The provider qualifications are commensurate with the products or services being provided. Items shall meet applicable standards of manufacture, design and installation.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: An episode is one contact where equipment, services or supplies are given to a client.
2. CIRT reporting requirements are below. ↓

CIRT REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	SCSM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	SCSM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	SCSM	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	SCSV (VENDOR)	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	SCSM	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	9999
OA3B	SCSM	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	9999
OA3ES (SUPPLEMENTAL)	SCSM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999
OA3ES (DIRECT PAY)	DPSCSM	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	9999

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Speech Therapy

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB

PROGRAM AUTHORITY:

<u>Program Funding</u>	<u>Specific Authority</u>
CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(11), (23) 42 U.S.C. 3030d

A. DESCRIPTION: Speech therapy is a service provided to produce specific functional outcomes in the communication skills of a client with a speech, hearing or language disability. The service shall be prescribed by a physician. The service may also include a speech therapy assessment, which does not require a physician's prescription. In addition, this service may include training direct care staff and caregivers and monitoring those clients to ensure they are carrying out therapy goals correctly.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. This service may be provided in the therapist's office, in the client's residence, or other appropriate settings in the community.
2. Speech/language pathologists identify and evaluate communication and swallowing problems. The speech therapist may determine the need for personal alternatives or augmentative systems and recommends and trains for utilization of such systems.

C. PROVIDER QUALIFICATIONS: Providers shall be governed by the Board of Speech-Language and Audiology and shall abide by the Code of Ethics last revised November 16, 2001. Speech-language pathologists/audiologists shall practice in accordance with Chapter 468, Florida Statutes, and Chapter 59A-8, Florida Administrative Code.

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Speech Therapy

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of direct service with or on behalf of a client.
2. A clinical record shall be maintained for each client and include an evaluation of the client's needs, statement of problems, plan of care or service provision plan, and service/progress notes.
3. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
CCE	SPTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	SPTH	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	SPTV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	SPTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999
OA3B	SPTH	MONTHLY AGGREGATE REPORTING	NO REQUIREMENT	9999

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Specialized Adult Day Care

PROGRAM FUNDING SOURCE(S): ADI

PROGRAM AUTHORITY:

Program Funding

Specific Authority

Rulemaking

Section 430.08, F.S.

ADI

Sections 430.501-504, F.S.

Sections 429.918, F.S.

- A.** DESCRIPTION: Florida's Alzheimer's Disease Initiative (ADI) provides services to meet the changing needs of individuals and families affected by Alzheimer's disease and similar memory disorders. The ADI provides caregiver respite services and support. ADI respite includes in-home, facility-based (usually at adult day care centers), emergency, and extended care (up to 30 days) for caregivers who serve patients with memory disorders.

In addition to Respite Care Services, clients may be eligible to receive Specialized Alzheimer's Disease Day Care Services from a licensed day care center in accordance with Chapter 429.918, F.S. Clients eligible for these services shall have a documented diagnosis of Alzheimer's disease or a dementia-related disorder (ADRD) from a licensed physician, licensed physician assistant, or a licensed advanced practice registered nurse.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

- 1.** A Specialized Adult Day Care Center (ADCC) must be licensed in accordance with Chapter 429.918, F.S. to provide the following client care and services:
 - a.** Provide therapeutic, behavioral, health, safety, and security interventions; clinical care; support services; and educational services that are customized for the specialized needs of a participant's caregiver and the participant who is affected by Alzheimer's disease or an irreversible, degenerative condition resulting in dementia.
 - b.** Provide ADRD participants with a program for dementia-specific, therapeutic activities, including, but not limited to, physical, cognitive, and social activities appropriate for the ADRD participant's age, culture, and level of function.

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- c. Maintain at all times a minimum staff-to-participant ratio of one staff member who provides direct services for every five ADRD participants.
- d. Provide ADRD participants with hands-on assistance with activities of daily living, inclusive of the provision of urinary and bowel incontinence care.
- e. Use assessment tools that identify the ADRD participant's cognitive deficits and identify the specialized and individualized needs of the ADRD participant and the caregiver. This assessment shall be conducted when the ADRD participant is initially admitted into the center and shall be updated when the ADRD participant experiences a significant change, but no less frequently than annually.
- f. Create an individualized plan of care for each ADRD participant which addresses the identified, dementia-specific needs of the ADRD participant and the caregiver. The plan of care shall be established when the ADRD participant is initially admitted into the center and reviewed at least quarterly.
- g. Conduct a monthly health assessment of each ADRD participant which includes, but is not limited to, the ADRD participant's weight, vital signs, and level of assistance needed with activities of daily living.
- h. Complete a monthly update in each ADRD participant's file regarding the ADRD participant's status or progress toward meeting the goals indicated on the individualized plan of care.
- i. Assist in the referral or coordination of other dementia-specific services and resources needed by the ADRD participant or the caregiver, such as medical services, counseling, medical planning, legal planning, financial planning, safety and security planning, disaster planning, driving assessment, transportation coordination, or wandering prevention.
- j. Offer, facilitate, or provide referrals to a support group for persons who are caregivers to ADRD participants.
- k. Provide dementia-specific educational materials regularly to ADRD participants, as appropriate, and their caregivers.

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- l.** Routinely conduct and document a count of all ADRD participants present in the center throughout each day. This count must be compared to each ADRD participant's attendance record in order to ensure that an ADRD participant is not missing from the center.
- m.** Be a secured unit or have working alarm or security devices installed on every door that is accessible to the ADRD participant and provides egress from the center or areas of the center designated for the provision of adult day care - specialized Alzheimer's services.
- n.** Not allow an ADRD participant to administer his or her own medication.
- o.** Condition the ADRD participant's eligibility for admission on whether the ADRD participant has a coordinated mode of transportation to and from the adult day care center, to ensure that the participant does not drive to or from the center.

C. PROVIDER QUALIFICATIONS:

- 1.** Specialized Adult Day Care centers shall be licensed by the Agency for Health Care Administration in accordance with Chapter 429.918, Part III, Florida Statutes, and Chapter 58A-6, Florida Administrative Code.

An adult day care center licensed under this part must provide the following staff training:

- a.** Upon beginning employment with the facility, each employee must receive basic written information about interacting with participants who have Alzheimer's disease or dementia-related disorders.
- b.** In addition to the information provided under paragraph (a), newly hired adult day care center personnel who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete initial training of at least one hour within the first three months after beginning employment. The training must include an overview of dementias and must provide instruction in basic skills for communicating with persons who have dementia.

APPENDIX A: Service Descriptions and Standards

Specialized Adult Day Care

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Specialized Adult Day Care

An adult day care center may not claim to be licensed or designated to provide specialized Alzheimer's services unless the adult day care center's license has been designated as such pursuant to s. 429.918.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of actual client attendance at the Specialized Adult Day Care center is one unit of service. Actual client attendance is defined as the period between the time of arrival and the time of departure from the day care center.
2. Hours of daily attendance shall exclude transportation time to and from the center. The cost of the transportation is not to be included in the unit rate and shall be billed separately.
3. CIRTS reporting requirements are below ↓

CIRTSREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	RESFA	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	310

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Telephone Reassurance

PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB

PROGRAM AUTHORITY:

Program Funding

Specific Authority

LSP

Specific Appropriations

OAAIIIB

Older Americans Act, Title III, Part B, Section 321, (a)(5)
42 U.S.C. 3030d

- E. DESCRIPTION:** Telephone reassurance is defined as communicating with designated clients by telephone on a mutually agreed schedule to determine their safety and to provide psychological reassurance, or to implement special or emergency assistance.
- F. DELIVERY STANDARDS/SPECIAL CONDITIONS:** A client must be homebound to receive this service. Records shall be maintained specifying the agreed to emergency procedures. Assistance shall be sent to the home, if contact cannot be made. Schedules should provide coverage for temporary absences, and weekend and holiday coverage is encouraged.
- G. PROVIDER QUALIFICATIONS:** Volunteers are encouraged to provide telephone reassurance.
- H. RECORD KEEPING AND REPORTING REQUIREMENTS:**
1. Unit of Service: An episode of telephone reassurance is one documented telephone contact with one client or one household. Phone calls made with no response cannot be billed.
 2. CIRT reporting requirements are below. ↓

CIRTREPORTINGREQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
LSP	TERA	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	9999
OA3B	TERA	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	9999

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Transportation

PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIB, OAAIIE, OAAIIEG

PROGRAM AUTHORITY

Program Funding

Specific Authority

CCE	Sections 430.201-207, F.S.
HCE	Sections 430.601-608, F.S.
LSP	Specific Appropriations
OAAIIB	Older Americans Act, Title III, Part B, Section 321, (a)(2) 42 U.S.C. 3030d
OAAIIE	Older Americans Act, Title III, Part E, Section 373(b)(5)

A. DESCRIPTION: Transportation is defined as travel to or from community services and resources, health and medical care, shopping, social activities, or other life sustaining activities.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. All transportation provided with federal, state and local government funds shall be purchased through a contractual arrangement with the community transportation coordinator (CTC) or approved coordination provider within the coordinated system. Exceptions are permitted in accordance with Chapter 41-2, Florida Administrative Code.
2. When transportation suited to the unique and diverse needs of an elderly person cannot be met through the coordinated system; the provider may purchase or provide transportation utilizing the following alternatives:
 - a. Privately owned vehicle of an agency volunteer or employee;
 - b. State owned vehicles;
 - c. Privately owned vehicle of a family member or custodian;
 - d. Common carriers, such as commercial airlines or bus; or

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- e. Emergency medical vehicles.
 - 3. The provider may utilize other modes of transportation when the CTC determines it is unable to provide or arrange the required service.
 - 4. Providing transportation through sources other than the CTC shall be approved by the CTC. Local procedures for the review/approval process apply.
 - 5. Transportation providers shall hold applicable licenses issued by the Department of Highway Safety and Motor Vehicles in accordance with Chapter 322, Florida Statutes, and shall maintain minimum vehicle liability insurance coverage, as required by law.
- C. PROVIDER QUALIFICATIONS:** As determined by the community transportation coordinator, in accordance with Chapter 427, Florida Statutes, and Chapter 41-2, Florida Administrative Code.
- D. RECORD KEEPING AND REPORTING REQUIREMENTS:**
- 1. Unit of Service---Individual: A unit of service is a one-way trip (the single entrance, travel to a destination, and exit of a client from a transportation vehicle).
 - 2. Unit of Service---Group: A unit of service is a one-way trip (the single entrance, travel to a destination, and exit of clients, regardless of the number of clients, from a transportation vehicle).
 - 3. CIRTS reporting requirements are on the next page.

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

APPENDIX A: Service Descriptions and Standards

Section II: Services

Transportation

CIRTS REPORTING REQUIREMENTS				
PROGRAM	SERVICE	REPORTING OF SERVICES	OAA CLIENT REQUIREMENTS	MAX UNITS
ADI	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
CCE	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
CCE	TRSG	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	TRSG	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
HCE	TRSV	MONTHLY AGGREGATE REPORTING BY CLIENT	N/A	100
LSP	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	30000
LSP	TRSG	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	30000
OA3B	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	50000
OA3B	TRSG	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	50000
OA3E	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3E	TRSG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	100
OA3E3G (GRANDPARENT)	TRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3E3G (GRANDPARENT)	TRSG	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	100
OA3E (DIRECT PAY)	DPTRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3E (DIRECT PAY)	DPTRS	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	100
OA3E3G (GRANDPARENT) (DIRECT PAY)	DPTRS	MONTHLY AGGREGATE REPORTING BY CLIENT	MONTHLY AGGREGATE REPORTING BY CLIENT	100
OA3E3G (GRANDPARENT) (DIRECT PAY)	DPTRS	MONTHLY AGGREGATE REPORTING	NO REQUIREMENTS	100

Appendix B

Co-Payment for Service Guidelines for

**Community Care for the Elderly
and
Alzheimer's Disease Initiative**

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section I: Legal Authority

LEGAL AUTHORITY:

- A.** Alzheimer’s Disease Initiative (ADI) Co-Pays:
 - 1. Florida Statutes, Section 430.503
 - 2. Chapter 58D-1, F.A.C.

- B.** Community Care for the Elderly (CCE) Co-Pays:
 - 1. Florida Statutes, Section 430.204(8)
 - 2. **F.A.C.** Chapter 58C-1, F.A.C.

- C.** must be

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section II: Guidelines

GUIDELINES:

Collecting co-payments for services from clients is an important step for providers of CCE and ADI services to undertake. General revenue resources to support services for the elderly cannot meet the growing need for services. Every eligible client must be given the opportunity to participate in the co-pay for services. It is critical that case managers assess potential clients for their ability to participate in the cost of their care.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section III: Overview

OVERVIEW:

- A.** Co-payments (co-pay) shall be charged to all non-exempt CCE and ADI clients based on the client's ability to pay and include the gross income of the married, live-in spouse. Income from other family members or persons living in the household is not considered. Clients who receive Older Americans Act (OAA) services are not exempt from being assessed a co-payment under CCE or ADI. For ADI, services of a specified value may be accepted in lieu of a co-payment. Provider agencies shall develop their own written procedures for accepting services of a specified value.
- B.** No co-payments will be assessed on any CCE or ADI client whose income is at, or below, the federal poverty level (FPL) as established each year by the U.S. Department of Health and Human Services. The co-payment fee schedule will commence at \$1 above the established FPL each year.
- C.** Eligibility shall be by self-declaration of income. **"Self-declaration"** means a statement of income made by the person applying for CCE or ADI services. Self-declaration is all that is required for eligibility determination and does not include any documentation other than the signature of the individual making the statement on the Financial Worksheet and Assessed Co-Payment Form (Attachment 1). The self-declaration statement is assumed to be true at the time it is made. The person making the statement should be advised that the provider has the option of verifying the statement and that verification of income will be requested if there is a review or appeal of the provider's actions regarding co- pay.
- D.** Providers may ask clients who are exempt from co-payment assessment to contribute whatever amount they can on a voluntary basis. Voluntary contributions shall be handled in accordance with agency procedures.
- E.** Clients who are assessed a co-payment shall not pay an amount that exceeds the full cost of services received.
- F.** Clients wishing to contribute more for the services than the assessed co- payment, or who wish to pay the full cost of the services, may do so.
- G.** A client who is put on an assessed priority consumer list for services shall not be billed a co-payment for case management until services are commenced.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section III: Overview

- H. The co-payment to be assessed is based on the gross income of the client or the client and live-in spouse. Income is determined by completing the CCE/ADI Eligibility Financial Worksheet and Assessed Co-Payment Form (Attachment 1). See Attachment 2, Co-Pay Financial Worksheet Instructions for completing Attachment 1.
- I. To determine the co-payment to be assessed, add the applicable gross income amounts and compare the total to the sliding co-pay schedule (See Attachments 3 and 4 for schedules).
- J. Income information shall be considered confidential.
- K. Clients who are exempt from being assessed a co-payment are:
 - 1. Active HCE clients including clients who are on the assessed priority consumer list for HCE services only, unless CCE or ADI services are initiated while the client is waiting for HCE services;
 - 2. Active CCE clients who are caregivers for HCE clients;
 - 3. Active CCE or ADI clients in APPL status for SMMC LTC;
 - 4. Persons referred by Adult Protective Services staff of the Department of Children and Families as high risk for alleged abuse, neglect or exploitation, and who receive services for a period not to exceed 31 days (and within 30 days, a case manager needs to assess the client to determine if co-payments will be charged for ongoing CCE or ADI services); and
 - 5. No co-payments will be assessed on any CCE or ADI client whose income is at, or below, the federal poverty level (FPL) as established each year by the U.S. Department of Health and Human Services. The co-payment fee schedule will commence at \$1 above the established FPL each year.
 - 6. No CCE or ADI client may have their services terminated for inability to pay their assessed co-payments. Area Agencies on Aging, in conjunction with provider agencies, must establish procedures to remedy financial hardships associated with co-payments and ensure there is no interruption in service(s) for inability to pay..

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section III: Overview

NOTE: It is not necessary to complete the Financial Worksheet and Assessed Co-Payment Form for a client who is exempt from being assessed a co-payment. Case managers should clearly note in the case file that the client is exempt and state the reason why

- L. Services Exempt from Co-Pay Assessment: information, referral/assistance, and intake services are exempt from the co-pay assessment requirement.
- M. Clients wishing to pay the full cost of the services, or who wish to contribute monthly an amount that meets or exceeds the co-pay amount they would be charged are not required to complete the eligibility determination process. All CCE and ADI clients are required to provide the case manager with a self-declared monthly income amount. This amount will be enough information for the case manager to determine if the contribution or full payment the client wishes to make meets or exceeds the co-payment that will be charged. A narrative entry in the client file, which describes the contribution or full payment for services arrangement, will suffice. Fiscal records must show receipt of a contribution or full payment for services from the client each month in accordance with the provider's billing procedures.
- N. The executive director of the provider agency may waive a client's co-payment. The total amount waived for all clients cannot exceed ten percent (10%) of the provider's targeted co-payment collection goal for the year. A written explanation for the waiver of the co-payment must be placed in the client file.
- O. Assets are self-declared by the client and include the following:
 - 1. More than one car (if the car is less than 7 years or more than 25 years old);
 - 2. Cash surrender value of life insurance policies (only if total face value is over \$2,500);
 - 3. Checking accounts;
 - 4. Savings accounts;
 - 5. Cash on hand;

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section III: Overview

6. Certificates(s) of Deposit;
 7. IRAs;
 8. Revocable burial contracts;
 9. Trusts;
 10. Stocks/bonds/mutual funds; and
 11. Real property (not homestead).
- P. The provider shall develop written billing and collection procedures to ensure the existence of a clear audit trail between the co-payment assessed and that collected.
- Q. Clients in common between CCE and ADI must have one designated case manager from either the CCE or ADI program for billing purposes. AAAs shall work with providers to develop written procedures applicable to clients in common. The procedures shall address the methodology for projecting the annual goal, case management responsibilities, and billing and collection of co- payments.
- R. When determining a couple's co-pay obligation, if both persons are enrolled in either CCE or ADI, the intent is for a household couple to be assessed only one co-payment. A co-pay amount should be assessed utilizing the 'Co-Pay Schedule for Couple' form and attributed once to either of the couple's program enrollment.
- NOTE: The case file for the spouse of an enrolled client, for whom the couple's co-pay is being recorded, should contain a copy of the co-pay assessment forms, and a case note indicating that the couple's co- payment is being collected for an enrolled spouse.**
- S. Services Requiring Co-Payment:
1. **CCE:** Refer to Chapter 5, Community Care for the Elderly (CCE) Program for the CCE services subject to co-payments.
 2. **ADI:** Refer to Chapter 6, Alzheimer's Disease Initiative (ADI) Program for the ADI services subject to co-payments.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section IV: Determination of Client's Ability to Pay

DETERMINATION OF CLIENT'S ABILITY TO PAY:

- A.** The case manager shall explain the co-payment assessment procedures to the client/responsible party with emphasis on the following points:
 - 1.** Co-payment is a requirement per state statutes (Chapters 430.204(8) and 430.503, F.S.) to be collected for CCE and ADI services in accordance with rules adopted by the Department and the client's ability to pay;
 - 2.** It is collected to offset some or all the costs of the services received by the client;
 - 3.** It is determined by completing the financial worksheet and assessed co- pay form;
 - 4.** Income is and assets are self-declared;
 - 5.** A co-pay amount for all the services received each month will be charged to clients with the ability to pay their assessed co-payment;
 - 6.** Clients shall be informed of their right to request a review of their ability to pay the assessed amount; and
 - 7.** Referral is made to the appropriate agency for a full eligibility determination if the client appears to be eligible for Medicaid or other assistance after a review of self-declared income and assets.
- B.** The case manager shall complete the assessment process in accordance with the Instructions for Completion of the Financial Worksheet and Assessed Co- Pay Form (Attachment 2) by following the steps below:
 - 1.** Determine whether the client is exempt from assessment, as detailed in Overview, Section L;
 - 2.** Complete for all eligible clients during the initial assessment in CCE or ADI program;
 - 3.** Obtain the client's signature on financial worksheet/and assessed co-pay form;
 - 4.** Prepare the care plan; and
 - 5.** Discuss the care plan and agency co-pay procedures with the client.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section IV: Determination of Client's Ability to Pay

C. The case manager shall discuss problems that may arise with the client as follows:

1. **Client refusal to comply:** Services will be offered at full cost if client/responsible party refuses to provide information on income needed to determine ability to pay.
2. **Client refusal to accept case management:** Core services cannot be offered without case management which, at a minimum, must include semi-annual and annual visits and other activities necessary to coordinate and document service delivery.
3. **Client request for review from provider agency:** Each client/ responsible party has the right to question the co-payment assessment and request a re-determination of ability to pay.
4. **Refusal to pay co-payments:** Refusal (not due to inability to pay) may result in termination of services.
5. **Change in financial circumstances:** Determination of ability to pay shall be done annually and may be done at any time deemed necessary by the agency. Should the client's financial circumstances change, the client's or responsible party's written or verbal request accompanied by information pertinent to the change, may be used to change the co-payments by re-assessing the client.

D. If the case manager determines that a client cannot be assessed a co-payment, he/she may request approval of the agency executive director to **waive** the assessment. Agencies may waive up to ten percent (10%) of the co-payment annual goal to be collected from clients.

1. The reason for the waiver shall be noted in the client file; and
2. The agency executive director shall sign the client file entry waiving the co-payment assessment.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section V: Collection of Payments

COLLECTION OF CO-PAYMENTS:

The provider agency shall establish written procedures for billing, collecting, and expending client co-payments. There must be a clear audit trail between the amounts assessed, collected, and expended.

A. Method:

1. There shall be a clear audit trail displaying the amounts assessed, collected, and expended.

B. Designation and Billing of Responsible Parties:

1. The client's name or the identified financially responsible party's name shall be recorded in the client's file.
2. If the court appoints a guardian who is responsible for the client's finances, the bill for the assessed co-payments shall be sent in accordance with the court order.
3. Individuals, including parents and adult children, who have not been officially declared financially responsible for the client, shall not be billed unless they offer to pay on behalf of the client.

C. Role of the Voluntary Payer:

1. A voluntary payer is an individual, other than the client, guardian of the client, or court-appointed financially responsible party, who volunteers to pay the client's assessed co-payments.
2. If the voluntary payer continues to contribute an amount equal to or greater than the client's assessed co-payment(s), the client shall not be billed.
3. Should the voluntary payer cease to contribute an amount equal to or greater than the client's assessment, co-payments to be charged will be reviewed with the client prior to requesting payment.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section V: Collection of Payments

- D. Contributions** (Applicable to clients who pay an amount equal to or greater than the co-payment for their income range):
1. Clients who wish to contribute more than the assessed co-pay may do so without receiving a bill.
 2. Client contributions shall be recorded in fiscal records when received.
 3. The financial worksheet and assessed co-pay form are not required to be completed, if the intake form includes the gross monthly income of the client, or the client and spouse, if applicable. However, the client file shall contain a narrative entry documenting the contribution arrangement.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VI: Termination of Services Due Delinquent Payments

TERMINATION OF SERVICES DUE TO DELINQUENT PAYMENTS OF ASSESSED CO-PAYMENTS:

- A.** Assessed co-payments will be considered delinquent when full payment has not been received after 30 days from the billing date, or according to the agency billing procedures.
- B.** No client may have their services terminated for inability to pay their assessed co-payment. Area Agencies on Aging, in conjunction with provider agencies, must establish procedures to remedy financial hardships associated with co-payments and ensure there is no interruption in service(s) for inability to pay..
- C.** Providers will develop their own termination procedures for clients who refuse to pay assessed c-payments (not due to inability to pay). . Once a client is terminated, the action must be noted in the Client Information and Registration Tracking System (CIRTS) using the code “TRRP” (Terminated Refusal to Pay).
- D.** Provider agency directors may elect to waive the assessed co-payment, if it is believed that termination of services would not be in the best interests of the client. If a client’s co-payment is reduced or waived entirely, a written explanation for the change must be placed in the client file. .A written explanation for the waiver must be included in each individual client file. Up to ten percent (10%) of the provider agency co-payment annual goal may be waived.
- E.** Other considerations:
 - 1.** If the client has been provided services on an emergency basis, 14 working days shall be allowed for assessment. If the client, guardian or responsible party refuses to provide information on income to determine the ability of the client to pay within those 14 days, services will be terminated unless the co-payment assessment is waived. A written explanation for the waiver must be included in the client’s file.
 - 2.** If the client has been provided services because of a high-risk Adult Protective Services referral, CCE co-payments will be waived during the first 31 days of service or until the vulnerable adult’s crisis situation has been resolved as determined by the CCE Lead Agency and APS staff to determine the ability to pay, services will be terminated, unless the co- pay assessment is waived. A written explanation for the waiver must be included in the client’s file. For additional information about APS referrals, refer to the APS Referrals Operations Manual.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VI: Termination of Services Due Delinquent Payments

3. Clients who leave the program (e.g., nursing home placement, death, move out of area) are still responsible for the co-payments owed. The provider agency may determine what course of action to take to recoup what is owed.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VII: Review and Grievance Process

REVIEW AND GRIEVANCE PROCESS:

- A.** Please refer to Appendix D, entitled “Minimum Guidelines for Recipient Grievance Procedures,” in this Handbook.
- B.** The method of review and grievance process customarily used by the individual provider agency shall apply in cases relevant to assessment of CCE and ADI clients; however, the following guidelines are to be incorporated and applied uniformly to all cases:
 - 1.** A request for review of the assessed co-payments must be made by the client, guardian or other financially responsible person in writing or in person. The date of receipt of the request for review shall be noted and placed in the client's file.
 - 2.** The client is responsible for producing documentation, which supports the request for review. Documentation could include proof that income sources used in the original determination were incorrect or any other source of documentation supporting the review request.
 - 3.** The client, guardian or financially responsible person shall be informed of the review date and may be present to offer further documentation.
 - 4.** Should the client wish to have services continue during the review process, he/she shall be responsible for payment of any co-payments based on the original financial worksheet and assessed co-pay form. If the provider agency is found to have been in error in the determination of the co-payment, an appropriate refund shall be made to the client.
 - 5.** Should the provider agency confirm the individual's ability to pay, it shall establish retroactively the effective date from which the client shall make payment to the provider agency.
 - 6.** If the client disagrees with the provider agency's finding, he/she may initiate a formal grievance through the AAA in the PSA.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VII: Review and Grievance Process

- 7.** If the provider agency determines that the client was overcharged, payment shall be made in either one of two ways:
 - a.** If the client stays in the program, the client's account shall reflect the new charge, the deducted overcharge, and the new total with the client being advised in writing of the charges; or
 - b.** If the client leaves the program, the overpayment shall be credited to the client's account and a refund (if necessary) sent to the client/responsible party by certified mail.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VIII: Provider Agency Records

PROVIDER AGENCY RECORDS:

Provider agency records must be maintained with proper documentation.

A. Client case files must contain the following:

1. Financial worksheet and assessed co-pay form with client's signature and date, which documents the assessment of the client's ability to pay, or a statement in the case narrative of the reason for exemption or waiver of assessment of co-payments.
2. A copy of written or notation of verbal notice of change of financial circumstances, if applicable.
3. A statement in the case narrative regarding the client's refusal to pay co-payment (not due to inability to pay) and date of termination of services or that a waiver was granted.

B. The following are required either in the client case file or in a separate file containing client reviews if there is non-payment of co-payments:

1. Documentation of provider's effort to resolve non-payment issues.
2. Documentation of date and detail of client's request for review of assessment.
3. Report of review action.
4. Evidence of payment to client by provider agency or to provider agency by client, if applicable.
5. Notice of client's appeal to AAA, if applicable.

C. The provider agency must also maintain the following information in fiscal records:

1. List of clients determined able to pay.
2. Master account of co-payments assessed, collected, owed for each fiscal year.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section VIII: Provider Agency Records

3. Names and amounts paid by clients wishing to contribute an amount equal to or more than an assessed co-payment.
 4. Billing accounts recorded in ledgers (in accordance with accepted accounting practice) with "accounts receivable" reflecting only the amount of co-payments owed.
 5. Number of clients terminated for refusal to pay assessed co-payments (not due to inability to pay).
 6. Number of clients exempt or waived from termination for non-payment of co-payments.
 7. Number of clients exempt from paying co-payments.
- D.** Staff training in the implementation of co-pay assessment and collection procedures shall be documented and maintained in personnel or agency training files.
- E.** Each provider agency shall submit an annual co-payment collection report to the AAA by July 30 of each year. The report shall be prepared in accordance with the format in Attachment 4.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Section IX: Area Agency Responsibilities

AREA AGENCY RESPONSIBILITIES:

The Area Agency on Aging shall:

- A.** Distribute guidelines, summary of any changes made to the guidelines, and any other policy memos from the Department of Elder Affairs (DOEA).
- B.** Review provider agencies, as needed, to ensure the implementation of co-pay assessment with all eligible clients and compliance with co-pay guidelines.
- C.** Conduct regularly scheduled monitoring visits to provider agencies to review:
 - 1.** Co-pay assessment compliance;
 - 2.** Sampling of CCE and ADI clients' ability to pay as determined by the Financial Worksheet and Assessed Co-Pay form; and
 - 3.** Assessed co-payments, as based on co-pay amounts for total quantity of services received.

Note: Additional monitoring visits should be conducted by agency staff to correct any problems with the co-pay initiative.

- D.** Provide appeal procedure for those requesting an appeal of their determination to pay.
- E.** Ensure that all new and existing case managers are trained in the co-payment assessment procedures.
- F.** Submit a consolidated annual co-payment collections report (see Attachment 4) to the Department no later than August 30 of each year.

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Appendix B: Co-Payment for Service Guidelines – ADI and CCE Programs

Attachment 1: Eligibility Financial Worksheet and Assessed Co-Payment Form

COMMUNITY CARE FOR THE ELDERLY (CCE) and ALZHEIMER'S DISEASE INITIATIVE

(ADI) ELIGIBILITY FINANCIAL WORKSHEET AND ASSESSED CO-PAYMENT FORM

EXEMPTIONS: Completion of this form is not required for Adult Protective Services (APS) high-risk referrals and clients receiving Home Care for the Elderly.

1. **CLIENT'S NAME:** _____ **SPOUSE'S NAME:** _____
2. **MONTHLY INCOME INFORMATION** - Fill in all sources received.

	Individual	Spouse	Total
a. Social Security (SSA), including Medicare premium	\$	\$	\$
1 a). Supplemental Security Income (SSI)	\$	\$	\$
2 a). Social Security Disability Insurance (SSDI)	\$	\$	\$
b. Veterans Administration (VA) benefits	\$	\$	\$
c. Disability Payments, including Worker's Compensation (Exclude disability payments reported under a. and b above)	\$	\$	\$
d. Retirement Pension (Railroad, Union, Government and Private)	\$	\$	\$
e. Interest/Dividend Income: Individual Retirement Accounts (IRAs); Certificates of Deposits (CDs); bank accounts and annuity income, including civil service	\$	\$	\$
f. Rental Property Income	\$	\$	\$
g. Estate/Trust Fund Income	\$	\$	\$
h. Alimony	\$	\$	\$
i. Regular Contributions from Another Person	\$	\$	\$
j. Temporary Assistance for Needy Families (TANF)	\$	\$	\$
k. Other Income	\$	\$	\$
Total Gross Monthly Income	\$	\$	\$

3. **ASSESSED CO-PAYMENT MONTHLY AMOUNT (FROM CO-PAYMENT SCHEDULE) \$** _____

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Appendix B: Co-Payment for Service Guidelines

Attachment 1: CCE/ADI Eligibility Financial Worksheet & Assessed Co-Payment Form

4. ASSET INFORMATION – Include all assets sources.

	Individual	Spouse	Total
a. More than one car (if car is less than 7 years old or over 25 years old)	\$	\$	\$
b. Cash Surrender Value of Life Insurance Policies (only if total face value is over \$2,500)	\$	\$	\$
c. Checking Account(s)	\$	\$	\$
d. Saving Account(s)	\$	\$	\$
e. Cash on hand	\$	\$	\$
f. Certificate(s) of Deposit (CDs)	\$	\$	\$
g. Individual Retirement Account(s) (IRAs)	\$	\$	\$
h. Revocable Burial Contract	\$	\$	\$
i. Trust(s)	\$	\$	\$
j. Stocks/Bonds/Mutual Funds	\$	\$	\$
k. Real Property (not homestead)	\$	\$	\$
Total Assets:	\$	\$	\$
Deduct up to \$2,500 in burial funds for an individual (up to \$5,000 in burial funds for a couple)	\$	\$	\$
Subtotal Assets:	\$	\$	\$

5. CLIENT'S STATEMENT AND SIGNATURE

By my signature below, I do hereby affirm that the income and asset information I have provided is a true and correct statement of my present financial circumstances. I also authorize and agree to release to any appropriate representative of the Community Care for the Elderly program or Alzheimer's Disease Initiative, as applicable, any financial records needed to verify financial information. I agree to pay the co-pay amount assessed for services delivered. I understand that the co-pay amount will not exceed the cost of the services I receive each month. I have been informed of my right to request a review by the provider agency to resolve any disagreements regarding the co-payments to be charged for services. If the resolution is still unsatisfactory to me, I understand that I may appeal to the Area Agency on Aging.

Signature of Client or Responsible Party

Date

Name of Worksheet Preparer

Date

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Appendix B: Co-Payment for Service Guidelines

Attachment 2: 2020 Co-Pay Financial Worksheet Instructions

NOTE: Completion of the co-pay financial worksheet is required for clients receiving Community Care for the Elderly (CCE) and Alzheimer's Disease Initiative (ADI) services only. Adult Protective Services (APS) high-risk referrals and clients receiving Home Care for the Elderly are exempt from co-pay assessment.

1. Enter the name of the client and the client's spouse, as applicable. Information is to be reported on spouses only if they reside in the home with the client.
2. Monthly Income Information: Enter the gross monthly amounts for the client and the client's spouse, if applicable. Use even dollar amounts (50 cents or less is 0; 51 cents or more is \$1.00).
 - a. Social Security (SSA): Include the amount of the Social Security check after deductions. If a Medicare premium was deducted, add it back in.
 - o Supplemental Security Income (SSI): Include the amount of the monthly SSI check.
 - o Social Security Disability Insurance (SSDI): Include the amount of the monthly SSDI check.
 - b. Veterans Administration (VA) benefit: Include the monthly amount of the benefits check.
 - c. Disability Payments: Include Worker's Compensation and the monthly amount of any private disability insurance payments received. Disability payments that are excluded include Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI) and Veterans Administration (VA) benefits.
 - d. Retirement Pension (Railroad, Union, Government and Private): Include the monthly amount of any retirement check received. The amount of the check is likely to be a net amount after deductions are taken. If the client has a check stub or knows the gross amount, enter the gross amount. If the pension check is received quarterly or annually, divide the amount by the appropriate number to obtain a monthly income amount.
 - e. Interest/Dividend Income: Include income received from Individual Retirement Accounts (IRAs), Certificates of Deposit (CDs), bank accounts and annuities, including civil service. If payments are received quarterly or annually, divide the amount by the appropriate number to obtain a monthly income amount.
 - f. Rental Property Income: Include any income from rental property (must be at fair market value).
 - g. Estate/Trust Fund Income: Include any income received on a monthly basis from estate and/or trust fund accounts. If payments are received quarterly or annually, divide the amount by the appropriate number to obtain a monthly income amount.

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Attachment 2: 2020 Co-Pay Financial Worksheet Instructions

- h. Alimony: Include any income received monthly from court-ordered alimony support payment.
 - i. Regular Contributions from Another Person: Include any income received on a regular basis (monthly, quarterly, annually). Do not include any gift income, regardless of frequency or amount. Gift income is defined as income from a person, family, or friend not legally obligated to provide such to the client. Payment of bills (e.g., phone, electric, gas) by someone on the client's behalf is not considered a regular contribution.
 - j. Temporary Assistance for Needy Families (TANF): Include the amount of assistance.
 - k. Other Income: Include other regularly received income not included in any of the above categories. For example, if the spouse is employed, enter the gross monthly amount earned as "other income."
 - Total Gross Monthly Income: Total each entry to arrive at the figure.
3. Refer to the co-pay charts (Attachments 3 and 4) to find the income range for individual client or couple and enter the co-pay amount for the client's income range.
4. Asset Information:
- a. Include the declared value of the client's additional car(s), only if the car is less than seven years old or over 25 years old. One car is excluded no matter the age or type. A couple, if both are receiving services, may own two cars.
 - b. If the total face value of life insurance policies exceeds \$2,500.00, count the cash value of the policies as an asset. These policies may be designated
 - c. Include the balance of the client's checking account(s) on the day of the application. If the client jointly holds an account with another person ("and"), the funds and any interest received are equally divided. If the client has unrestricted access to the funds (_____"or"____), the entire balance and all interest received are considered the client's.
 - d. Include the balance of the client's savings account(s) on the day of the application. If the client jointly holds an account with another person ("and"), the funds and any interest received are equally divided. If the potential client has unrestricted access to the funds (_____"or"____), the entire balance and all interest received are considered the client's.

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- e. The cash that is “on hand” should be included. Cash from a regular source of income that has already been included on the financial worksheet (i.e., money from a cashed Social Security check) should not be included.
- f. Include the cash surrender value of Certificates of Deposit (CDs), minus any penalties for early withdrawal. Certificates of Deposit (CDs) can also be designated as burial funds.
- g. Include the cash surrender value of Individual Retirement Accounts (IRAs), minus any penalties for early withdrawal. Individual Retirement Accounts (IRAs) cannot be designated as burial funds.
- h. Include the cash value of a revocable burial contract.
- i. Include the total balance of a trust account if the trust was set up by the client for his/her benefit, or if the spouse set up a trust for the client, Include the total balance of a trust account if the trust was set up by the client for his/her benefit, or if the spouse set up a trust for the client, regardless of availability. Trust money or property held by a trustee for the benefit of an individual who is the beneficiary should not be included. The principal balance of such trusts is not usually available to the beneficiary; thus, it is not considered an asset.
- j. Include the value of any stocks, bonds, and mutual fund shares owned by the client. The value of stocks is determined by the closing price as of the date of application. This information can be found in newspapers and on the Internet. The value of bonds and mutual fund shares can be verified through a stockbroker. Verification of the value of United States (US) Savings Bonds can be obtained from a bank.
- k. Include the value of real property owned in Florida or elsewhere. This includes land and other associated buildings on land in which the client has an ownership interest, such as mineral rights, timber rights, leasehold, or an allotment to farm on a piece of land. If ownership is shared, the value is divided equally among the owners. If rental income of a fair market value is received, the property is not counted as an asset.

Enter the total/subtotal assets. Clients may designate up to \$2,500 (individual) or \$5,000 (couple) as burial funds to help bring their assets within limit.

- 5. Have the client or responsible party sign and date form after reading the affirmation statement. Complete information as indicated for the person preparing the worksheet.

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2019 CO-PAY SCHEDULE FOR INDIVIDUAL

Attachment 3

Monthly Income Range				Monthly Income Range			
From	To	Co-Pay	Percent of Income	From	To	Co-Pay	Percent of Income
\$0	\$1,041	\$0	0.00%	\$2,239	\$2,361	\$57	2.41%
\$1,042	\$1,074	\$18	1.68%	\$2,362	\$2,394	\$58	2.41%
\$1,075	\$1,107	\$19	1.68%	\$2,395	\$2,427	\$59	2.42%
\$1,108	\$1,140	\$20	1.72%	\$2,428	\$2,460	\$60	2.43%
\$1,141	\$1,173	\$21	1.75%	\$2,461	\$2,493	\$61	2.44%
\$1,174	\$1,206	\$22	1.79%	\$2,494	\$2,526	\$62	2.45%
\$1,207	\$1,239	\$23	1.82%	\$2,527	\$2,559	\$63	2.45%
\$1,240	\$1,272	\$24	1.86%	\$2,560	\$2,592	\$64	2.46%
\$1,273	\$1,305	\$25	1.89%	\$2,593	\$2,625	\$65	2.47%
\$1,306	\$1,338	\$26	1.92%	\$2,626	\$2,658	\$66	2.48%
\$1,339	\$1,371	\$27	1.94%	\$2,659	\$2,691	\$67	2.48%
\$1,372	\$1,404	\$28	1.97%	\$2,692	\$2,724	\$68	2.49%
\$1,405	\$1,437	\$29	1.99%	\$2,725	\$2,757	\$69	2.50%
\$1,438	\$1,470	\$30	2.02%	\$2,758	\$2,790	\$70	2.50%
\$1,471	\$1,503	\$31	2.04%	\$2,791	\$2,823	\$71	2.51%
\$1,504	\$1,536	\$32	2.06%	\$2,824	\$2,856	\$72	2.52%
\$1,537	\$1,569	\$33	2.08%	\$2,857	\$2,889	\$73	2.52%
\$1,570	\$1,602	\$34	2.10%	\$2,890	\$2,922	\$74	2.53%
\$1,603	\$1,635	\$35	2.12%	\$2,923	\$2,955	\$75	2.53%
\$1,636	\$1,668	\$36	2.14%	\$2,956	\$2,988	\$76	2.54%
\$1,669	\$1,701	\$37	2.16%	\$2,989	\$3,021	\$77	2.54%
\$1,702	\$1,734	\$38	2.18%	\$3,022	\$3,054	\$78	2.55%
\$1,735	\$1,767	\$39	2.19%	\$3,055	\$3,087	\$79	2.55%
\$1,768	\$1,800	\$40	2.21%	\$3,088	\$3,120	\$80	2.56%
\$1,801	\$1,833	\$41	2.22%	\$3,121	\$3,153	\$81	2.56%
\$1,834	\$1,866	\$42	2.24%	\$3,154	\$3,186	\$82	2.57%
\$1,867	\$1,899	\$43	2.25%	\$3,187	+ 3% of Income		3.00%
\$1,900	\$1,932	\$44	2.26%				
\$1,933	\$1,965	\$45	2.28%				
\$1,966	\$1,998	\$46	2.29%				
\$1,999	\$2,031	\$47	2.30%				
\$2,032	\$2,064	\$48	2.31%				
\$2,065	\$2,097	\$49	2.33%				
\$2,098	\$2,130	\$50	2.34%				
\$2,131	\$2,163	\$51	2.35%				
\$2,164	\$2,196	\$52	2.36%				
\$2,197	\$2,229	\$53	2.37%				
\$2,230	\$2,262	\$54	2.38%				
\$2,263	\$2,295	\$55	2.39%				
\$2,296	\$2,328	\$56	2.40%				

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2019 CO-PAY SCHEDULE FOR COUPLE

Attachment 4

Monthly Income Range				Monthly Income Range			
From	To	Co-Pay	Percent of Income	From	To	Co-Pay	Percent of Income
\$0	\$1,410	\$0	0.00%	\$2,979	\$3,006	\$82	2.72%
\$1,411	\$1,438	\$26	1.81%	\$3,007	\$3,034	\$83	2.73%
\$1,439	\$1,466	\$27	1.81%	\$3,035	\$3,062	\$84	2.74%
\$1,467	\$1,494	\$28	1.84%	\$3,063	\$3,090	\$85	2.74%
\$1,495	\$1,522	\$29	1.87%	\$3,091	\$3,118	\$86	2.75%
\$1,523	\$1,550	\$30	1.91%	\$3,119	\$3,146	\$87	2.76%
\$1,561	\$1,578	\$31	1.94%	\$3,147	\$3,174	\$88	2.77%
\$1,579	\$1,606	\$32	1.96%	\$3,175	\$3,202	\$89	2.77%
\$1,607	\$1,634	\$33	1.99%	\$3,203	\$3,230	\$90	2.78%
\$1,635	\$1,662	\$34	2.02%	\$3,231	\$3,258	\$91	2.79%
\$1,663	\$1,690	\$35	2.05%	\$3,259	\$3,286	\$92	2.79%
\$1,691	\$1,718	\$36	2.07%	\$3,287	\$3,314	\$93	2.80%
\$1,719	\$1,746	\$37	2.10%	\$3,315	\$3,342	\$94	2.81%
\$1,747	\$1,774	\$38	2.12%	\$3,343	\$3,370	\$95	2.81%
\$1,775	\$1,802	\$39	2.14%	\$3,371	\$3,395	\$96	2.82%
\$1,803	\$1,830	\$40	2.16%	\$3,399	\$3,426	\$97	2.83%
\$1,831	\$1,858	\$41	2.19%	\$3,427	\$3,454	\$98	2.83%
\$1,859	\$1,886	\$42	2.21%	\$3,455	\$3,482	\$99	2.84%
\$1,887	\$1,914	\$43	2.23%	\$3,483	\$3,510	\$100	2.84%
\$1,915	\$1,942	\$44	2.25%	\$3,511	\$3,538	\$101	2.85%
\$1,943	\$1,970	\$45	2.27%	\$3,539	\$3,566	\$102	2.85%
\$1,971	\$1,998	\$46	2.28%	\$3,567	\$3,594	\$103	2.86%
\$1,999	\$2,026	\$47	2.30%	\$3,595	\$3,622	\$104	2.87%
\$2,027	\$2,054	\$48	2.32%	\$3,623	\$3,650	\$105	2.87%
\$2,055	\$2,082	\$49	2.34%	\$3,651	\$3,678	\$106	2.88%
\$2,083	\$2,110	\$50	2.35%	\$3,679	\$3,706	\$107	2.88%
\$2,111	\$2,138	\$51	2.37%	\$3,707	\$3,734	\$108	2.89%
\$2,139	\$2,166	\$52	2.30%	\$3,735	\$3,762	\$109	2.89%
\$2,167	\$2,194	\$53	2.40%	\$3,763	\$3,790	\$110	2.90%
\$2,195	\$2,222	\$54	2.42%	\$3,791	\$3,818	\$111	2.90%
\$2,223	\$2,250	\$55	2.43%	\$3,819	\$3,846	\$112	2.91%
\$2,251	\$2,278	\$56	2.44%	\$3,874	\$3,874	\$113	2.91%
\$2,279	\$2,306	\$57	2.46%	\$3,875	\$3,902	\$114	2.92%
\$2,307	\$2,334	\$58	2.47%	\$3,903	\$3,930	\$115	2.92%
\$2,335	\$2,362	\$59	2.49%	\$3,931	\$3,958	\$116	2.93%
\$2,363	\$2,390	\$60	2.50%	\$3,953	\$3,986	\$117	2.93%
\$2,391	\$2,418	\$61	2.51%	\$3,987	\$4,014	\$118	2.94%
\$2,419	\$2,446	\$62	2.52%	\$4,015	\$4,042	\$119	2.94%
\$2,447	\$2,474	\$63	2.53%	\$4,043	\$4,070	\$120	2.94%
\$2,475	\$2,502	\$64	2.55%	\$4,071	+	3% of Income	3.00%
\$2,503	\$2,530	\$65	2.56%			3% of Income	3.00%
\$2,531	\$2,558	\$66	2.57%			3% of Income	3.00%
\$2,559	\$2,586	\$67	2.58%			3% of Income	3.00%
\$2,587	\$2,614	\$68	2.59%			3% of Income	3.00%
\$2,615	\$2,642	\$69	2.60%			3% of Income	3.00%
\$2,643	\$2,670	\$70	2.61%			3% of Income	3.00%
\$2,671	\$2,698	\$71	2.62%			3% of Income	3.00%
\$2,699	\$2,726	\$72	2.63%			3% of Income	3.00%
\$2,727	\$2,754	\$73	2.64%			3% of Income	3.00%
\$2,755	\$2,782	\$74	2.65%			3% of Income	3.00%
\$2,783	\$2,810	\$75	2.66%			3% of Income	3.00%
\$2,811	\$2,838	\$76	2.67%			3% of Income	3.00%
\$2,839	\$2,866	\$77	2.68%			3% of Income	3.00%
\$2,867	\$2,894	\$78	2.69%				
\$2,895	\$2,922	\$79	2.70%				
\$2,923	\$2,950	\$80	2.70%				
\$2,951	\$2,978	\$81	2.71%				

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Attachment 4:

Annual Co-Pay Collection Report

COMMUNITY CARE FOR THE ELDERLY AND ALZHEIMER'S DISEASE INITIATIVE
ANNUAL CO-PAY COLLECTION REPORT

PROVIDER NAME, ADDRESS & PHONE #:	CONTRACT #: CONTRACT PERIOD: PSA:	REPORT PERIOD: FROM: TO:

1. Number of persons assessed co-payments:
2. Number of persons terminated for non-payment of assessed co-payments:
3. Number of persons waived from termination for non-payment of co-payments:
4. Number of persons waived from assessment of co-payments:
5. Number of persons exempt from paying co-payments:
6. Total amount of co-payments assessed:
7. Total amount of co-payments, contributions or full payments collected:
8. Total amount of co-payments expended:

I certify that the above report is a true reflection of the period's activities.

SIGNATURE

TITLE

DATE

Appendix C

Client Information and Registration Tracking System (CIRTS)

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Appendix C: Client Information and Registration Tracking System (CIRTS)

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Appendix C: Client Information and Registration Tracking System (CIRTS)

Section I: Introduction

INTRODUCTION AND LEGAL AUTHORITY:

The Client Information and Registration Tracking System (CIRTS) is the database for client, program and service information. Data entry requirements are based on federal and state mandates. The following programs require client data to be collected for reporting purposes:

- A. Older Americans Act (OAA);
- B. Community Care for the Elderly (CCE);
- C. Alzheimer's Disease Initiative (ADI);
- D. Local Services Programs (LSP);
- E. Emergency Home Energy Assistance for the Elderly Program (EHEAP);
- F. Home Care for the Elderly (HCE); and
- G. Respite for Elders Living in Everyday Families (RELIEF)

Specific Legal Authority:

Program:	Reference:
A. OAA	Refer to specific legal authority cited in Chapter 3
B. CCE	Refer to specific legal authority cited in Chapter 4
C. ADI	Refer to specific legal authority cited in Chapter 5
D. LSP	General Appropriations Act, State of Florida
E. EHEAP	Section 409.508, F.S.; Chapter 73C-26, F.A.C; 42 USC 8621 et seq.; 45 CFR, Subpart H
F. HCE	Refer to specific legal authority cited in Chapter 6
G. RELIEF	Refer to specific legal authority cited in Chapter 7

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Appendix C: Client Information and Registration Tracking System (CIRTS)

Section II: Reporting Requirements

REPORTING REQUIREMENTS:

- A.** Program enrollment information must be entered on all clients receiving case management or OAA and LSP Registered Services, all individuals receiving services through OAA Title III-E, and LSP and OA3B clients receiving transportation services. Additionally, effective January 1, 2018, congregate and home-delivered meal services provided through LSP and C1 or C2 must be reported using the Monthly Aggregate Reporting by Client method. The following individuals must be enrolled in CIRTS:
- Clients enrolled in General Revenue Programs (ADI, CCE, HCE and LSP)
 - OAA Title III-E clients,
 - OAA IIIB clients receiving Registered Services, and transportation,
 - OAA IIIC1, C2, clients receiving meals, nutrition screening, and nutrition education, and guests of clients.
 - Guests under age 60 must be enrolled with the eligibility code, UN60.
 - OAA IIID clients
 - Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) clients
 - RELIEF clients
- B.** Unless otherwise specified in contract, AAAs are responsible for establishing timeframes for CIRTS data entry which are as close to real-time as possible. **AAAs and providers are responsible for ensuring CIRTS data accuracy.**
- C.** Demographic information required in CIRTS can be found on the top portion of the Screening Form (DOEA Form 701S), Condensed Assessment (DOEA 701A), Comprehensive Assessment (DOEA 701B) and Congregate Meals Assessment (DOEA 701C).
- D.** Assessment information must be entered in accordance with the Assessment Instructions (DOEA 701D).
- E.** Program/Service Codes are found in Appendix A-Service Descriptions and Standards.
- F.** For EHEAP clients, the demographic screen is completed using the applicant's demographic data on the EHEAP application. EHEAP eligibility and benefit award information is entered on the EHEAP Application screen, by clicking the EHEAP button at the bottom of the demographics screen. Upon completion of the EHEAP application screen, data is imported to the Enrollment screen.

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Section II: Reporting Requirements

- G. All clients receiving case management must have care plan data entered in CIRTS (see Attachment 1).
- H. Reporting services on the “Services by Provider – Individual SSN,” “Services by Provider – Aggregate,” or the “Services by Client” screen is required for all

DOEA Programs, except waiver programs. Reporting methods are as follows:

1. Monthly Aggregate Reporting by Client:

- a. Each client must be enrolled.
- b. Individual service units are entered monthly at a minimum for each client; if the service has a variable cost, the billed amount is required.

2. Monthly Aggregate Reporting:

- a. Enter total units for all services not requiring “by client” reporting.
- b. These entries are made on the “Services by Provider –Aggregate” screen.
- c. If the service has a variable cost, the billed amount is required. Clients only receiving services which require aggregate reporting do not need to be in CIRTS.

3. Monthly Aggregate Reporting – Annual Unduplicated Count: For programs and services requiring an unduplicated client count:

- a. Each client must be enrolled. If the client is already enrolled, verify demographics and enrollment information.
- b. To count a client as unduplicated on the “Services by Client” or “Services by Provider – Individual SSN” screen, enter the SSN, program and service received once per fiscal year (October through September for federal programs or July through June for state programs). Enter "0" in the Units field.

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Section II: Reporting Requirements

- c. Actual units of service are entered monthly on the “Services by Provider - Aggregate” screen.

Program/Service Codes and the reporting method required for each service are in Appendix A — Service Descriptions and Standards.

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Section III: Electronic Completion of Client Assessment

ELECTRONIC COMPLETION OF CLIENT ASSESSMENT IN CIRTS:

- A. Electronic assessment includes the following:
 - 1. Direct on-line completion of client/caregiver information in CIRTS during the assessment using an Air Card and VPN (Virtual Private Network); or
 - 2. Completion of client/caregiver information in an alternative electronic format and entering or transmitting the information into CIRTS, based on timeframes established by the Area Agency on Aging.
- B. The client assessment instrument may be completed electronically, provided the following conditions are met:
 - 1. The electronic assessment format must contain all the data elements of the DOEA 701S, 701A, 701B or 701C, depending on the type of assessment being conducted.
 - 2. Comments relevant to client/caregiver conditions must be completed.
 - 3. All of the required fields must be completed in CIRTS. "Notes and Summary" sections provided throughout the assessment forms are to be used to document relevant elaborations or details.
 - 4. Handwritten notes on the paper screening or assessment forms must be entered in the appropriate CIRTS field.
- C. The case narrative in the client's file must document the date of the assessment and the type of instrument completed. A hard copy of the completed client assessment instrument must be made available to DOEA upon request.

Care Plan information must be entered on the Care Plan screen and the client must be registered in CIRTS. If a reassessment is done, the Care Plan screen must be updated; this includes the annual reassessment

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Appendix C: Client Information and Registration Tracking System (CIRTS)

Section III: Electronic Completion of Client Assessment

The chart below compares the paper Care Plan fields to the corresponding CIRTS fields on the Care Plan screen. A CIRTS Care Plan screen example showing an annual reassessment update is on the following page.

CARE PLAN FIELD	CIRTS FIELD
Social Security #	SSN
Client Name	First/Last Name
Case Manager	Owner/provider
SERVICES NEEDED BLOCK	
Date (from the problem column)	Date (located next to the Srvc Column)
Service	Service
Frequency and Duration: Frequency and Duration NEEDED column on the Care Plan indicates NEEDED service units to enter into CIRTS. Do not enter information from the Care Plan PLANNED column on the Care Plan screen, Services Needed Column. Examples: If a client needs <u>personal care for 4 hours per week</u> per the Care Plan, the Care Plan screen Services Needed block would indicate <u>4</u> in the "Units" field. CIRTS will insert "HRS" in the "Typ" field. Enter "Wk" for "Frq", since weekly is indicated on the Care Plan. If a client needs <u>respite 4 hours 2 times a week</u>, enter <u>8</u> in the "Units" field. CIRTS will insert "HRS". Indicate "Wk" in "Frq" field, since weekly is indicated on the Care Plan.	Units (number of units of service to be delivered each frequency period) Type (CIRTS will insert the unit type associated with the service, i.e., EPS, HRS, etc.) Frq (Increment of time such as month or week) NOTE: DURATION IS NOT ENTERED IN CIRTS
Service Began/Ended	End Date
SERVICES PLANNED BLOCK	
Provider/Program	Prog (program from which the client will receive services - one service can have multiple programs)
Frequency and Duration: Frequency and Duration PLANNED column on the Care Plan indicates PLANNED service units to enter into CIRTS. Do not enter information from the Care Plan NEEDED column on the Care Plan screen, Services Planned column. Examples: If a client receives <u>personal care 3 hours per week</u> per the Care Plan, the Care Plan screen Services Planned block would indicate <u>3</u> in the "Units" field. CIRTS will insert "HRS" in the "Typ" field. Enter "Wk" for "Frq", since weekly is indicated on the Care Plan. If a client receives <u>respite 3 hours 2 times a week</u>, enter <u>6</u> in the "Units" field. CIRTS will insert "HRS". Indicate "Wk" in "Frq", since weekly is indicated on the Care Plan.	Units (number of service units delivered each frequency period) Type (CIRTS will insert the unit type associated with the service, i.e., EPS, HRS, etc.) Frq (Increment of time used such as month or week) NOTE: DURATION IS NOT ENTERED IN CIRTS
Date Service Began/Ended	Start Date/End Date

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Section III: Electronic Completion of Client Assessment

To update the Care Plan annually in CIRTS, terminate all current service lines, effective the date of the annual reassessment. Enter a new service line for each service determined appropriate based on the annual reassessment using the following day's date. If it is determined that the services will continue as they did the previous year, the same information regarding units, type, and frequency may be added in the corresponding columns. See screen shot below for an example of a care plan updated in CIRTS at the annual reassessment.

SERVICES NEEDED							SERVICES PLANNED					
PSA	Date	Service	Units	Typ	Frq	End Date	Prog	Units	Typ	Frq	Start Date	End Date
02	12/18/2015	CA	2	HRS	YR		CCE	2	HRS	YR	12/18/2015	
02	12/18/2015	CM	8	HRS	YR		CCE	8	HRS	YR	12/18/2015	
02	12/18/2015	EAR	365	DAY	YR		CCE	365	DAY	YR	12/18/2015	
02	12/18/2015	HDM	10	MEL	WK		CCE	10	MEL	WK	12/18/2015	
02	12/18/2015	HMK	4	HRS	WK		CCE	4	HRS	WK	12/18/2015	
02	12/18/2015	PECM	1	EPS	MO		CCE	1	EPS	MO	12/18/2015	
02	12/17/2014	CA	2	HRS	YR	12/17/2015	CCE	2	HRS	YR	12/17/2014	12/17/2015
02	12/17/2014	CM	6	HRS	YR	12/17/2015	CCE	6	HRS	YR	12/17/2014	12/17/2015
02	12/17/2014	COMP	2	HRS	WK	12/17/2015	CCE	2	HRS	WK	12/17/2014	12/17/2015
02	12/17/2014	EAR	365	DAY	YR	12/17/2015	CCE	365	DAY	YR	12/17/2014	12/17/2015
02	12/17/2014	HDM	5	MEL	WK	12/17/2015	CCE	5	MEL	WK	12/17/2014	12/17/2015
02	12/17/2014	PECM	1	EPS	MO	12/17/2015	CCE	1	EPS	MO	12/17/2014	12/17/2015
02	06/17/2015	OTH	1	EPS	YR	06/17/2015	CCE	1	EPS	YR	06/17/2015	06/17/2015
02	06/17/2015	SCSM	1	EPS	YR	06/17/2015	CCE	1	EPS	YR	06/17/2015	06/17/2015
02	06/15/2015	SCSM	1	EPS	YR	06/15/2015	CCE	1	EPS	YR	06/15/2015	06/15/2015
02	12/19/2013	CA	6	HRS	YR	12/16/2014	CCE	6	HRS	YR	12/19/2013	12/16/2014
02	12/19/2013	CM	12	HRS	YR	12/16/2014	CCE	12	HRS	YR	12/19/2013	12/16/2014
02	12/19/2013	COMP	2	HRS	WK	12/16/2014	CCE	2	HRS	WK	12/19/2013	12/16/2014
02	12/19/2013	EAR	365	DAY	YR	12/16/2014	CCE	365	DAY	YR	12/19/2013	12/16/2014
02	12/19/2013	HDM	5	MEL	WK	12/16/2014	CCE	5	MEL	WK	12/19/2013	12/16/2014
02	11/12/2014	PECI	1	EPS	YR	12/16/2014	CCE	1	EPS	YR	11/12/2014	12/16/2014
02	11/12/2014	PECM	1	EPS	MO	12/16/2014	CCE	1	EPS	MO	11/12/2014	12/16/2014
02	12/19/2013	TRS	1	TRP	DA	12/16/2014	NDP	1	TRP	DA	12/19/2013	12/16/2014
02	12/20/2012	CA	12	HRS	YR	12/18/2013	CCE	12	HRS	YR	12/20/2012	12/18/2013
02	12/20/2012	CM	12	HRS	YR	12/18/2013	CCE	12	HRS	YR	12/20/2012	12/18/2013

Appendix D

Minimum Guidelines for Recipient Grievance Procedures

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PURPOSE OF APPENDIX D:

- A.** The purpose of Appendix D is to outline the minimum guidelines for recipient grievance procedures that apply to programs administered by the Department, except for the Statewide Medicaid Managed Care Long-Term Care Program.
- B.** Legal Providers should have an internal grievance procedure that addresses both denial of service and complaints about manner or quality of legal assistance. Grievance policies that comport with requirements of the Legal Services Corporation are sufficient to meet this standard. At a minimum, the procedure must provide applicants with:
 - 1. Adequate notice of the grievance procedures;
 - 2. Information on how to file a grievance or complaint, and;
 - 3. An opportunity for review of that complaint by the Legal Provider's Executive Director or the Executive Director's designee.
- C.** In computing any period prescribed by these guidelines, the last day of the established time frame shall be included, unless it falls on a Saturday, Sunday or legal holiday. If the last day falls on a Saturday, Sunday or legal holiday, the established time frame shall be extended until the end of the next business day.

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Specific Legal Authority

SPECIFIC LEGAL AUTHORITY:

- A.** Americans with Disabilities Act
- B.** Section 306(a) (10) Older Americans Act of 1965, as amended
- C.** Section 430.04(2)(g), F.S.

Notice to the Recipient of Adverse Action Taken and Explanation of the Grievance Procedure

NOTICE TO THE RECIPIENT OF ADVERSE ACTION TAKEN AND EXPLANATION OF THE GRIEVANCE PROCEDURE:

A. Written Prior Notice:

1. The service provider shall inform the recipient in writing of the adverse action to be taken not less than ten (10) calendar days prior to the effective date of the adverse action.
2. Prior notice is not applicable when the health or safety of the recipient is endangered, if action is not taken immediately; however, notice must be made as soon thereafter as practicable.

B. Continuation of Services: Services cannot be reduced or terminated and there can be no other adverse action during the 10-day period.

C. Notice Contents: The notice shall contain the following elements:

1. A statement of what action is being taken;
2. The reason(s) for the intended action;
3. An explanation of:
 - a. The recipient's right to a grievance review. The request shall be made in writing and delivered within ten (10) calendar days of the date the notice is postmarked. The service provider shall offer the recipient assistance in writing, submitting and delivering the request.
 - b. The recipient's right, after a grievance review, for further appeal.
 - c. The recipient's right to seek redress through the courts, if applicable.
4. **Statement of Services Continuation:** A statement indicating that if a grievance review is requested, current services will continue until a final decision is made regarding the adverse action; and
5. **Representation:** A statement advising that the recipient may represent himself/herself or use legal counsel, a relative, a friend or other qualified representative in the review proceedings.

D. Records: All records of the above activities shall be preserved in the recipient's file.

Grievance Review Procedure Upon Timely Receipt of a Written Request for Review

GRIEVANCE REVIEW PROCEDURE UPON TIMELY RECEIPT OF A WRITTEN REQUEST FOR REVIEW:

- A. Written Acknowledgement:** Within seven (7) calendar days after receiving a request for review, the service provider shall acknowledge receipt of the request in writing. This written acknowledgment shall also provide notice of:
1. The date, time and place scheduled for the review;
 2. The designation of one or more impartial reviewers who have not been involved in the decision at issue;
 3. The opportunity to examine the recipient's case record within a reasonable time before the review. Copies of the case record shall be provided at no cost to the recipient, if requested;
 4. The opportunity for the recipient or the recipient's representative to informally present argument, evidence or witnesses at a reasonable time before or during the review; and
 5. A contact person for any accommodations required under the Americans with Disabilities Act, including assistance, if needed, to attend the review, and assurance that the intended adverse action will not be taken until all appeal rights have been exhausted.
- B. Reasonable Accommodations:** All grievance reviews shall be conducted at a reasonable time, date and place by one or more impartial reviewers who have not been directly involved in the initial determination of the adverse action.
- C. Written Confirmation of Decision:** The reviewer(s) shall provide written notification to the recipient, within seven (7) calendar days after the grievance review. The written notice shall include the following information:
1. The decision and the detailed reason(s) for the decision;
 2. The effect the decision has on the recipient's current benefits, if favorable, or the circumstances regarding continuation of current benefits until all appeal rights are exhausted, if not favorable;
 3. The recipient's right to appeal an adverse decision to the AAA by written request within seven (7) calendar days, except in decisions involving the professional judgment of a legal assistance provider;

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Grievance Review Procedure Upon Timely Receipt of a Written Request for Review

4. The availability of assistance in writing, submitting and delivering the appeal to the appropriate agency;
5. The recipient's right to represent himself/herself or be represented by legal counsel, a relative, a friend or other qualified representative; and
6. The recipient's right to file a grievance with the Florida Bar relative to complaints involving the provision of legal representation in cases where the recipient is represented by a legal assistance service provider.

**Procedures for Appeals of a Grievance Review Decision Upon Timely Receipt of a Written Appeal
to the Area Agency on Aging**

***PROCEDURES FOR APPEALS OF A GRIEVANCE REVIEW DECISION UPON TIMELY
RECEIPT OF A WRITTEN APPEAL TO THE AREA AGENCY ON AGING:***

- A. Written Acknowledgement:** Within seven (7) calendar days after receiving a notice of appeal of a grievance review decision, the AAA shall send the recipient written acknowledgement of receipt of the appeal notice. The written acknowledgement shall also provide notice of:
1. The date, time and place of the scheduled appeal hearing;
 2. The designation of one or more impartial AAA officials who have not been involved in the decision at issue;
 3. The opportunity to examine the recipient's case record within a reasonable time before the appeal hearing. Copies of the case record shall be provided at no cost to the recipient, if requested;
 4. The opportunity for the recipient or the recipient's representative to informally present argument, evidence or witnesses during the appeal;
 5. A contact person for any accommodations required under the Americans with Disabilities Act, including assistance, if needed, to attend the appeal hearing; and
 6. A statement that current benefits will continue until all appeal rights are exhausted.
- B. Reasonable Accommodations:** All appeal hearings involving grievance reviews shall be conducted at a reasonable time, date and place by one or more impartial AAA officials who have not been directly involved in the determination of the adverse action.
- C. Written Confirmation of Decision:** The designated AAA official(s) shall provide written notification to the recipient within 7 calendar days after the grievance review appeal is heard. The notification shall include the following information:
1. The decision and the detailed reason(s) for the decision;
 2. The effect the decision has on the recipient's current benefits, if favorable, or the circumstances regarding continuation of current benefits until all appeal rights are exhausted, if not favorable;

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**Procedure for Appeals of a Grievance Review Decision Upon Timely Receipt of a Written Appeal
to the Area Agency on Aging (AAA)**

- 3.** The recipient's right to appeal the AAA's decision, if applicable; and
 - 4.** A contact person for any accommodations required under the Americans with Disabilities Act.
- D. Final Decision:** The AAA's decision shall be the final decision.
- E. Records:** All records of the above activities shall be preserved and remain confidential. A copy of the final decision shall be placed in the recipient's file.

Appendix E

Background Screening Clearinghouse Instructions

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Appendix E: Background Screening Clearinghouse Instructions

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Attachment: Affidavit of Compliance – Employee

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Appendix E: Background Screening Clearinghouse Instructions

Section I: Introduction and Requirements

Per Section 435.12 F.S., the Agency for Health Care Administration (AHCA), in consultation with the Department of Law Enforcement, created the Clearinghouse.

The purpose of the Clearinghouse is to provide a single data source for background screening results of persons required to be screened by law for employment in positions that provide services to children, the elderly, and disabled individuals. The Clearinghouse allows the results of criminal history checks to be shared among specified agencies when a person has applied to volunteer, be employed, be licensed, or enter into a contract that requires a state and national fingerprint-based criminal history check.

Introduction

All Candidates and Providers (Agency on Aging, Lead Agency or Local Providers) who are Direct Service Providers (DSP) pursuant to per Section 430.0402 (1) (b), F.S., are required to complete a Level 2 background screening through the Department of Elder Affairs Portal – Care Provider Background Screening Clearinghouse (Clearinghouse). Background Screenings previously completed through another Specified Agency is not considered fulfillment of this obligation.

The Background Screening clearinghouse is not intended to be used in place of your human resources department and should not be used for non-direct service providers. Improper use of the clearinghouse may result in penalties to the Department by Florida Department of Law Enforcement (FDLE) and Federal Bureau of Investigation (FBI).

- **All** Candidates who are Direct Service Providers (DSP) per Section 430.0402 (1) (b), F.S., are required to complete a Level 2 background screening with an attached photograph through the Care Provider Background Screening Clearinghouse (Clearinghouse).
- **All** DSP (Candidates) of any service provider agency, subcontractor, or vendor of the Department of Elder Affairs (Department/DOEA) are required to have a *DOEA-Aging Network* eligibility determination in the Clearinghouse.
- **All** Providers of Department programs are required to enter all eligible participating Candidates within the *Specified Agency* “Employee/Contractor Roster” tab of the Clearinghouse within 10 business days.
- An Employer may hire a Candidate into a position that requires background screening prior to the Candidate completing the screening process. This period is for training and orientation purposes only, and the Employee shall not provide direct service until the screening process is finalized and the Employee’s status is “Eligible” within the *DOEA-Aging Network* Clearinghouse.

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Section I: Introduction and Requirements

- Use of the Clearinghouse must be limited to Direct Service Providers as defined by 430.0402 (1) (b), F.S.
- Failure to comply with any background screening requirement is a violation of Section 430.0402, F.S.

A. Volunteers: Chapter 430.0402(c)

1. Volunteers that are DSP who assist on an intermittent basis for less than 20 hours per month and who are not listed on the Department of Law Enforcement Career Offender Search or the Dru Sjodin National Sex Offender Public Website.
 - a.. The program that provides services to the elderly is responsible for verifying that the volunteer is not listed on either database.
 - b.. Once the Department is participating as a specified agency in the clearinghouse created under s.[435.12](#), the provider shall forward the volunteer information to the Department of Elder Affairs if the volunteer is not listed in either database specified in subparagraph 1. The department must then perform a check of the clearinghouse. If a disqualification is identified in the clearinghouse, the volunteer must undergo level 2 background screening pursuant to chapter 435 and this section.

Specified agencies include:

- Agency for Health Care Administration (AHCA);
- Agency for Persons with Disabilities (APD);
- Department of Children and Families (DCF);
- Department of Elder Affairs (DOEA);
- Department of Health (DOH);
- Department of Juvenile Justice (DJJ);
- Division of Vocational Rehabilitation within the Department of Education (DOEVR); and
- Local licensing agencies approved pursuant to Section 402.307, F.S.

Specified agencies of the Clearinghouse are identified through registration in the Clearinghouse, based upon statutory screening authority.

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Section II: Instructions - Account Registration and Generating a User Agreement

Portal Registration Overview:

The Care Provider Background Screening Clearinghouse (Clearinghouse) website is maintained by the Agency for Health Care Administration (AHCA) and available through the AHCA web portal (Portal). If you are not enrolled on the Portal, you will need to create a Portal account before requesting access to background screening by submitting a user agreement. The user agreement for new accounts must be received and approved by agency staff before accessing the site.

The link to the Portal is <https://apps.ahca.myflorida.com/SingleSignOnPortal>. Once access is granted users may initiate a screening, search for screening results, connect to specified agency screenings, select a Livescan service provider and connect to the service provider's website to schedule appointments, and create and maintain an employee roster. Instructions for using the Clearinghouse results website can be found at http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/BGS_results.shtml

Registration in the Clearinghouse:

All Department/DOEA direct service provider, Area Agency on Aging, Lead Agency, and Local Providers must create a user account under the DOEA agency *drop down screen within the Clearinghouse portal* and generate a user agreement in the Background Screening Clearinghouse. Email a scanned copy of the user registration agreement, driver's license and proof of contractual agreement with the Lead Agency and submit doeannetwork@elderaffairs.org for processing.

First Time Portal User Requirements

First-time Users are required to create a log-in and a password to access the Clearinghouse. These credentials can be established by visiting the AHCA web portal at <https://apps.ahca.myflorida.com/SingleSignOnPortal>

Once on the website:

- A. Select "[New User Registration.](#)"
- B. Check the confirmation box and select continue.

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- C. Complete the Account registration by entering all required information indicated by the red asterisk (*) and select **“Register”** to continue.
- D. Select **“Return to Login”** to request access to the Clearinghouse results website.

Portal Users Requirements

The Portal Login page will provide authorized user access to external systems maintained by AHCA. To view and maintain information:

- A. Enter the User ID and Password created in the previous steps. Select **“Log In.”**
- B. From the drop-down list, select **“Department of Elder Affairs”** (DOEA) under Background Screening Clearinghouse.
- C. Select **“Request Program Access”** to continue.
- D. A role is necessary to obtain proper access. Select **“Provider”** from the drop- down list.
- E. Select the **“Provider Type.”**
- F. Start typing the **“Provider Name”** associated with your DOEA account.
- G. Select your provider from the list when it appears. Select **“Add Provider.”**
 - If your Provider information is not located in the drop-down selection, please contact the Department for instructions using the contact information provided below, remember this takes 24 hours to be added to the Provider List:

Contact – Background Screening Unit
Email Address – doeainetwork@elderaffairs.org
Subject Line – BGS User Registration
Body of Email – Require Template for User Registration.

- H. If the requested Provider is correct, select **“Submit Request and Generate User Agreement.”**
 - If it is incorrect, select Delete and choose the appropriate **“Provider Name.”**
“Submit Request and Generate User Agreement with a copy of Driver’s License.”

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- I. Select the link in the upper right corner and print the document. Both, the signature of the User and the Provider are required prior to sending the agreement to the Department for approval.
- J. Send, via encrypted email, the scanned copy of the "User Registration Agreement" with a copy of Applicant's driver's license to doeanetwork@elderaffairs.org.

Note: Your request for access to the Clearinghouse Results Website will be in 'Pending' status until the DOEA Coordinator receives and processes your "User Registration Agreement." Only after the approval occurs, will the User have access to the Clearinghouse.

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Rules in the Clearinghouse

Each User must access the Clearinghouse website and abide by the following rules:

- **Create a unique account.** (There is no limit on the number of Users per program Provider).
- **Do not disclose or lend your USER ID AND/OR PASSWORD to anyone.** Your User ID and Password serve as your "electronic signature." This means that you are responsible for the consequences of unauthorized or illegal transactions. Copies of all User Registrations and supporting documents are required for monitoring purposes.
 - **Failure to comply:** Sharing a User ID and Password will result in immediate suspension of access to the Clearinghouse.
 - Providers cannot regain access to the Clearinghouse Portal until a Corrective Action Plan is in place.
 - All User Registration Violation information and a Corrective Action Plan must be submitted to the AHCA for further review.
- **Do not browse or use Clearinghouse information for unauthorized or illegal purposes.**
 - Per Section 435.11(1)(b), F.S., it is a misdemeanor of the first degree to use records information for purposes other than screening for employment or to release records information to other persons for purposes other than screening for employment.
 - **Do not** make any disclosure of Clearinghouse data that is not specifically authorized.
 - **Do not** intentionally cause corruption or disruption of data files.
- **Edit your user information (i.e., email address, phone number), as needed.**

It is important that you maintain a current email address. Your email address will be required should you need to have your password reset.

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Also, important notifications are sent to the email address on file within the Portal, such as background screening updates, Employee arrest notifications, account registration notices, and portal updates.

Passwords must be updated every 90 days. Failure to do so will result in being locked out of the system. If you have been locked out of the system or forgotten your password, please go to the "Reset Password Instructions" under the Portal Log-In, and follow all prompts

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Utilizing the Clearinghouse:

Once DOEA access has been granted the direct service provider agency, subcontractor, or vendor of the Department/DOEA will receive a message from the Users Home page of the "Portal Landing" at <https://apps.ahca.myflorida.com/SingleSignOnPortal>, and may begin the process of fingerprinting candidates and adding or updating the employee roster. However, it is necessary for service provider agencies, subcontractors, and vendors to initiate a search to determine whether the Candidate is already in the Clearinghouse before initiating a new screening .

Many of our specified agencies are human services governmental entities, responsible for administration of similar services to authorized service populations, it is common for Direct Service Providers to provide services across corresponding specified agencies within the Clearinghouse; However, Direct Service Provider Candidates of DOEA programs are required to have a *DOEA-Aging Network* eligibility determination in the Clearinghouse.

The Clearinghouse Results Website allows users to initiate a screening, search for screening results, connect to specified agencies' screenings, select a LiveScan service provider, and connect to the service provider's website to schedule appointments. Utilizing the Clearinghouse website to initiate screening requests provides the user the following benefits:

- Ability to share results of criminal history checks among specified agencies;
- Ability to view subsequent arrest information for employees with retained fingerprints (only available to current employers of the individual);
- Ability to track screenings from the time the screening request is initiated in the Clearinghouse until a determination is made;
- Ability to receive email notifications regarding status updates to requests initiated;
- Ability to search for LiveScan service providers by certain criteria (county, name, etc.). Provides information and ability to connect to the fingerprint service provider's website to make appointments;
- Ability to receive the Transaction Control Reference Number (TCR#) needed for sending an applicant to be rescreened for rejected prints;

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- Ability to access Public Record version of state criminal history record (RAP sheet) for review by the **provider requesting the original screening**;
- Ability to connect to a screening request in process for notification when results are available (reduces duplicative screening);
- Ability to create a “status” report and a “completed screening listing” report of screenings requested by the User eliminating the need to search for each screening result individually;
- Ability to maintain an employee roster by entering hire and separation dates for each employee. This facilitates a notification to the employer if the eligibility status of an employee changes; and
- Section 435.12(2)(c) requires an employer of persons subject to screening by a specified agency to register with the Clearinghouse and maintain the employment status of all employees within the Clearinghouse. Initial employment status and any changes in status must be reported within **10 business days**.
- Ability to access the Redesigned Individual Profile Page that includes:
 - Eligibility results;
 - Photograph, if the individual is in the Clearinghouse;
 - Department of Health professional licensure status;
 - Screenings in process;
 - State criminal history report viewable for the provider initiating the screening; and
 - Employment history.

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Section III: Results – Website Overview

Clearinghouse Results Website Portal Access:

- A. Log in at <https://apps.ahca.myflorida.com/SingleSignOnPortal>.
- B. On the “Portal Landing,” select Background Screening Clearinghouse- DOEA;
- C. From the Program Access, select the Background Screening Clearinghouse link to access the Clearinghouse results website.

Candidate Search

Prior to sending any Candidate to the LiveScan Vendor (Fingerprint Provider), Clearinghouse Users are required to initiate a search to determine whether the Candidate is already within the Clearinghouse to avoid replication of Candidate information within the system.

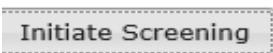
Search for Screening Results

The “Search Page” allows the User to review the eligibility status of a Candidate, if the Candidate has undergone a screening or has a screening in-process with the Clearinghouse. If the Candidate does not have a eligibility status with a DOEA – Network Provider, the User can initiate a screening from this browser.

Note: If you know an individual has not been screened, you may click the ‘Initiate Screening’ tab located on the navigation bar.

- Enter the individual’s:
 - Social Security Number AND
 - Last Name OR
 - Date of Birth
- Select ‘Search’

Search Result: A screening result for this individual was not found in the Clearinghouse result website. You may initiate a screening by selecting the “Initiate Screening” button

A rectangular button with a dashed border and the text "Initiate Screening" in a bold, sans-serif font.

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Section III: Results – Website Overview

Enter Profile Information:

- Enter all required information, as designated by the red asterisks (*)
 - Enter the mailing address of the individual being screened
 - Please note that the height and weight limits are set by the Florida Department of Law Enforcement. If an applicant falls outside of the established limits, please select the closest match.
- Ensure all information is accurate and select the 'Next' button

Required Provider Procedures:

DOEA is a participant of the Privacy Policy Form, OIG LEIE, and NNAR website lists.

Privacy Policy:

The privacy policy requires an acknowledgment that the Candidate/Employee has received a copy of the privacy policies from the Florida Department of Law Enforcement and the Federal Bureau of Investigation, which describes the exchange of information where criminal record results will become part of the Care Provider Background Screening Clearinghouse.

The Candidate/~~Employee~~ must indicate understanding and agreement that they have read and complied with guidelines contained in the privacy policies prior to the Level 2 screening being initiated.

Check Department of Health and Human Services Office of Inspector General (OIG) List:

Search Medicare/Medicaid Exclusions

Individuals who do not have a prior screening must be manually checked in the OIG List of Excluded Individuals and Entities (LEIE), upon initial screening. Once an individual has a record in the Clearinghouse system, an automated review of the OIG LEIE will occur when the list is updated every 30 days.

To employ or contract with any individual participating within any DOEA Program all service providers, subcontractors, and vendors are required to complete an online search of the OIG LEIE and a Level 2 Criminal History Screening.

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The OIG LEIE website lists individuals and entities excluded from federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act. There is no fee associated with conducting a search on the OIG LEIE website.

When you **select the “OIG Search”** button, you will be redirected to the OIG’s website. Follow the instructions to search for the individual and complete the OIG LEIE search. Close the OIG website and return to the Clearinghouse OIG Search page.

Check the affirmation box to confirm the search was conducted and **select “Initiate Screening”** to continue or “Cancel” if you do not wish to proceed with the screening.

Note: Health care providers that receive federal funding and employ an individual on the LEIE may be subject to civil monetary penalties (CMP). Individuals on the Exclusion List are not eligible for employment with providers of Medicare and/or Medicaid services.

National Nurse Aide Registry (NNAR) Search

The NNAR is a web service that allows providers to check multiple state Nurse Aide Registries at once. These are auto-match results based on personal identification information provided by the candidate of states that participated in the NNAR. The states currently participating in the NNAR are Florida, Georgia, New Mexico, Ohio, Oregon, Utah, Washington D.C., and West Virginia. When you initiate a new screening, resubmission or agency review, a NNAR search will be performed and display as a separate step in the initiation process.

If a match of the applicant is found on a participating state’s registry, to confirm the results, use the provided hyperlink on the registry research page to perform a manual search of the registry.

The registry check and its results are provided for informational purposes only and have no bearing on Agency eligibility determinations.

Select **Initiate Screening** to continue.

Initiate New Screening: To initiate a new screening for a Candidate, select “Initiate Screening,” and follow prompts.

If the Candidate has a screening, the Candidate’s “Profile Page” will appear. If screened by another specified agency and entered in the Clearinghouse, the eligibility status will be “agency review required.”

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Section III: Results – Website Overview

If a Candidate possesses an “Eligibility Statement” from another *Specified Agency* within the Clearinghouse, a Provider is required to request a DOEA Agency Review at no cost. The DOEA Agency Review is possible if a photograph is attached to the Profile Page. However, if no photograph is attached to the Profile Page, a DOEA Agency Review will not be available, and the Provider will have to “Initiate a New Screening.”

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Agency Review Benefits:

The Department/DOEA Agency Review allows the Specified Agency to make an eligibility determination for employment purposes. Benefits of requesting a DOEA Agency Review include the following:

- “Agency Review” requests are FREE to the Provider and Candidate/Employee.
- The Candidate does NOT need to visit a LiveScan location to submit new fingerprints. The Provider will receive a copy of the public rap sheet after initiating a DOEA Agency Review.

Prior to initiating an Agency Review for a Candidate/~~Employee~~, the user must complete the following actions:

- A. Ensure the “Clearinghouse Screening Available” indicator states “Yes”;
- B. Ensure the “Privacy Policy” has been signed and acknowledged;
- C. Ensure the “Office of Inspector General (OIG) List of Excluded Individuals and Entities” has been searched and acknowledged;
- D. Ensure the “National Nurse Aide Registry (NNAR)” search has been completed;
- E. Ensure the demographic portion of the profile page is completed;
- F. Ensure the correct Social Security Number is on the “LiveScan Request Form”;
- G. Complete the “Requesting Provider” field within the Clearinghouse;
- H. Provide Candidate with a “LiveScan Request Form,” **before** the fingerprinting process;
- I. Instruct the Candidate to request a photograph from the LiveScan Vendor at the time of LiveScan fingerprinting and ensure correct photograph has been uploaded to Candidate/Employee Profile Page;
- J. Return to the Clearinghouse Website upon receipt of email notification to check the Candidate’s status.
- K. The Provider will receive a copy of the public rap sheet after initiating a DOEA Agency Review.

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Initiating an Agency Review:

To ensure the appropriate criteria is applied during the screening review, the position type and reason for screening the individual is required by the Department/DOEA for processing letters.

- Select the “Initiate Agency Review” button.
- Select the **provider** that the individual has applied to work for from the drop-down list.
- Please note the provider drop-down will only display if you are accessing the website on behalf of multiple providers.
- Select the **position** that the individual is applying for from the drop-down list.
- Select the “**Privacy Policy**” link to view and print the privacy policy. Check the affirmation box to confirm that the Candidate/~~Employee~~ has signed and agreed to the Privacy Policy.
- If a candidate already has a signed Privacy Policy on file, they do NOT have to resign the updated Privacy Policy.

Initiate Resubmission: The retention of fingerprints in the Clearinghouse provides cost savings for Candidates that have had a lapse in employment greater than 90 days.

If there is a lapse in employment, a new national criminal history check (including the resubmission of the retained fingerprints) is required. A new state criminal history search will also be conducted at no additional charge.

To initiate a resubmission for a Candidate, select “Initiate Resubmission,” and follow prompts.

Benefits of Initiating a Clearinghouse Renewal:

- The request and payment for screening renewal occurs in one system resulting in cost savings.
- An updated criminal history is completed to ensure compliance with background screening requirements.
- The current cost for a Clearinghouse Renewal is \$42.00, a cost-saving of over \$30; the average cost for a new screening is \$75.00.
- The processing time is faster since the request is immediately sent to the Clearinghouse; no need to wait for the employee to be fingerprinted at a LiveScan Service Provider location.

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- The print retention time is extended an additional five years.

To initiate a Clearinghouse Renewal, select the **Initiate Renewal** button from the Person Profile Page and follow the prompts.

For the Clearinghouse Renewal Instruction Guide, log in at

[http://elderaffairs.state.fl.us/doea/bs/Clearinghouse Renewals User Guide.pdf](http://elderaffairs.state.fl.us/doea/bs/Clearinghouse_Renewals_User_Guide.pdf)

Initiate Clearinghouse Renewal: A Clearinghouse Renewal is completed from the Users Home page of the “Portal Landing” at <https://apps.ahca.myflorida.com/SingleSignOnPortal>.

A welcome message and your provider information will appear on the Clearinghouse Results Website Home page. This page will also display the **Employees with Expiring Retained Prints** table and bulletin messages.

If an employee is on your ~~Employee~~/Contractor roster and their retained prints expiration date is within the renewal window, their information will display in the **Employees with Expiring Retained Prints** table. You can renew an employee by selecting **Renew**, their **Last Name**, or from the **Person Profile** page.

Providers may initiate a Clearinghouse Renewal **60 days** before the “Retained Prints Expiration Date” is reached.

If the Clearinghouse Renewal is not initiated 14-days before the “Retained Prints Expiration date,” a new screening will need to be initiated.

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Section IV: Employee/Contractor Roster

Employee/Contractor Roster

The employment history records are vital to receiving necessary information from the Clearinghouse, or another *Specified Agency*, and receiving updates such as follows:

- Subsequent arrest notifications; and
- Expiring retained fingerprint notifications;
- The Florida Department of Law Enforcement removes all screenings that do not have an active link to a Provider in the Retention Data Base.

Add Employment/Contractor Record

Per Section 435.12(2) (c) F.S., an Employer of persons, subject to screening by a *Specified Agency* is required to register with the Clearinghouse and maintain the employment status of all Employees within the Clearinghouse. Initial employment status and any changes in employment status are required to be entered within 10 business days.

Add employment history:

- A. Open the “Candidate Profile Page” and select “Add Employment/Contractor Record.” and Enter the required information and select “Save.” This will bring you back to the “Candidate Profile Page.”
- B. View the new employment record displayed in the “Employment/Contractor History” section.

Edit Employment Record

You may edit an Employee record from the “Employment/Contractor History” section on the “Applicant Profile Page,” or from the “Employee/Contractor Roster Tab” as follows:

- A. Select the “Edit” link under the action column for the Candidate record you wish to update and enter the required information and select “Save.”
- B. Enter an end date for the employment record by selecting the calendar icon in the “End Date” column.
- C. Enter the required information and select “Save.”

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Section V: Required Forms

Required Forms

All approved *DOEA-Aging Network Candidates* and all approved SHINE Volunteers are required to sign the “Affidavit of Compliance Candidate Form, Effective June 2019 – most current version,” and attach the “Eligibility Statement.”

These documents remain within the personnel records; however, for SHINE Volunteers, a copy of the “Eligibility Statement” is required to be sent to the DOEA SHINE Contract Manager. Email transmission of the Required Forms must be encrypted.

The following forms are a requirement for monitoring purposes:

- Signed and dated Privacy Policy;
- If a candidate already has a signed Privacy Policy on file, they do NOT have to resign the updated Privacy Policy.
-
- “Eligibility Statement” with proof of Employment History from DOEA;
- This **is not a screenshot** of the Profile Page. Each Provider must scroll down to the bottom of the Profile Page, and select the “View/Print Version Tab.”
- This will give you the “Eligibility Statement” with Provider instructions and the *Specified Agency* statute for Background Screening.
- Signed and dated Affidavit of Compliance Employee Form, Effective June 2019 ~~April 2016~~.
- The Candidate **should not sign** the DOEA Affidavit Compliance Employee Form prior to the receipt of the Eligibility Determination Notification.

Note: The Affidavit of Compliance Employee Form, Effective April 2016 is included as Attachment 1.

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Section VI: Computing Devices, Electronic Mail and Physical Documentation

Computing Devices, Electronic Mail, and Physical Documentation

The purpose of this section is to outline the responsibilities associated with the safeguarding of Candidates/Employees. Personally Identifiable Information (PII) and Criminal Justice Information (CJI). These responsibilities are applicable to DOEA employees and DOEA – Aging Network Clearinghouse participants. Detailed guidance regarding the operational compliance of processing and maintaining PII and CJI can be found in the following documents:

- Criminal Justice Information Services (CJIS) Security Policy – Version 5.6,
- Link: <http://www.fdle.state.fl.us/NCJA-CSP-Compliance/Resources>
- Federal Information Processing Standards Publication 140-2, Security Requirements for Cryptographic Modules – Dated December 3, 2002
- Link: <https://www.nist.gov/publications/security-requirements- cryptographic-modules-includes-change-notices-1232002>

Computing Devices and Physical Documentation

Computing devices used and the storing of physical documentation involved in the Candidate/Employee background screening/eligibility process shall at a minimum:

- 1) Adhere to CJIS Security Policy – Version 5.6, Dated June 5, 2017, Section 5.9.2 – *Controlled Area*.
- 2) Adhere to CJIS Security Policy – Version 5.6, Dated June 5, 2017, Section 5.10.1.2.1 – *Encryption for CJI in Transit*.
- 3) Adhere to Section 5.10.1.2.2 – *Encryption for CJI at Rest*.

Electronic Mail

All electronic mail messages containing PII, CJI, and information and/or document(s) related to the Candidate/Employee background screening/eligibility process shall be encrypted. Electronic mail encryption shall be utilized by both DOEA employees and DOEA – Aging Network Clearinghouse participants.

Request Assistance

Requests for assistance, clarification, or general questions regarding the responsibilities related to PII and CJI should be sent to the DOEA Background Screening Coordinator.

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Section VII: Clearinghouse Concerns

Concerns

All *DOEA- Aging Network* Clearinghouse concerns are to be addressed within an encrypted email:

Notification to the Background Screening Coordinator – Valerie Brinkley (850) 414-2093

Email Address: doeanetwork@elderaffairs.org

Subject Line: BGS Clearinghouse Concern

Body of Email; State the exact problem and include a screenshot (if possible.) When inquiring about a Candidate/~~Employee~~, the following information is required:

- Full Name
- DOB

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Section VIII: Resources

Clearinghouse Informational Page:

The additional resources listed below are located on the Clearinghouse informational page at the following Website:

http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/CH_Instruction_Guides.shtml.

User Registration Training:

- User Registration Training Video
- User Registration Guide

Clearinghouse Results Training Videos:

- User Registration Training Video
<https://www.youtube.com/watch?v=NehJeDC7ejw&feature=youtu.be>
 - Introduction and Tabs
<https://www.youtube.com/watch?v=gN-MYogroPE&feature=youtu.be>
 - Search and Profile Page
<https://www.youtube.com/watch?v=MlOLqXJhqN8&feature=youtu.be>
 - Initiating a New Screening
<https://www.youtube.com/watch?v=RM10x21oG1o&feature=youtu.be>
 - Adding Employment
<https://www.youtube.com/watch?v=wZtyGs20Zj8&feature=youtu.be>
 - Initiating an Agency Review
https://www.youtube.com/watch?v=U42v_soWU_o&feature=youtu.be
 - Initiating a Resubmission
https://www.youtube.com/watch?v=zO_tHB55T1M&feature=youtu.be
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Clearinghouse Results Website Guide:

- Department of Elder Affairs
http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/docs/Clearinghouse_Results_InstructionGuide_DOEA.pdf

FORMS:

- Additional Information: (last bullet on left)
http://ahca.myflorida.com/MCHQ/Central_Services/Background_Screening/Regulations_Forms.shtml
- Regulations and Forms:
 1. Clearinghouse Applicant Request Form
 2. Privacy Policy

Chapter 1

**DOEA Sponsored Programs:
General Information, Planning Process
and Aging Network, Monitoring, and
Program Reporting Requirements**

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 1: DOEA Sponsored Programs: General Information, Planning Process & Aging Network, Monitoring, and Program Reporting Requirements

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Section I: General Information

PURPOSE OF HANDBOOK:

- A. Official Document:** This handbook is an official document of the State of Florida, Department of Elder Affairs (DOEA). DOEA develops program policies, procedures, and standards applicable to agencies which are recipients/providers of funding under the following programs:
1. Alzheimer's Disease Initiative (ADI)
 2. Community Care for the Elderly (CCE)
 3. Home Care for the Elderly (HCE)
 4. Local Services Program (LSP)
 5. Older Americans Act (OAA) as amended
 6. Respite for Elders Living In Everyday Families (RELIEF)
- B. State Unit on Aging:** The Department of Elder Affairs is, by law, Florida's State Unit on Aging (SUA). As such, it is required to provide written policies to carry out its activities.
- C. State and/or Federal Requirements:** This handbook is designed to do the following:
1. Reflect the provisions of legislation, state policies, and procedures;
 2. Interpret state and/or federal requirements for services funded under ADI, CCE, HCE, LSP, OAA, and RELIEF;
 3. Specify DOEA's procedures for carrying out the overall responsibilities and functions of the SUA; and
 4. Provide a reference for use by contract agencies in administering and providing services funded under these programs

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SCOPE OF HANDBOOK:

- A. Scope:** This handbook includes general requirements and policies applicable to all recipients of funding from ADI, CCE, HCE, LSP, OAA, and RELIEF.
- B. Minimum Standards:** This handbook sets forth the minimum standards required for specific programs.
 - 1. Provider Responsibility:** All provider agencies must ensure their services to older persons comply with these minimum standards.
 - 2. Monitoring:** All monitoring of service quality is to be performed based on these standards.
- C. Technical Assistance:** Provider requests for technical assistance or clarification regarding the contents of this handbook should be directed to the Area Agency on Aging (AAA) for response. The AAA, in turn, should request technical assistance or clarification from DOEA if assistance is needed.

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REVISIONS AND CHANGES TO THE HANDBOOK:

- A. Handbook Revisions:** Any revisions to this handbook will be made in accordance with DOEA policies and procedures and will be announced in the form of official revised or additional handbook pages. The revised pages of this handbook will be disseminated under the signature of the Secretary of the Department.
- B. Policy Changes and Clarifications:** DOEA has established procedures to ensure that AAAs receive consistent communication on policy, policy changes, policy clarifications, and information of interest to the aging network.
- 1.** The Secretary or Deputy Secretary of the Department shall communicate policy and information matters to the AAA as follows:
 - a. Notice of Policy:** The Notice of Policy is designed to communicate new policy or change in existing policy.
 - b. Notice of Policy Clarification:** The Notice of Policy Clarification is designed to provide insight, explanation, or illumination on a policy that is currently in existence.
 - c. Notice of Instruction:** The Notice of Instruction is designed to communicate the requirement to perform a task or activity.
 - d. Notice of Transmittal:** The Notice of Transmittal is informational in nature and does not require action.
 - e. Contractual Amendment:** Changes to the programs and services handbook, which is an attachment to the contractual agreement, can be communicated through a contract amendment.
 - 2.** The AAAs shall disseminate the above-referenced notices to service providers as directed by the Department.
 - 3.** The Notice of Policy and Notice of Policy Clarification shall have the same authority as other handbook directives. Policy issuances shall be incorporated in future revisions of this handbook.

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AREA AGENCY ON AGING AND SERVICE PROVIDER COORDINATION ON POLICY MATTERS:

- A. PSA Collaboration:** Within each Planning and Service Area (PSA), the AAA and service providers should work collaboratively to serve seniors. AAAs should conduct regular meetings with providers to promote greater provider input in planning and advocacy efforts.

- B. Provider Appeals:** Providers have the right to appeal decisions made by the AAA to the AAA's board of directors after first trying to resolve issues with the AAA staff and executive director.

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INTERAGENCY COOPERATION:

The Department of Elder Affairs routinely participates with other agencies to represent the interest of older persons. Examples include:

	Name	Abbreviation
A.	Agency for Health Care Administration	AHCA
B.	Agency for Persons with Disabilities	APD
C.	Department of Agriculture and Consumer Services	DACS
D.	Department of Children and Families	DCF
E.	Department of Economic Opportunity	DEO
F.	Department of Education	DOE
G.	Department of Health	DOH
H.	Department of Transportation	DOT
I.	Division of Blind Services	DBS
J.	Department of Veterans' Affairs	DVA
K.	Executive Office of the Governor	EOG

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AUTHORITY FOR DOEA PROGRAMS:

DOEA has been given specific statutory authority under federal law, state law, and the Florida Administrative Code to operate its programs. The specific authority citations are identified in each of the succeeding chapters and appendices in this Handbook.

POLICY FORMULATION:

- A. Policy Development:** Policy development refers to the process of developing authoritative direction for planning and operating DOEA-funded programs and services. DOEA is responsible for preparing and promulgating policy concerning state and federal laws applicable to all programs and services.
- B. Policy Promulgation:** Significant policies affecting program design are contained in administrative rules promulgated in **Chapter 58** of the **Florida Administrative Code** under provisions of **Chapter 120, Florida Statutes**.
- C. Administrative Decisions:** Policies representing administrative decisions concerning procedures, specific program goals, and implementation methodologies are generally provided in this handbook.
- D. Statutory Authority:** DOEA is responsible for policy formulation.
 - 1. Existing Authority:** Policy formulation must be within existing governing statutory or regulatory authority.
 - 2. Aging Network Participation:** DOEA uses suggestions, comments, and recommendations from those in the aging network, including AAAs, provider agencies, and the public in its efforts to formulate policy.

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PROGRAM STANDARDS:

- A. Minimum Standards:** A primary DOEA function is the adoption of minimum standards for services and activities.
 - 1. Acceptable Performance Levels:** DOEA sets standards to establish specific criteria that define acceptable levels of program performance.
 - 2. Location of Minimum Standards:** Service chapters, service definitions, and service goals contain minimum standards for the provision of services.
- B. Quality Assurance:** DOEA monitors annually and provides ongoing technical assistance to ensure compliance with established standards.

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BACKGROUND SCREENING:

Section 430.0402 (1) (a), F.S. requires Level 2 background screening for all direct service providers who are not exempt from background screening pursuant to Section 430.0402(2), F.S. Level 2 background screening includes fingerprinting for statewide criminal history records checks through the Department of Law Enforcement and national criminal history record checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.

DOEA has specific statutory authority under state law to require Level 2 background screening of all direct service providers. Instructions for completing background screening through the Care Provider Background Screening Clearinghouse, and the exceptions to Level 2 background screening are provided in Appendix E.

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USE OF DEPARTMENT OF ELDER AFFAIRS LOGO:

- 37. AAA Authorization:** The AAA may authorize the use of the most current DOEA logo in projects and presentations when DOEA funds are involved.
- 38. Written Request:** The AAA shall provide written authorization for using the most current logo upon written request from a DOEA-funded entity.
- 39. Authorization Determination:** The AAA shall make such determinations on a case-by-case basis.

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DEFINITIONS:

The following definitions apply throughout this handbook unless defined differently elsewhere or the context indicates otherwise. Definitions pertaining to a specific topic may be found in the chapter addressing that subject. Service definitions are contained in Appendix A of this handbook.

1. **Abuse:** Any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental, or emotional health. Abuse includes acts and omissions.
2. **Access Point:** A service provider or other entity that performs one or more ADRC functions under an agreement with the ADRC.
3. **Administration on Aging (AoA):** The agency, within the Administration for Community Living (ACL) of the U.S. Department of Health and Human Services, is charged with the responsibility of administering the provisions of the Older Americans Act, except for Title V, which is administered by the U.S. Department of Labor. The principal official of the AoA is the Assistant Secretary for Aging.
4. **Adult Family Care Home:**
 - a. An adult family care home is a private home where one to three aged or disabled adults receive room and board, personal care, and supervision.
 - b. The family care sponsor serves as a substitute family for the aged or disabled person.
 - c. In turn, the family care sponsor is paid for the expenses of caring for an extra person or persons in his/her home.
5. **Advisory Council:** A council organized to provide advice, suggestions, and recommendations concerning programs for older persons. Advisory councils exist at DOEA, each AAA and nutrition providers. Supportive services providers are not required to have advisory councils; however, providers are required to have some mechanism for receiving participant feedback. An advisory council does not have policy or decision-making authority. It provides advice and recommendations that may then be reviewed by the governing body (board of directors) of the grantee agency.

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6. Agency for Health Care Administration (AHCA): AHCA is the chief health policy and planning entity for the state; primarily responsible for oversight of the state's Medicaid program, and the licensure of health care facilities.
7. **Aging and Disability Resource Center (ADRC):** The Department of Elder Affairs administers programs and services for elders across the state of Florida through 11 Area Agencies on Aging, which operate Aging and Disability Resource Centers (ADRCs). The ADRCs function as a single, coordinated system for information and access to services for all Floridians seeking long-term care resources. The ADRCs provide information and assistance about state and federal benefits, as well as available local programs and services.
8. **Allowable Cost:** Categories of costs that can be charged to a grant or contract.
9. **Alzheimer's Disease (AD):**
 - a. A disease that affects the cells of the brain. It produces a diminished capacity to think or understand; as well as the inability to perform routine duties.
 - b. It affects primarily elderly individuals from all socio-economic levels.
 - c. There are also several other related disorders, which mimic Alzheimer's disease.
 - d. Memory loss, to the extent experienced by AD clients, is not a natural part of the aging process, as was popularly believed in the past.
 - e. There is no treatment available to stop or reverse the mental deterioration characteristic of AD.
 - f. An absolute diagnosis can only be made upon examination of brain tissue, usually at autopsy.
10. **Alzheimer's Disease Initiative (ADI):** A state general revenue funded program for providing the following: respite care, , memory disorder clinic services and a brain bank. For program description and service eligibility requirements, see Chapter 5, Administration of the Alzheimer's Disease Initiative (ADI).

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11. Alzheimer's Disease-or Related Dementias (ADRD): Used as an inclusive umbrella term for the variety of diseases that have dementia, cognitive impairment, memory loss, and/or changes in behavior as major symptoms. The ADRD spectrum includes individuals who live with Alzheimer's disease (AD), frontotemporal degeneration (FTD), Lewy body dementia (LBD), vascular contributions to cognitive impairment and dementia (VCID), as well as mixed etiology dementias (MED). ([NIH, 2019](#))
12. **Area Agency on Aging (AAA):**
 - g. Under the authority of the Older Americans Act of 1965, as amended, DOEA designates this entity within a PSA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.
 - h. The AAA is authorized to accept contributions, gifts or grants to fund community care service systems.
13. **Area Plan on Aging (Area Plan for the Planning and Service Area):**
 - i. A plan developed by the AAA outlining a comprehensive and coordinated service delivery system in its PSA in accordance with 45 CFR 1321. It follows the uniform area plan format prescribed and provided by DOEA.
 - j. This plan identifies funding resources, sets forth measurable objectives, and identifies the planning, coordination, and evaluation activities to be undertaken for the period of the plan. The area plan must be submitted to DOEA for approval prior to contracting for funding.
14. **Assisted Living Facility (ALF):** An ALF provides room and board as well as other personal services for its residents. It is designed for the person who does not require bed care except for minor temporary illness, not to exceed seven consecutive days, and who would benefit from living in a group setting.

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15. **Assistive Technology:** Equipment, technology, and engineering that are appropriate and assist in meeting the needs of, and addressing the barriers confronted by individuals with functional limitations. The term “assistive technology device” means any item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.
16. **Audit (independent):** A formal examination of an organization’s accounts or financial situation by a certified public accountant that results in the auditor issuing an attestation (opinion) on the fairness of the financial statements. An audit may also include an examination of compliance with applicable terms, laws, and regulations.
17. **Below Poverty Level:** Having income below the amount annually established by the federal government as the poverty level.
18. **Board of Directors:**
 - a. A group of individuals serving as the legally recognized body of an organization, such as the AAA or service provider.
 - b. A board of directors, in contrast to an advisory council, has policy-making responsibility and is required to operate per a charter and a set of bylaws
10. **Breach of Contract:** Material noncompliance with the terms of the contract.
11. **Budget:** A budget for the purposes of this handbook is a financial plan of action and an aid to program coordination and implementation.
12. **Caregiver:** This is an individual responsible for the care of an older individual, either voluntarily because of family relationship or friendship (known as an informal caregiver), or by contract or receipt of payment for care (known as a formal caregiver).
13. **Care Plan:**
 - a. The tool used by the case manager to document a client’s assessed needs, services to be provided, and costs associated with the provision of services.

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- b. The care plan is a plan of action, developed in conjunction with the client, caregiver, and the client's family or representative. It is designed to assist the case manager in the overall management of the client's care.
- 14. **Case Management:** A client-centered service that assists clients in identifying physical and emotional needs and problems through an interview and assessment process; discussing and developing a plan for services which addresses these needs; arranging and coordinating agreed upon services; and monitoring the quality and effectiveness of the services.
- 15. **Case Record:** A client-specific file, maintained manually and/or electronically, that contains necessary client information, client assessment, and other required forms, and narrative recordings of contacts and assistance provided.
- 16. **Client:** An individual being assessed or served in a DOEA program.
- 17. **Community:** A geographic area designated by the AAA after considering the incidence of need, availability and delivery pattern of local services, and natural boundaries of neighborhoods. A community may be a county, a portion of a county, or two or more counties.
- 18. **Community Care for the Elderly (CCE):** A program to assist eligible, functionally impaired elderly person age 60 and over in living dignified and reasonably independent lives in their own homes or in the homes of relatives or "caregivers" through the provision and coordination of various community-based services. For program description and service eligibility requirements, see Chapter 4, Community Care for the Elderly (CCE).
- 19. **Community Care Service System:**
 - a. A service network offering a variety of home-delivered services, day care, case management, and other basic network services for functionally impaired elderly persons.
 - b. Service agencies under the coordination of a single Lead Agency provide the services.
 - c. Its purpose is to provide a full range of preventative, maintenance, and restorative services to functionally impaired elderly persons.

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20. **Comprehensive Assessment and Review for Long-Term Care Services (CARES):** DOEA's nursing home pre-admission assessment program, which provides a comprehensive, on-site assessment of individuals seeking admission to a nursing home under a state, assisted program. The program explores all available options to nursing home placement and recommends, and may facilitate, alternative placements for individuals who are determined able to remain in the community. The program represents the state's commitment to meet the individual's needs by recommending placement and proper support services in the least restrictive, most appropriate setting possible.
21. **Contract:** A legally binding agreement between the state and another entity, public or private, for the provision of services.
22. **Contractor/Subcontractor:** The entity selected as the result of a procurement decision using competitive or non-competitive methods to provide goods or services pursuant to a legally executed agreement. The contractor/subcontractor can be a recipient, subrecipient or vendor.
23. **Contract Manager:** A person designated, respectively, by the Department or the AAA to manage the performance of the contract.
24. **Contribution:** A voluntary donation.
25. **Co-pay:** A fee assessed to persons receiving CCE and ADI services. The fee is based on the person's income level and ability to pay.
26. **Corrective Action:** Action taken by a recipient/subrecipient that corrects identified deficiencies, produces recommended improvements, or demonstrates that deficiencies or findings are either invalid or do not warrant action.
27. **Dementia:**
- a. The loss of cognitive functions (such as thinking, remembering, and reasoning) of sufficient severity to interfere with an individual's daily functioning.
 - b. Dementia is not a disease. It is a group of symptoms which may accompany certain diseases or conditions. Symptoms may also include changes in personality, mood, and behavior.

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28. **Dementia Care and Cure Initiative (DCCI):** DCCI encourages the collaboration of area agencies on aging, memory disorder clinics, service providers, and other community entities to engage their communities to be more dementia caring, promote better care for Floridians affected by dementia, and support research efforts to find a cure.
29. **Department:** The Florida Department of Elder Affairs (DOEA).
30. **Department of Children and Families (DCF):** The state agency responsible for social and financial assistance services for categorically eligible children and adults.
31. **Department of Economic Opportunity (DEO):** The state agency that provides DOEA with a portion of Low-Income Home Energy Assistance Program (LIHEAP) funding, to administer the Emergency Home Energy Assistance for the Elderly Program (EHEAP).
32. **Department of Health:** The Florida Department of Health works to protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.
33. **Department of Health and Human Services (DHHS):** The federal agency, which includes the AoA, responsible for administering the Older Americans Act programs.
34. **Designee:** Anyone whom the client wants to be involved in assisting or to act on behalf of the client in obtaining services and communicating with the agency providing services. This definition includes any court-appointed guardians or attorneys-in-fact.
35. **Direct Costs:** Expenses that can be easily associated with a project, service or other direct program activity. For example, an expense for purchasing and delivering meals (e.g. salaries and fringe benefits, travel, supplies) is a direct cost of that service; wages for an individual who performs homemaker and chore can be directly allocated to these services proportionate to time spent in each service. Expenses must be consistently treated as either a direct or indirect cost in like circumstances. For example, administrative costs cannot be allocated directly to some programs but allocated indirectly to others.

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36. **Direct Service Provider:** A person age 18 or older who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living areas, funds, personal property, or personal identification information as defined in s. 817.568. The term includes coordinators, managers, and supervisors of residential facilities and volunteers.
37. **Disallowed Costs:** A charge to a grant that the awarding agency determines to be unallowable, in accordance with the applicable cost principles or other terms and conditions contained in the award. The Department will not pay for these expenditures and the disallowed expenditure becomes the responsibility of the recipient or subrecipient and must be paid for with non-state/federal resources.
38. **Elder Helpline Information and Referral Service:** An access service for individuals and community agencies seeking unbiased information about local, state, or federal social and human services, resources, and opportunities for older adults and persons with disabilities.
39. **Emergency Home Energy Assistance for the Elderly Program (EHEAP):** A program that assists low-income households experiencing a home energy emergency provided the household includes at least one person, age 60 or older. The program is administered by DOEA, through a contract with the Department of Economic Opportunity (DEO).
40. **Equipment:** Tangible nonexpendable personal property, including exempt property, charged directly to the funding source, having a useful life of more than one year and an acquisition cost of \$5000 (federal) or \$1000 (state) or more per unit.
41. **Evidence-Based Program:** Programs to assist older individuals and their family caregivers in learning about and making behavioral changes intended to reduce risk of injury, disease, and disability among older individuals. Programs are based on research and provide documented health benefits.
42. **Exploitation:** "Exploitation" means, but is not limited to, the following:
- a. Improper or illegal use or management of a vulnerable adult's funds, assets, or property with the intent to temporarily or permanently deprive the person of the use, benefit, or possession of the funds, assets, or property for the benefit

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- b. of someone other than the vulnerable adult; or
- c. Intentional or negligent failure to effectively use a vulnerable adult's income and assets for the necessities required for that person's support and maintenance.

43. Federal Flow Through Funds: An arrangement where the initial source of funds for a project is directly attributable to the federal government through a grant or contract to a nonfederal sponsor, such as the funds received by the subrecipient AAA from DOEA. Federal flow-through funds gain the identity of federal funds upon receipt of an award to the state and federal rules apply to the receipt, spending, and accounting of the funds unless expressly exempted by the federal agency initially making the award.

44. Federal Regulations:

- a. Non-statutory policies/procedures/requirements adopted by U.S. governmental agencies to fulfill and implement a statutory purpose.
- b. Regulations are published in the Federal Register and are codified in the Code of Federal Regulations (CFR).
- c. These regulations have the force and effect of law and are binding on agencies or persons to which they apply.

45. Fiscal Compliance: Assurance that funds are appropriately spent and that the work is completed to specified standards.

46. Fiscal Year: A specified twelve-month period during which state and/or federal funding sources are expended. Specific fiscal years are listed below:

- a. The Federal Fiscal Year (FFY) - October 1 through September 30.
- b. The State Fiscal Year (SFY) - July 1 through June 30.
- c. OAA Title III Contract Year - January 1 through December 31.
- d. Provider Fiscal Year - a specified twelve-month period determined by the provider agency.

47. Florida Abuse Hotline: The program/system administered by the Florida Department of Children and Families to identify and investigate abuse, neglect and exploitation cases.

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48. **Focal Point:** Refers to Community Focal Point, which is a facility established under the Older Americans Act to encourage the maximum collocation and coordination of services for older individuals.
49. **Frail/Functionally Impaired Elderly Person:** A person 60 years of age or older, with -physical and/or mental limitations including Alzheimer's disease or a related disorder with neurological brain dysfunction, that restricts an individual's ability to perform normal activities of daily living or threatens the individual's capacity to live independently.
50. **Functional Assessment:**
- a. A comprehensive, systematic, and multidimensional review of a person's ability to remain independent and in the least restrictive living arrangement.
 - b. Persons assessed by case managers will be asked questions to determine status and needs pertaining to the following functional areas (also known as assessment sections):
 - i. Memory
 - ii. Sensory and Communication
 - iii. Mental health
 - iv. Behavior and Supervision;
 - v. General physical health;
 - vi. Activities of Daily Living
 - vii. Instrumental Activities of Daily Living;
 - viii. Nutrition;
 - ix. Health condition(s);
 - x. Therapies or Special services;
 - xi. Medications and Substance Use;
 - xii. Caregiver assessment;
 - xiii. Social resources;
 - xiv. Abuse Screening; and
 - xv. Living environment.

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51. **Generally Accepted Accounting Principles (GAAP):** These are the uniform minimum standards for financial accounting and reporting that govern the form and content of the financial statements of an entity. GAAP encompass the conventions, rules and procedures necessary to define accepted accounting practices at a time. They include broad guidelines of general application, and detailed practices and procedures. The primary authoritative body on the application of GAAP to state and local governments is the Governmental Accounting Standards Board.
52. **Greatest Economic Need:** The need resulting from an income level at or below the poverty level established by the U.S. Department of Health and Human Services.
53. **Greatest Social Need:** The need caused by noneconomic factors, which restricts an individual's ability to perform normal daily tasks or threatens his/her capacity to live independently. These needs include the following:
- a. Physical and/or mental disabilities;
 - b. Language barriers;
 - c. Cultural, social or geographical isolation; and
 - d. Isolation due to racial or ethnic status.
54. **HIPAA: Health Insurance Portability and Accountability Act of 1996.** HIPAA is the federal law passed governing the transmission, disclosure and security provided by covered entities and their business associates for protected health care information.

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55. Home Care for the Elderly (HCE):

- a. The program encourages the provision of care for elders in family-type living arrangements in private homes as an alternative to nursing homes or other institutional care settings.. A relative or other caregiver, living in the home, provides basic services of maintenance, supervision, and any necessary specialized service needs on a not-for-profit basis. For a description of the program and service eligibility requirements, see Chapter 6, Administration of the Home Care for the Elderly Program.

56. Home-bound: Individuals who are confined to their homes for any period and are unable to leave the residence without assistance from another person.

57. Independent Contractor: A person working or an entity under contract and not as an employee of the contracting entity. The contracting entity does not pay unemployment, disability or workers' compensation insurance, or withhold taxes from payments made to the person.

58. Indirect Costs: Expenses that have been incurred for common or joint objectives and that cannot be readily associated with a program or service function (usually management and general administrative expenses).

59. In-Kind: A service or item the subrecipient or a third party donates or pays for from nonfederal funds to the operations of a funded project. In the project budget, a subrecipient must designate an in-kind contribution and must reference the contribution as a real direct project cost. A subrecipient must keep a written record of the in-kind contribution and make the record available to the auditors.

60. Internal Control: A system of checks and balances within a business enterprise that ensures that the enterprise's assets are properly safeguarded, and that the financial information produced by the enterprise is accurate and reliable.

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- 61. Lead Agency:** An agency designated by an AAA at least every six (6) years through competitive procurement, in each community care system which has the authority and responsibility to:
- a. Provide case management;
 - b. Perform functional assessments; and
 - c. Integrate and coordinate the delivery of service to functionally impaired elderly persons.
- 62. Level 2 Screening:** Security background investigations as a condition of employment and continued employment which includes, but need not be limited to, fingerprinting for statewide criminal history records checks through the Department of Law Enforcement, and national criminal history record checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.
- 63. Long-Term Care Ombudsman Program (LTCOP):** Federally funded program in compliance with the OAA and 45 CFR 1321, which provides for investigation and resolution of complaints made by or for older persons in long-term care (LTC) facilities. The program monitors laws, regulations, and policies regarding LTC facilities and carries out related protective advocacy.
- 64. Matching Funds:** Financial contribution by the grantee when required level of match is required for cost sharing.
- 65. Means Test:** The use of an individual's income or resources to accept, deny or limit their receipt of services. The test is prohibited for services under OAA.
- 66. Monitoring:** The collection and analysis of contract agencies' performance data related to current and past activities to determine whether the agency:
- a. Complied with its contracts and state and federal rules,
 - b. Adhered to standards of good practice within the industry, and

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- c. Produced outcomes consistent with DOEA's statutory mission and focus.

67. Senior Center : A community or neighborhood facility used for the organization and provision of a broad spectrum of services for elders including the health, social, nutritional, and educational services. These facilities may also be used for recreational and group activities for older persons.

68. Neglect:

- a. The failure or omission on the part of the caregiver or vulnerable adult to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, which a prudent person would consider essential for the well-being of a vulnerable adult; or
- b. The failure of a caregiver or vulnerable adult to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness that produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death.

69. Nonprofit Organization:

- a. A nonprofit organization is a corporation, trust, association, cooperative, or other organization which is:
 - xvi. Operated primarily for scientific, education, service, charitable, or similar purposes in the public interest;
 - xvii. Not organized primarily for profit; and
 - xviii. Uses its net proceeds to maintain, improve and/or expand its operations.
- b. No part of the net earnings may benefit any private shareholder or individual.

70. Nutrition Services Incentive Program (NSIP): A program that provides cash and/or commodities to supplement congregate and home-delivered meals provided under the authority of the Older Americans Act. For program description and service eligibility requirements, see Chapter 3, Older Americans Act.

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- 71. Older Americans Act (OAA):** Federal legislation that provides funding for social services for persons age 60 and older.
- a. The Act emphasizes the development of a comprehensive and coordinated service delivery system for the elderly; elimination of duplicating and overlapping functions; the integration of social and nutritional services; and
 - b. The establishment of priorities and methods for serving older persons with greatest economic or social need with attention to low- income older individuals, including low-income minority, individuals with limited English proficiency, and older individuals residing in rural areas. Such methods must conform to state and AAA policies.
- 72. OAA Title III B:** Older Americans Act section providing funding for supportive service programs, including multipurpose senior centers, for older persons.
- 73. OAA Title III C1:** Older Americans Act section providing funding for congregate meals, outreach, and nutrition education for older persons.
- 74. OAA Title III C2:** Older Americans Act section providing funding for home delivered meals, outreach, and nutrition education for older persons.
- 75. OAA Title III D:** Older Americans Act section providing funding for evidence-based disease prevention and health promotion services for older persons.
- 76. OAA Title III E:** Older Americans Act section known as the National Family Caregiver Support Program. It funds supportive services for caregivers who provide in-home care for frail older individuals and grandparents or older persons who are relative caregivers of children 18 years of age or younger or individuals with a disability.
- 77. OAA Title V:** Older Americans Act section providing for the Senior Community Service Employment Program (SCSEP).

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- 78. OAA Title VII:** Older Americans Act section which incorporates separate authorizations of appropriations for the:
- Long-Term Care Ombudsman Program;
 - Program for prevention of elder abuse, neglect, and exploitation; and
 - Elder rights and legal assistance programs.

Note: For program description and service eligibility requirements for the Title III and Title VII Programs, see Chapter 3, Older Americans Act.

- 79. 2 CFR PART 200 (Formerly OMB CIRCULAR A-110):** This part sets forth standards for obtaining consistency and uniformity among federal agencies in the administration of grants to, and agreements with, institutions of higher education, hospitals, and other nonprofit organizations. DOEA, as the recipient of federal awards, shall apply the provisions of this part to subrecipients performing substantive work under those federal grants and agreements that are passed through or awarded to its subrecipients.
- 80. Personal Identification Information:** Any name or number that may be used, alone or in conjunction with any other information, to identify a specific individual, including any of the following:
- Name, postal or electronic mail address, telephone number, Social Security number, date of birth, mother's maiden name, official state-issued or United States-issued driver's license or identification number, alien registration number, government passport number, employer or taxpayer identification number, Medicaid or food assistance account number, bank account number, credit or debit card number, or personal identification number or code assigned to the holder of a debit card by the issuer to permit authorized electronic use of such card;
 - Unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation;
 - Unique electronic identification number, address, or routing code;
 - Medical records;
 - Telecommunication identifying information or access device; or
 - Other number or information that can be used to access a person's financial resources.

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- 81. **Planning and Service Area (PSA):** A geographic service area established by the Department, in which the programs of the Department are administered, and services are delivered.
- 82. **Procurement:** The method used to select contractors and subcontractors (recipients, subrecipients, and vendors) for award, and includes both competitive and noncompetitive methods. It is also the process of obtaining services, supplies and equipment in conformance with applicable laws and regulations.
- 83. **Program Income:** Gross income earned by a recipient/sub recipient that is directly generated by the grant-supported project/activity or earned because of the award.
- 84. **Purchase of Services Contracting:** A form of contracting that constitutes a legally binding agreement between two parties (generally a state agency and a nonprofit entity) that contain mutually binding obligations requiring the nonprofit entity, under a privatization arrangement, to deliver services to a third party (consumer) at the behest and direction of the government agency.
- 85. **Quality Assurance:** Evaluation of the quantity, quality, economy and appropriateness of services in accordance with prescribed standards of care and level of professionalism. It also includes methods for determining participants' level of satisfaction with services being delivered.
- 86. **Recipient/Subrecipient:** A person or entity (not an employee), who performs all or part of the services under a contract with a pass-through entity. Recipients and subrecipients typically determine program eligibility, are responsible for program decision-making and must adhere to compliance requirements. Their performance is measured against state and federal goals, and federal and state program funds are used to carry out services under programs.
- 87. **Rural Area:** As defined by the United States Census Bureau, any population, housing, or territory not included within an urban area..

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- 88. Service Provider:** An entity that is awarded a sub-grant or contract from an AAA to provide direct services under the following programs:
- a. Older Americans Act,
 - b. Alzheimer's Disease Initiative,
 - c. Community Care for the Elderly,
 - d. Home Care for the Elderly, or
 - e. Local Services Program.
- 89. Significant Change:** A difference in an individual's health status after an accident or illness; an actual or anticipated change in the individual's living situation, a change in the caregiver relationship; loss of or damage to the individual's home or deterioration of the home environment; or, loss of the spouse or caregiver.
- 90. Single Audit:** A financial internal control and compliance audit of a nonfederal entity administering federal awards and state financial assistance including the financial statements of the entity. The federal Single Audit Act and Florida Single Audit Act (Section 215.97, F.S.) require an independent audit be performed if a subrecipient expends $\geq$ a threshold of \$750,000 of federal or \$500,000 state awards.
- 91. State:** The State of Florida.
- 92. State Plan on Aging:**
- a. A multi-year plan developed by the Department which describes the service needs of elders; identifies priority services and target client groups; provides for periodic evaluation of activities and services funded under the plan; and provides for the administration of funds available through the Older Americans Act.
 - b. The plan will be based on area plans in accordance with the requirements of the Act.

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- 93. State Unit on Aging:** The single state agency designated to develop and administer the State Plan on Aging. In Florida, this is the Department of Elder Affairs.
- 94. Subcontract/Sub-award/Sub-grant:** An agreement or secondary contract in which a third party agrees to perform some of the activities defined in a primary contract proposal. This agreement or secondary contract is agreed upon at the time of the original proposal submission, but not initiated until after the award has been made to the designated organization.
- 95. Technical Assistance:** The provision of information to recipient and subrecipients with the goal of increasing the competence or capacity in an area. Technical assistance should be ongoing and proactive.
- 96. Units of Service:**
- a. A standard method for counting and reporting services provided.
 - b. Units of service are listed with each service description in Appendix A.
- 97. Vendor:** An entity providing goods or services pursuant to an agreement and not meeting the definition of recipient/subrecipient

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ABBREVIATIONS/ACRONYMS TERM

AAA Area Agency on Aging

ACL Administration for Community Living

AD Alzheimer's disease

ADI Alzheimer's Disease Initiative

ADRD Alzheimer's Disease or Related Dementia

ADL Activities of Daily Living

ADRC Aging and Disability Resource Center

ALF Assisted Living Facility

AoA Administration on Aging

APCL Assessed Priority Consumer List

APD Agency for Persons with Disabilities

CCE Community Care for the Elderly

CIRTS Client Information and Registration Tracking System

DCCI Dementia Care and Cure Initiative

DEO Department of Economic Opportunity

DCF Department of Children and Families

DOEA Department of Elder Affairs

EHEAP Emergency Home Energy Assistance for the Elderly Program

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F.A.C. Florida Administrative Code

F.S. Florida Statutes

HCE Home Care for the Elderly

IADL Instrumental Activities of Daily Living

ICP Institutional Care Program

LSP Local Service Program

LTCOP Long-Term Care Ombudsman Program

MDC Memory Disorder Clinic

NH – Nursing Home

NSIP Nutrition Services Incentive Program

OAA Older Americans Act

PSA Planning and Service Area

PACE Program for All-Inclusive Care

QMB Qualified Medicare Beneficiary

RDI Recommended Dietary Intake

SLMB Special Low-Income Medicare Beneficiary

SMMC LTC Statewide Medicaid Managed Care Long-term Care

SNAP Supplemental Nutrition Assistance Program

SSI – Supplemental Security Income

SPA Service Provider Application

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Section II: Planning Process and Aging Network

PURPOSE:

- A. Planning Process:** This section outlines the planning responsibilities of DOEA.
- B. Guidance:** The section also provides guidance to the AAAs for the following tasks concerning the comprehensive and coordinated area plan for services to older persons:
 - 1. Planning;
 - 2. Development;
 - 3. Preparation;
 - 4. Coordination; and
 - 5. Submission of the area plan.

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Section II: Planning Process and Aging Network

INTRODUCTION:

- A. **Legislation:**** The Department of Elder Affairs is the agency constitutionally designated by Florida voters to “serve as the primary state agency responsible for administering human services programs for the elderly.” (Section 430.03, Florida Statutes). The Department is Florida’s State Unit on Aging and, as such, receives federal Older Americans Act funds to provide opportunities and supports for older persons to live independent, meaningful, productive lives in their communities.
- B. **Mission:**** The Department's mission is to promote the well-being, safety, and independence of Florida’s seniors, their families, and caregivers..
- C. **Vision:**** For all Floridians to live well and age well.
- D. **Responsibilities:**** The Department is responsible for preparing the Florida State Plan on Aging (Section 307, Older Americans Act of 1965 as amended) and the Long-Range Program Plan (Chapter 216, Florida Statutes).

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STATE PLAN ON AGING:

- A. Purpose:** The state plan on aging, published at two-year, three-year, or four-year intervals, is necessary for the Department to remain eligible to participate in grants to the states from allotments under the Older Americans Act of 1965 (as amended), and to comply with its statutory mandates provided under Chapter 430, Florida Statutes, and the Older Americans Act of 1965 (as amended).
- B. Plan Contents:** The state plan on aging includes the following:
- 1. General Descriptions:**
 - a.** Conditions of older Floridians;
 - b.** Current service system;
 - c.** Department goals and objectives under the plan; and
 - d.** Department priority initiatives (strategies) to be pursued to achieve its goals and objectives.
 - 2. Fund Allocations:** A formula for the intrastate allocation of anticipated Older Americans Act Title III funds.
 - 3. Assurances:** All the general and specific operational assurances required by law and regulation.

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PUBLIC INPUT IN THE PLANNING PROCESS:

To achieve its legislatively mandated purposes, the Department will “hold public meetings regularly throughout the state for purposes of receiving information and maximizing the visibility of important issues.” [Section 430.04(13), Florida Statutes]

- A. Philosophy:** DOEA’s philosophical basis of all planning efforts is that agency plans should be:
 - 1. Driven by issues developed at the local level;
 - 2. Practical and understandable to constituents; and
 - 3. Focused on addressing the needs of elders.
- B. Practicality:** The Department’s system for collecting public input utilizes and builds upon, rather than supplants, existing local planning activities. At the same time, recognizing the fiscal constraints on the state, the Department uses various methods to gather public input from individuals and organizations that represent the interest of Florida’s elders.
- C. DOEA Foundation Principle:** Local communities and the people served should have a major impact on the Department’s direction.
 - 1. **Florida Law:** In the section of Florida law creating the Department, several mechanisms were developed to ensure that the Department’s multiple constituencies have a major role in the Department’s planning and functioning.
 - 2. **Stakeholders:** The law identifies the Department’s stakeholders and includes any person, group, association, private or public entity, or governmental body directly or indirectly affected by the activities of the Department.
 - 3. **AAAs:** Directors of the AAAs are key informants in all the Department’s planning efforts.

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STRATEGY FOR GATHERING PUBLIC INPUT:

- A. Input Process:** The Department developed its public input process to use and build upon the existing mechanisms listed in B below. The purpose of the public input process is to provide:
1. Direction in the development of its plans;
 2. Evaluation of current plans; and
 3. Feedback on Department strategies to meet unmet needs.
- B. DOEA Plan Creation/Revision:** For the creation and revision of the Department's plans, staff collate information gained from sources, such as the following:
1. Public meetings and/or hearings;
 2. Key informants;
 3. Focus groups on aging issues;
 4. Meetings with AAA directors and planning staff;
 5. Survey responses and other data sources; and
 6. Other meetings and hearings.
- C. Priority Issues:** Staff of the Department uses this information to formulate draft priority issues.
- D. State Plan:** After Department staff develops the draft state plan, input from AAAs and other stakeholders is incorporated into the document.

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AREA AGENCIES ON AGING (AAA):

- A. AAAs:** Eleven (11) AAAs administer a substantial portion of Florida's programs for elders.
- B. OAA Authority:** Sections 305(a)(1)(E) and (a)(2)(A) of the Older Americans Act (OAA) specify that a single agency will be designated in each PSA to locally plan and administer OAA programs.
- C. Board of Directors:** A board of directors governs each AAA.

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AREA PLANS:

A. Federal Requirements:

1. Federal regulations at 45 CFR 1321.53 require that each AAA, as part of its mission and under the leadership and direction of DOEA, proactively perform planning, monitoring and evaluation relating to programs for older persons.
2. OAA Section 306(a) requires AAAs to prepare and develop an area plan for a two, three or four-year period determined by the State Agency and based upon a uniform format for area plans within the state.

B. Specific Services: Area plans shall describe in detail the specific services to be provided in serving the PSA's older population.

C. Plan Development: The area plan is developed based on an assessment of an area's need, and incorporates public input obtained through public hearing and information solicited from elders, their caregivers, and service providers.

D. AAA Goals/Objectives/Strategies: The area plan also outlines the goals and objectives that the AAA and its staff and volunteers plan to accomplish each year and the strategies to show how they plan to achieve those goals and objectives.

E. Performance and Outcome Measures: The area plan includes outcome and output performance measures. Goals, objectives, and strategies are associated with the relevant outcomes. Achieving the goals and objectives helps ensure successfully meeting outcome and output standards.

F. Financial Information: The area plan includes information to illustrate the distribution of funding by services, funding source, provider, and county.

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AREAWIDE PLANNING RESPONSIBILITIES:

- A. AAA Primary Functions:** The AAA's primary functions are to:
1. Develop a comprehensive and coordinated system within the PSA for the provision of supportive and nutrition services for older persons; and
 2. Establish, maintain, or develop multiple sources of information, referral, screening, and services, where appropriate.
- B. Planning:** The term planning refers to the process of making rational decisions affecting the future wherein:
1. **An analysis** of organizational, network, and PSA capacities and characteristics is conducted;
 2. **Needs and priorities** are established;
 3. **Goals and objectives** are defined to attend to identified needs and priorities; and
 4. **Strategies** are detailed by the agency and service system (network of service provider agencies) to achieve the defined goals and objectives.
- C. Area Plan:** Area plans are the foundation of the state plan on aging. As determined by the Department, area plans are developed and submitted by each AAA on a three-year cycle, and an update is submitted by the AAA to the Department annually., or They document and provide assurances as to how the AAA and the service provider network will:
1. Address the identified needs of elders within the PSA;
 2. Conduct targeted outreach to OAA priority groups of elders in the PSA; and
 3. Maintain compliance with the rules, regulations and policy guidance governing the Older Americans Act and all other programs sponsored by the Department.

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- D. Appropriate Planning Criteria:** Proper planning is based on the following:
1. Current knowledge of the conditions of older persons.
 2. Knowledge about the extent of the need for services.
 3. Knowledge about the location of older persons who may need services.
 4. Realistic appraisal of existing available organizational, community, and PSA resources.
 5. An analysis, based on numbers 1, 2, 3, and 4 above, to determine how best to conduct outreach and provide services to improve the welfare of elders in the PSA.
- E. Evaluation Process:** To evaluate the effectiveness of the use of resources in meeting needs, the plan must explicitly incorporate a properly designed system of performance measures including outputs and outcomes. This system must include, at a minimum, a prescribed set of performance measures that the Department considers necessary for the proper administration of the statewide system of Older Americans Act providers. The plan must include the AAA's strategies for achieving the prescribed performance and outcome measures.

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UNIFORM AREA PLAN FORMAT:

A. Plan Format and Availability:

- 1. Uniform Format:** The Department will prepare a uniform format for use by AAAs in developing their area plans.
- 2. Availability:** The Department will distribute the uniform area plan format to the AAAs via Notice of Instruction, which will include relevant guidance and time frames.

B. Area Plan Format Comments/Suggestions:

- 1. Comments/Suggestions:** DOEA's policy is to accept comments or suggestions regarding any aspects of the uniform area plan format from any source at any time during the year.
- 2. Format Review:** DOEA shall consider such comments and suggestions at the next review of the uniform area plan format.

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PREPARATION OF THE MULTI-YEAR AREA PLAN:

- A. The AAAs shall prepare area plans on a **multi-year cycle**, as directed by the Department. Subsequent years, after the original multi-year plan submission, shall include an **annual update** consisting primarily of financial and programmatic documentation.
- B. Area plans will be prepared in a format prescribed and provided by the Department in accordance with the requirements of the Older Americans Act, as amended.
- C. **Public Hearing Requirement:** Each AAA shall conduct at least one public hearing on the multi-year area plan.
 - 1. **Adequate Notice:** The AAA shall provide older persons, public officials and interested parties at least 15 days' notice of the **time, date and location** of the public hearing. If the AAA proposes to provide a service directly, other than outreach, information and assistance, or referral, a public hearing must be held. The hearing notice must clearly list each proposed service the AAA plans to provide directly.
 - 2. **Reasonable Opportunity:** The time and location of the hearing must permit a reasonable opportunity for older persons, public officials and other interested persons to participate. The hearing location must meet Americans with Disabilities Act (ADA) standards for accessibility.

PREPARATION OF AREA PLAN ANNUAL UPDATE:

- A. **Annual Update Requirements:** DOEA will provide the AAA with specific requirements for the annual update of the multi-year area plan through Notice of Instruction.
- B. **Review and Approval at the Local Level:**
 - 1. The AAA advisory council must review and sign-off on the multi-year area plan and annual update. The signature of the advisory council chair is required prior to the annual update's submission to DOEA.
 - 2. The AAA board of directors must review and approve the area plan annual update. The signature of the board president is required prior to the annual update's submission to DOEA.

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REVIEW AND APPROVAL OF AREA PLAN AND AREA PLAN ANNUAL UPDATE:

- A. DOEA Responsibility:** DOEA will carefully review the multi-year area plan or annual update and advise the AAA in writing as to the acceptance of the plan or update. If the plan or update is not acceptable, the Department will provide the AAA with written comments regarding the need for revisions. The Department's responsibility is to ensure that the final multi-year area plan and annual updates conform to OAA requirements, and that all comments and suggestions identified in the review have been addressed in the final submission.
- B. DOEA/AAA Contract:** Once the multi-year area plan or annual update is submitted to DOEA, it becomes a referenced exhibit in the formal contract with DOEA for federal and state funding.
 - 1. Changes:** DOEA must approve any changes to the goals and objectives of the multi-year area plan or annual updates.
 - 2. Noncompliance Issues:** DOEA may require changes at any time in any portion of the multi-year area plan or annual updates if the Department determines the document is incompatible with established policy, or the document is not in compliance with current program guidelines and criteria for use of funds.
- C. Identified Multi-Year Area Plan or Annual Update Deficiencies:** If there are portions of the multi-year area plan or annual update which DOEA determines to be deficient, DOEA may proceed with the multi-year area plan or annual update and contract approval by placing a condition of award in the contract language, or by requiring the AAA to correct the identified deficiencies by a specific date.
- D. Unacceptable Multi-Year Area Plan or Annual Update:** If DOEA determines the final multi-year area plan or annual update is unacceptable as submitted and is subject to disapproval, DOEA shall promptly advise the AAA of the likelihood of such disapproval. The AAA shall be given a specified time to revise the multi-year area plan or annual update to be in full compliance with the required changes.

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- E. Continued Noncompliance:** If DOEA determines the AAA changes continue to be inadequate to bring the plan to an acceptable standard, the following policies will apply:
- 1. Certified Mail/Hand Delivered Notification:** The DOEA Secretary shall submit a formal notification letter addressed to the AAA executive director with a copy submitted to the president (chairperson) of the AAA governing board. The notification shall be submitted by U.S. Certified Mail or hand delivered. The notification shall contain the following:
 - a. Reason for Disapproval:** A brief statement of the reasons the submitted multi-year area plan or annual update cannot be approved;
 - b. Facts/Circumstances/Evidence:** Information as to the facts, circumstances and evidence which substantiate the multi-year area plan or annual update disapproval;
 - c. Chronology:** A brief chronological summary of DOEA actions to identify the deficiencies and assist the AAA for corrective action;
 - d. AAA Remedies:** A summary of the observed AAA actions to remedy the identified deficiencies to date; and
 - e. Fair Hearing:** The AAA's right to request a hearing on this decision under Chapter 120.57(2), F.S., within 15 days after receipt of the formal notification.
 - 2. AAA Designation Withdrawal:** The disapproval of a multi-year area plan or annual update is valid justification for withdrawal of the AAA designation. For this reason, the formal disapproval notification may be combined with procedures outlined in Chapter 4, Older Americans Act, Section 1, of this handbook or precede the de-designation process.

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PURPOSE OF MONITORING AND QUALITY ASSURANCE:

This section addresses various aspects of monitoring and quality assurance for DOEA administered programs from the perspective of the Department, the AAA and service providers.

MONITORING AND QUALITY ASSURANCE OVERVIEW:

- A. DOEA as Pass-Through Entity:** The Department of Elder Affairs, as the designated State Unit on Aging (SUA) and pass-through entity, is responsible for monitoring the activities of subrecipients as necessary to ensure that state and federal awards are used in compliance with laws, regulations, contract provisions, and grant agreements. The Department is also responsible for achieving performance outcomes.
- B. Monitoring and Quality Assurance:** Monitoring is the review process used to determine a subrecipient's compliance with the requirements of state and federal programs, applicable laws and regulations, and required results and outcomes. Monitoring includes internal control review to determine if financial management and accounting systems are adequate to control and account for program funds in accordance with state and federal requirements. Quality assurance is the comprehensive approach of reviewing, assessing, evaluating, and improving the quality of services provided by subrecipients, sub-grantees and service providers.
- C. Monitoring Focus:** The Department's subrecipient monitoring encourages proactive measures and addresses strategic areas or business processes that may impact services delivery. Key monitoring emphasis areas include:
 - 1. Corporate Governance and Oversight;
 - 2. Effective Internal Controls Establishment and Implementation;
 - 3. Effective and Efficient Public Resources Management;
 - 4. Continuous Improvement of Business Processes and Service Delivery;
 - 5. Administrative, Operational and Program and Fiscal Oversight of Subrecipients Monitoring;
 - 6. Quality Assurance and Standards of Care; and
 - 7. Legislatively Mandated Performance Outcome Measures.

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- D. Monitoring Premises:** Area Agencies on Aging are designated local level administrative entities that plan and coordinate federal and state funded services and local services.

Area Agencies on Aging establish and maintain an effective internal control system to ensure that:

1. Program goals and outcome measures are met;
2. Resources are safeguarded and properly accounted for;
3. Laws and regulations are followed;
4. Reliable data is obtained, maintained, and disclosed appropriately;
5. Significant or material events with a potential impact on service delivery or quality are promptly communicated verbally and in writing; and
6. Generally accepted good practice standards are followed in delivering timely high-quality services to clients.

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ROLES AND RESPONSIBILITIES:

- A. DOEA's Role and Responsibility:** As the pass-through entity, the Department is responsible for ensuring all federal funds it receives, including those passed through to subrecipients and contractors, are used solely for program-related purposes.
- B. AAA's Role and Responsibilities:** As the DOEA subrecipient, the AAA is responsible for complying with all sub-award and contract agreement requirements and the applicable laws and regulations resulting from receiving federal and state funds. These responsibilities include:
- 1.** Ensuring the AAA has a procurement, property management and financial management system that properly accounts for all program activities, equipment and expenditures.
 - 2.** Establishing program budgets and a method for tracking actual costs against the budget.
 - 3.** Keeping abreast of grant and program changes affecting AAA policies, procedures, and requirements.
 - 4.** Developing and submitting an annual AAA subrecipient and subcontractor monitoring plan.
 - 5.** Informing subrecipients and subcontractors of contractual and compliance requirements and monitoring their performance and compliance.
 - 6.** Reviewing subrecipients' and subcontractors' single audit reports, issuing management decisions within six months of audit findings and ensuring that subrecipients take effective and timely corrective action.
 - 7.** Requiring subrecipients and subcontractors to grant Department representatives' access to original and complete records for monitoring.

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8. Ensuring the AAA's subrecipient and subcontractor monitoring plan considers the following:
 - a. Total number of subcontracts;
 - b. A program description of each program being monitored;
 - c. Risk assigned for each subrecipient and contractor (see sample risk factors in Section VII).
 - d. Previous monitoring year findings summary;
 - e. Identification and communication of current or remaining issues, problems or deficiencies in writing;
 - f. Corrective action plans and time schedule; and
 - g. Complete and thorough follow-up on corrective actions taken, including the review of supporting documentation and files to ensure required corrective action is implemented.
- C. **Service Providers' Role and Responsibilities:** As the subrecipient or subcontractor, the service provider is responsible for complying with all sub-award or contract agreement requirements, including compliance with laws and regulations related to receiving federal or state funds.

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PROGRAM LEVEL REQUIREMENTS:

- A. Allowed Activities:** Program funds can be used solely for allowable activities defined by the program requirements. Expenditures charged against state funds must be authorized by law and must meet the intent of the law. Payment for activities not required by or for the benefit of the program(s) is not allowed and must be treated as disallowed costs.

In accordance with Department of Financial Services' Reference Guide to State Expenditures, state funds expenditures for items listed below are prohibited unless expressly provided by law:

1. Congratulatory telegrams;
2. Flowers and/or telegraphic condolences;
3. Presentation of plaques for outstanding service;
4. Entertainment for visiting dignitaries;
5. Refreshments such as coffee and doughnuts;
6. Decorative items (globes, statues, potted plants, picture frames, etc.) and
7. Greeting cards.

Only costs that are directly attributable to specific work activities under a grant or program that are part of the normal administration of the program are allowable for reimbursement.

- B. Allowable Cost/Cost Principles:** Program funds can be used for allowable expenditures only and must be recorded in accordance with cost principles as defined by the 2 CFR, Part 200. To qualify for reimbursement, program costs must:

1. Be necessary and reasonable for proper and efficient program administration (and allowable under the provisions of the applicable cost principles). Reasonable considerations include the following:
 - a. The restraints or requirements imposed by such factors as sound business practices, arms-length bargaining, laws and regulations, and terms and conditions of the program;

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- b. The market price for comparable goods and services;
 - c. Whether the individuals involved acted prudently considering their responsibilities to the agency, the public at large, and the granting agency; and
 - d. Whether the costs were incurred in accordance with applicable state procurement policy.
 - 2. Conform to any limitations or exclusions set forth in federal or state laws, or other governing limitations as to types or amounts of cost items.
 - 3. Be consistent with policies, regulations, and procedures that apply uniformly to both financially assisted activities and to other activities of the entity.
 - 4. Treated consistently. A cost may not be assigned to a program as a direct cost if any other cost under the same or like circumstances have been charged to a program as an indirect cost.
 - 5. Be determined in accordance with generally accepted accounting principles (GAAP).
 - 6. Not be allocable to or included as a cost of any other federal, state or other agency financed program in either the current or prior period.
 - 7. Be net of all applicable credits (program generated income).
 - 8. Be supported by the entity's accounting records and be adequately documented.
- C. Eligibility:** Program funds can be expended only for the benefit of persons meeting certain eligibility criteria. In addition to compliance requirements related to individual program or service recipients, eligibility also governs the following:
- 1. **Eligibility for group of individuals or area of service delivery:** Only eligible groups of individuals or individuals in an area of service can participate in the program.
 - 2. **Eligibility for subcontractors:** Department funds sub-awards can be made only to eligible providers and must be in accordance with program requirements.

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- D. Equipment and Real Property Management:** Title to equipment and real property acquired by a nonfederal entity with federal funds vest with the nonfederal entity (AAA), however, requests for disposition must be approved by the Department. An inventory listing of property acquired with federal funds must be maintained with the following data elements in accordance with 2 CFR, Part 200:
1. A description of the equipment;
 2. Manufacturer's serial number, model number, federal stock number, national stock number, or other identification number;
 3. Source of the funding for the property; ;
 4. Indication whether title vests with the recipient or the federal government;
 5. Acquisition date (or date received, if the equipment was furnished by the Federal Government) ;
 6. Information from which one can calculate the percentage of federal participation in the cost of the equipment (not applicable to equipment furnished by the federal government);
 7. Location and condition of the equipment and the date the information was reported;
 8. Unit acquisition cost; and
 9. Ultimate disposition data, including date of disposal and sales price, or the method used to determine current fair market value where a recipient compensates the federal awarding agency for its share.
- E. Matching, Level of Effort, and Earmarking:** Program funds must be spent and matched in accordance with specified program requirements. Matching level of effort, and earmarking are defined as follows:
1. **Matching or cost sharing:** Refers to the portion of project or program costs not borne by the Federal Government, including requirements to provide contributions (a specified amount or percentage to match program award). Matching may be in the form of allowable costs from third party contributions and/or cash from nonfederal sources.

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2. **Level of effort:** Refers to the portion of time spent on an activity expressed as a percentage of the total activity. Includes requirements for a specified level of service to be provided from period to period; a specified level of expenditures from nonfederal or federal sources for specified activities to be maintained from period to period; and federal funds to supplement and not supplant nonfederal funding of services.
 3. **Earmarking:** Refers to requirements that specify the minimum or maximum amount or percentage of the program's funding that may be used for specified activities, including funds provided to the subrecipient.
- F. **Period of Availability of Funds:** Grant funds are awarded for a specified time, usually one year (except for some programs that have "carry forward" of funds). Federal and state regulations prohibit the use of funds from a grant award outside its specified timeframe. Unexpended surplus funds cannot be used beyond the period of availability and must be returned to the awarding agency. Under certain circumstances, if approved, unobligated balances may be carried over and charged for obligations in the subsequent period.
- G. **Procurement:** The procurement requirement is established to ensure that goods and services are obtained in an effective manner and in compliance with laws and regulations, including prohibition of conflicts of interest, fair selection of vendors, and provision of open and free competition.
- H. **Suspension and Debarment:** The suspension and debarment requirements prohibit nonfederal entities from contracting or making covered transactions or sub-awards to parties that are suspended or debarred, or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods and services equal to or more than \$100,000. Potential reasons for suspension and debarment may include, but not be limited to, mismanagement of funds and non-compliance with laws and regulations.
- I. **Program Income:** Program income is gross income received that is directly generated by the grant-funded program during the grant period. Program income does not include interest on grant funds, rebates, credit discounts, refunds, and/or proceeds of the sale of equipment or property. This type of income includes, but is not limited to, the following:
1. Fees for services performed;

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2. Rental or lease of real or personal property acquired with program funds; and
3. Sale of commodities and program fabricated items.

J. Subrecipient Monitoring: The subrecipient monitoring requirement establishes that any nonfederal recipient of federal assistance, which passes that assistance (in whole or in part) to another recipient, is responsible for monitoring the activities of that subrecipient, as well as ensuring that they both comply with laws and regulations. Compliance includes ensuring that required audits are performed, as well as evaluating the impact of subrecipient activities and ability to comply with the law. A pass-through entity is responsible for identifying the following regarding a subrecipient:

1. CFDA/CSDA title and number;
2. Award name;
3. Name of awarding agency; and
4. Applicable compliance requirements.

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RISK-BASED MONITORING APPROACH:

- A. A risk-based monitoring approach involves identifying areas of risk and prioritizing monitoring around those risks.
- B. Risk Assessment Considerations: In delivering client services, risk exists at two levels – the program level and the subrecipient/subcontractor level.
- C. Risk assessment considerations at the program level include, but are not limited to, the following:
 - 1. **Program history:** Is it a new or long-established program or service? Have significant changes occurred?
 - 2. **Total funding:** Does this contract represent a significant portion of the total program funding?
 - 3. **Complexity:** Are program requirements simple or complex?
 - 4. **Client health and safety:** How vulnerable are the clients that the program serves?
 - 5. **Responsibility for key decisions:** Does the state agency, federal government, or the contractor make decisions about eligibility and amount or type of service to be provided to a client? For federal funds, is the contractor a vendor or subrecipient?
 - 6. **Federal risk assessment:** Has the U.S. General Accounting Office and U.S. Office of Management and Budget identified the program as high risk?
 - 7. **Payment method:** What type of payment method is used (e.g., cost reimbursement, unit rate, performance-based)? What experience does the Department have with the method?
 - 8. **Competition:** Are contracts awarded on a competitive basis, which includes detailed evaluations of the service proposal, costs and contractor qualifications, or are they awarded on an entitlement, sole source or noncompetitive basis?

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9. **Monitoring methods:** Are the existing methods of monitoring effective for this program? Do these monitoring methods effectively mitigate the other types of possible risks?
 10. **Client choice:** Is the client able to choose or select the service provider as required by some federal programs?
- D. **Risk assessment considerations at the client service subrecipient / contractor level include, but are not limited to, the following:**
1. **Total funding that the contractor receives from the Department:** Is the amount or percentage of total funding small or large? Does the contractor have only a few contracts or several contracts with the state?
 2. **Multiple funding sources:** Is the contractor receiving funding from several sources for similar services? Are multiple funding sources involved and to what extent?
 3. **Collaboration:** Has the contractor established and promoted a collaborative relationship between itself and all its funded service providers?
 4. **Length of time in business:** Has the contractor been in business for several years or is it a new client service provider?
 5. **Experience and past performance:** Does the contractor have contracts for similar services with other governmental entities? How extensive is the contractor's experience with the state for the types of services being provided?
 6. **Accreditation/licensure:** Are contractors subject to accreditation or licensure requirements?
 7. **Financial health and practices:** Is the contractor's financial condition good or poor? Does the contractor demonstrate sound financial practices? Is the contractor's financial recordkeeping system adequate for the number and complexity of funding? Is the contractor's cost allocation methodology equitable?
 8. **Current and prior audit experience:** Has the contractor had weaknesses in internal control over federal or state programs?

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9. **Oversight exercised by funding agencies:** Has there been monitoring or other reviews by any funding agency that could indicate the degree of risk? Is the contractor proposing to operate under a waiver from customary program and financial management requirements?
10. **Board of Directors:** If the contractor is a nonprofit organization, does the board take an active role in directing the organization, establishing management and programmatic (accounting, fiscal, procurement, etc.) policies and procedures and monitoring the organization's financial and programmatic performance?
11. **Subcontracting:** Does the contractor subcontract key activities? Does the contractor have an effective monitoring function to oversee these subcontracts?
12. **Organizational changes:** Has there been frequent turnover of contractor management, senior accounting staff, or key program personnel? Has the contractor taken on new services within the last 12 months? Has the contractor experienced a recent rapid growth, or downsizing? Has the contractor experienced reorganization within the last 12 months? Has the contractor changed major subcontractors?
13. **Management structure:** Is the organization centralized or decentralized? How much control does the organization have over decentralized functions?
14. **Legal actions:** Have any lawsuits been filed against the contractor within the last 12 months? Has any employee, officer and/or board member been involved in or alleged to have been involved in any allegations of fraud or malfeasance?
15. **Defaulted contracts:** Has the contractor defaulted on any of its contracts within the past five years? If so, what were the circumstances?

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E. Other risk assessment considerations:

- 1.** Type and number of prior period findings;
- 2.** Overall effectiveness of administrative and fiscal controls;
- 3.** Unresolved prior-period findings;
- 4.** OMB Circular A-133 “High Risk” designation;
- 5.** Management (DOEA/AAA) concerns/issues;
- 6.** Agency management, staff and key employee turnover;
- 7.** Ineffective subrecipient monitoring and oversight;
- 8.** Weak and/or ineffective internal controls;
- 9.** Conflicts of interest, fraud, unethical or illegal acts; and
- 10.** Quality of care concerns.

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ANNUAL MONITORING METHODOLOGY:

Monitoring Approach: The Department may use, but is not limited to, one or more of the following methods:

- A.** Desk reviews and analytical reviews;
- B.** Scheduled, unscheduled and follow-up on-site visits;
- C.** Client visits;
- D.** Review of independent auditor's reports;
- E.** Review of third-party documents and/or evaluation;
- F.** Review of progress reports;
- G.** Review of customer satisfaction surveys;
- H.** Agreed-upon procedures review by an external auditor or consultant;
- I.** Limited-scope reviews; and
- J.** Other procedures as deemed necessary.

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DOEA AREA AGENCY ON AGING MONITORING:

Focus Areas: The Department is responsible for monitoring the AAAs to ensure compliance with contract obligations and federal and state rules and regulations. Areas reviewed shall include, **but are not limited to**, the following:

A. Organization Governance, Leadership and Administration:

1. Board of Directors Governance and Oversight;
2. Single Audit Act Compliance;
3. Legislative/Strategic Outcome Measures; and
4. Prior Period Findings/Corrective Actions.

B. AAA Operations - Effectiveness, Efficiency and Appropriateness of Service Delivery:

1. Prioritization and Targeting;
2. Service Delivery/Client Satisfaction;
3. Grievance Procedures/Client Complaints;
4. Budgeting and Utilization of Resources; and
5. Information and Referral (OAA-I&R).

C. Regulatory/Contractual Compliance – Federal and State Programs:

1. Emergency Home Energy Assistance for the Elderly Program;
2. Nutrition Programs - OAA Title IIIC1 and IIIC2;
3. Health Promotion - OAA Title IIID;
4. National Family Caregiver Support Program – OAA Title IIIE;
5. Serving Health Insurance Needs of Elders; and
6. Elder Abuse Prevention – OAA Title VII.

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D. Financial Management, Internal Controls and Subrecipient Monitoring:

1. Subrecipient Monitoring and Oversight – Fiscal Only;
2. Subrecipient Monitoring and Oversight – Program Only;
3. Accounting, Fiscal and Operational Controls;
4. Co-Payments;
5. In-Kind;
6. Property Acquisition and Accountability;
7. Internal Controls; and
8. Procurement and Contracting.

E. Information Management and Data Integrity: Client Data Integrity

1. Client data is entered in the Department Client Information and Registration Tracking System (CIRTS) promptly and correctly; and
2. Subrecipient Monitoring and Oversight – for CIRTS entry and accuracy.

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AAA SUBRECIPIENT AND CONTRACTOR MONITORING:

The AAA shall monitor its subrecipients/contractors in accordance with its contract and/or agreement with each entity.

As part of its monitoring process, DOEA will review the AAA's subrecipient, contractor, subcontractor and vendor monitoring reports.

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Attachment A: Governing Laws and Regulations

GOVERNING LAWS AND REGULATIONS

A. Governing Laws and Regulations include, but are not be limited to, the following:

- 1. Origin and Source of Grant Requirements:** Grant and financial award requirements originate from several sources, including the following:
 - a. U.S. Constitution;
 - b. Statutes and Executive Orders;
 - c. Grant Enabling Statutes;
 - d. OMB Circulars and Codes of Federal Regulations (CFR); and
 - e. Public Policy Requirements;
- 2. Public Policy Requirements:** As a condition of receipt, federally-funded programs are governed by a myriad of federal rules and regulations. These rules and regulations apply to virtually all programs funded by federal resources and are as follows:
 - a. **Civil Rights Act of 1964:** Prohibits discrimination based on race, color or national origin in all federally funded programs.
 - b. **45 CFR Part 80:** Regulates implementation of Civil Rights Act of 1964.
 - c. **Age Discrimination Act of 1975:** Prohibits discrimination based on age in federally funded programs.
 - d. **45 CFR Part 90:** Regulates implementation of Age Discrimination Act of 1975.
 - e. **Americans with Disabilities Act of 1990, Public Law (P.L.) 101336:** Prohibits discrimination based on disability and provides equal opportunities in employment, state and local governmental entities, public accommodations, transportation and telecommunications for persons with disabilities.

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- f. **28 CFR Part 35:** Regulates implementation of Subtitle A of Title II of the Americans with Disabilities Act of 1990.

3. Government Imposed Restrictions:

- a. **Debarment and Suspension (Executive Order 12549):** Prohibits doing business with persons suspended or barred from doing business with any agency of the executive branch.
- b. **45 CFR Part 76:** Regulates implementation of Executive Order 12549, certifying that contractors have not been declared ineligible for participation in public transaction by a federal department or agency.
- c. **Anti-Lobbying Act (P.L. 101-121 Section 319):** Prohibits contractors of federal contracts, grants and loans from using appropriated funds for lobbying the executive or legislative branches of the federal government about a specific contract grant or loan.
- d. **Section 1352, Title 31 U.S.C:** Regulates implementation of the Anti-Lobbying Act. Contractor receiving more than \$100,000 per award of federally appropriated funds per fiscal year must certify that they will not use these funds to pay lobbying activities. They must also disclose each instance of lobbying that does occur.
- e. **Drug-Free Workplace Act of 1988 (41 U.S.V 702 et seq.):** Requires contractors and grantees of federal agencies to certify that they will provide drug-free workplaces. **(P.L. 100 - 690)**
- f. **45 CFR Part 82:** Regulates implementation of Drug-Free Act of 1988.
- g. **Section 504 of the Rehabilitation Act of 1973:** Prohibits discrimination based on handicap in federally funded programs.
- h. **Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191, Sections 261-264):** Requires covered entities to comply with HIPAA standards for the electronic exchanges, privacy and security of health information.

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- i. **Domestic Volunteer Act (P.L. 93-113):** Senior Companion Sections 430.07-430.071, Florida Statutes.
- j. **45 CFR Part 84:** Regulates implementation of uniform administrative requirements for grants and cooperative agreements of state, local and tribal governments.

4. Cost/Administrative Requirements:

- a. **Cash Management Improvement Act of 1990 (P.L. 101-453):**
Requires the timely transfer of funds between a federal agency and a state agency to encourage development of efficient cash management systems.
- b. **Program Fraud Civil Remedies Act of 1986 (P.L. 99-509):**
Establishes administrative procedures for imposing civil penalties and assessments against persons who make, submit, present or cause to be made, false, fictitious or fraudulent claims or written statements to authorities or to their agents.
- c. **Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224):** Provides criteria for distinguishing whether a transaction is procurement or financial assistance.
- d. **2 CFR, Part 200:**
 - Grants and Cooperative Agreements with States and Local Governments.
 - Cost Principles for State, Local and Indian Tribal Governments
 - Cost Principles for Nonprofit Organizations.
 - Regulates implementation of uniform administrative requirements for grants and agreements with institutions of higher education, hospitals and other nonprofit organizations.
- e. Federal Acquisition Regulation (FAR) Part 31.2: Cost Principles for Commercial Organizations
- f. **45 CFR Part 74:** Regulates implementation of uniform administrative requirements for awards and sub-awards to institutions of higher education, hospitals, other nonprofit organizations and commercial organizations.

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B. Governing State Laws and Regulations:

- 1.** Sections 430.201-203-205, F.S., Community Care for the Elderly (CCE)
- 2.** Sections 430.601-603, F.S., Home Care for the Elderly (HCE)
- 3.** Sections 430.501-504, F.S., Alzheimer's Disease Initiative (ADI)
- 4.** Section 430.071, F.S., Respite for Elders Living In Everyday Families (RELIEF)
- 5.** General Appropriations Act – Local Service Programs (LSP)
- 6.** Section 409.508, F.S., Emergency Home Energy Assistance for the Elderly (EHEAP)
- 7.** Chapter 73C-26, F.A.C., Emergency Home Energy Assistance for the Elderly (EHEAP)
- 8.** DOEA Rules, Regulations and Notices of Instruction (NOIs)
- 9.** Agreements and/or contracts.
- 10.** Department of Financial Services' Reference Guide for State Expenditures

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Section IV: Program Reporting Requirements

PROGRAM REPORTING REQUIREMENTS:

Program reports must be prepared and submitted as specified in DOEA contracts.

Chapter 2

Intake, Screening, Prioritization, Assessment, and Case Management

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Section I: Screening and Assessment Forms

Purpose: Screening and assessment forms are used to complete an initial assessment to place clients on the Department's statewide priority consumer list, or annual reassessment of clients enrolled in Department funded case-managed programs. The assessment forms are also used for active clients who have requested to update their assessment information when a significant change takes place.

The assessment helps to identify the client's conditions and resources in relation to the following:

- i. Mental Health/Behavior/Cognition;
- ii. Physical Health;
- iii. Activities of Daily Living (ADLs);
- iv. Instrumental Activities of Daily Living (IADLs);
- v. Nutrition Status;
- vi. Health Conditions/Special Services/Medications;
- vii. Caregiver Status;
- viii. Social Resources; and
- ix. Environmental Risks.

A. Screening and Assessment forms used to conduct client screenings and assessments:

- 1. DOEA Form 701S: Initial and Rescreen
- 2. DOEA Form 701C: Congregate Meals Assessment
- 3. DOEA Form 701B: Comprehensive Assessment
- 4. DOEA Form 701A: Condensed Assessment

B. Assessment Instructions (DOEA 701D): Specific and detailed instructions for completing the assessment forms are included in the Assessment Instructions (DOEA 701D).

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Section I: Screening and Assessment Forms

CRITERIA FOR ADMINISTRATION OF CLIENT SCREENING AND ASSESSMENT FORMS

- A. DOEA Screening Form 701S** is used for screening and re-screening individuals for enrollment and maintenance on the Assessed Prioritized Consumer List (APCL) for the Statewide Medicaid Managed Long-Term Care (SMMC LTC) Program and Department funded programs. Completion of the form generates a priority score and rank.. If the 701S is used for OAA, the screener will be directed to the nutrition risk section of Form 701S only if “YES” is answered to the question, “Do you need other assistance for food?” The nutrition risk score is generated when the nutrition risk section of the screening is completed.
- B. DOEA Assessment Form 701C** is used to complete initial assessments and annual reassessments for individuals for congregate meals and nutrition counseling services in the OAA Title III C1 program. A nutrition risk score is generated.

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C. DOEA Assessment Form 701B is administered face-to-face and used to complete initial comprehensive client assessments and annual client reassessments for all clients enrolled in SMMC LTC as well as the Department funded case managed programs listed below.

1. **ADI:** Alzheimer's Disease Initiative.
2. **CCE:** Community Care for the Elderly.
3. **HCE:** Home Care for the Elderly.
4. **LSP:** Local Services Program (if case management provided).
5. **OAA:** Older Americans Act (if case management provided).

Note: The 701B is completed by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program for clients enrolled in the SMMC LTC.

D. DOEA Condensed Assessment Form 701A is a shortened assessment based upon the 701B Comprehensive Assessment, to be administered face-to-face for non-case managed clients in LSP and OAA programs. A priority score, rank, and nutrition risk score are generated. The 701A is administered face-to-face and is used to complete initial assessments and annual client reassessments for the following:

1. OAA Registered Services including Adult Day Care, Adult Day Health Care, Chore, Congregate Meals, Escort, Home-Delivered Meals, Home Health Aide, Homemaker, Nutrition Counseling, Personal Care, and Respite. The service "Screening and Assessment" is the OAA service that is billed in CIRTS to conduct initial and annual reassessments.
2. OAA Title III-E Caregiver Support Program services that require client specific reporting in CIRTS. The 701A collects the required federal report data and establishes the required frailty level of elder recipients (60 or older) to receive OAA Title III-E Respite (Adult Day Health Care, Adult Day Care, Direct Pay Respite, In-Home Respite or Facility-Based Respite) or OAA Title III-Es, supplemental services. The 701A documents the required frailty level for eligibility with "two (2) or more ADL deficits" or "Yes" to the question, "Does client need supervision?"
3. OAA Title III-EG Caregiver Support Program services that require data for the annual federal report and eligibility for the OAA Title III-EG program.

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4. LSP services that are operated under OAA standards.

The appropriate DOEA Form, 701C, 701A, or 701B will be completed before or on the date of client enrollment to determine the client's eligibility for the program.

- E. Any of the DOEA Forms, 701C, 701S, 701A or 701B** may be used to document a significant change in a client's condition that occurs at any time between the initial and annual screening or at any time between the assessment and annual assessment. The screener or assessor will indicate the purpose for completing the form, including documentation of a significant change in one or more of the following domains: Health, Living Situation, Caregiver, Environment or Income.

NOTE: When the required initial or annual screening or assessment is completed, the reason is identified as initial or annual. When a screening or assessment is being completed more frequently than every 12 months, the box identifying the significant change prompting the unscheduled rescreen or reassessment is checked.

To document the significant change in the client's condition, the appropriate form is completed in its entirety. The 701A or 701B is completed face-to-face; the 701S is completed over the telephone and the 701C is completed at a meal site. Examples of significant changes include the following:

1. Change in health status after an accident or illness;
2. Change in living situation;
3. Change in the caregiver relationship;
4. Loss, damage or deterioration of the home environment;
5. Loss of spouse, family member or close friend; or
6. Loss of income.

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Section I: Screening and Assessment Forms

The following client scenarios are provided as examples to illustrate the screening and assessment requirements:

Screening and Assessment Summaries		
CIRTS Program Status Codes	Initial Screening/ Assessment	Annual Rescreening/ Reassessment/Significant Change
APCL ADI, CCE, HCE and LSP (CCE criteria),	701S	701S
SMMC LTC	701S	701S
APCL OAA (IIIB, IIIC, IIIE, IIIEG, and IIIES), LSP (OAA criteria) Delete previous note Note: The 701S will generate a nutrition risk score when the nutrition section is completed. Completion of the nutrition section is required if the response to the question, "Do you need other assistance for food?" is "Yes." Completion of the nutrition section is optional if the response to the question, "Do you need other assistance for food?" is "No."	Follow OAA targeting criteria 701S (except for IIIB transportation and IIIC1 services)..	Follow OAA targeting criteria 701S (except for IIIB transportation and IIIC1 services). completed annually to maintain the APCL status.
ACTV ADI, CCE, and HCE	701B	701B by case manager
APCL ADI, CCE, HCE and ACTV OAA C1	701S	701S and 701C (for IIIC1 only) annually
APCL OAA registered services and ACTV OAA C1	701C and 701S (except for IIIB transportation)	701C and 701S (except for IIIB transportation)

Note: All APCL SMMC LTC Clients shall complete an annual 701S rescreening. If the client is active in any other program, they shall complete that program's annual reassessment and a 701S.

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Screening and Assessment Summaries		
CIRTS Program Status Code	Initial Screening/Assessment	Annual Rescreening/Reassessment
APCL for any program except SMMC LTC, and ACTV in ADI, CCE, or HCE	701B	701B by case manager
APCL for any program except SMMC LTC, and ACTV in OAA receiving a registered service	701A	701A
APCL for any program except SMMC LTC, or ACTV OAE3G and ACTV in OA3E receiving at least one service that requires client specific reporting	701A	701A
ACTV ADI, CCE, HCE, SMMC LTC	701B	701B
ACTV any Department funded program (including OAA or LSP) and receiving Case Management	701B	701B
ACTV OAA receiving registered service(s)	701A	701A
ACTV O3C2	701A	701A
ACTV OAA C1 only	701C	701C
ACTV OAA receiving registered service and ACTV OA3E	701A	701A
ACTV OAA receiving registered service and ACTV OAA C1	701A	701A
ACTV OA3E receiving at least one service that requires client specific reporting only	701A	701A
ACTV OA3EG and OA3ES	701A	701A
ACTV LSP, if case managed	701B	701B
ACTV LSP, not case managed	Follow OAA criteria	Follow OAA criteria

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Section II. Intake and Screening

INTAKE AND SCREENING:

The following information addresses the ADRC and provider agency responsibilities as they pertain to the intake and screening process.

A. Entrance to Community Care Service System:

Individuals seeking services may enter the community care service system by direct contact with an ADRC or an access point. An access point is a service provider or other entity that performs one or more ADRC functions under an agreement with the ADRC. If the access point has a direct monetary funding agreement, the ADRC must have a process for monitoring and sanctioning the access point in accordance with Section 58B-1.005, F. A. C., including routine observation.

Access points may not perform any ADRC service functions for SMMC LTC applicants.

B. Intake Process:

- 1. Process Commencement:** The intake process begins when an individual seeks assistance by contacting the Elder Helpline or other access point.
- 2. Necessary Information:** Essential information about the nature of the person's physical, mental and functional abilities, concerns, limitations or problems, as well as general background information, is obtained during the intake process to assist in screening for eligibility and appropriate program and service referrals.

C. The Screening Form (701S):

- 1. DOEA Form 701S:** The Screening Form is used to collect common information about individuals applying for programs and services funded by the Department of Elder Affairs (DOEA) as well as SMMC LTC services. This form is administered over the telephone for the initial screening of applicants for long-term care programs. The form is used to re-screen individuals who are on a waiting list and not yet active in any program, or to rescreen individuals who are active in a DOEA-funded program and on the SMMC LTC waiting list.

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- a. It is also used to prioritize persons so that those in greatest need and with the least assistance available will receive services first. If the applicant cannot be served, he/she may be placed on the Assessed Priority Consumer List (APCL).
 - b. Attempts to contact the individual with the goal to complete a 701S are made within three business days after receipt of a client referral. If the screening cannot be performed at the time of contact, appointments must be scheduled as promptly as possible, but not later than 14 business days from the initial contact. Extenuating circumstances must be documented in ReferNET. Documentation in ReferNET must also include the date of the referral, date(s) that attempt(s) to contact were made, date(s) of successful contact(s), and the date the 701S is completed, if applicable.
2. **Staff Completing the DOEA FORM 701S:** Staff completing the 701S screenings must complete the DOEA web-based training and receive a certificate of completion before being eligible to conduct a screening using the 701S. To receive a certificate of completion, a score of 90 percent or above on the multiple-choice test is required.

Additionally, the ADRC must have policies and procedures that document quality assurance activities to include use of the Assessment Instructions (DOEA 701D), direct observation, coaching, and training of screening staff to ensure the accuracy and quality of the screenings being conducted. This includes the accuracy of the 701S data entry into CIRTS.
3. **Procedure for Completing the DOEA Form 701S:** The procedure for completing the Screening Form is described in the Assessment Instructions (DOEA 701D).

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D. APCL Maintenance and Prioritizing Enrollment of New Consumers

- 1. Assessed Priority Consumer List (APCL)**
 - a.** APCL is maintained in the CIRTSS when SMMC LTC services or services funded by Department are not available.
 - b.** Potential consumers or referring parties **must** be:
 - i. Informed about SMMC LTC, the eligibility process, and the waitlist, including the individual's potential for Medicaid eligibility, if the individual appears to be eligible;
 - ii. Provided suggestions regarding additional sources of assistance, including PACE, other Medicaid programs, Older Americans Act services, General Revenue programs, Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), and private pay options; and
 - iii. Provided ADRC contact information and encouragement to call for a significant change rescreening if the individual's situation changes.
 - iv. If there is a significant change in a consumer's condition between annual comprehensive assessments, then the purpose of the assessment will indicate changes in one or more of the following client conditions: Health, Living Situation, Caregiver, Environment, or Income. The new assessment will reflect a priority score and rank on the APCL.
 - c.** Screening of potential consumers must be performed by trained and certified staff.
 - d.** Information for consumers waiting for SMMC LTC or DOEA-funded services is entered in the CIRTSS enrollment screen with the program status of APCL.
 - e.** The priority score and rank are automatically generated in CIRTSS.
 - f.** Only one APCL is maintained for SMMC LTC and/or each DOEA-funded program in each Planning and Service Area.

Chapter 2, Intake, Screening, Prioritization, Assessment, and Case Management

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- iv. Individuals with the highest priority score starting with individuals with a rank of 5.
- d. CCE: Active clients identified through the assessment as potentially Medicaid eligible are required to be screened for Medicaid services by the ADRC.
- e. Regarding consumers who were screened using Form 701S, are released from the APCL and assessed using 701B:
 - i. ADI, CCE, and HCE applicants may continue with program enrollment regardless of the 701B priority score or rank.
 - ii. SMMC LTC potential clients are placed on APPL status in accordance with the Statewide Medicaid Managed Care Long-Term Care Program Enrollment Management System (EMS) procedures.
- f. SMMC LTC: Refer to the SMMC LTC Enrollment Management System for monthly release procedures and impact on 5, 6, 7 and 8 rank.
- g. Approval to begin the eligibility process for SMMC LTC is authorized by the Department's notification of an EMS release to the ADRCs.
- h. Once the client becomes active in SMMC LTC, CCE services may continue for 30 days after the client's SMMC LTC start date. The CCE ACTIVE span must be closed in CIRTSS once the 30 days have elapsed.

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Section III: Case Management Requirement

Purpose and Goals of Case Management:

Case management is a required service for clients with an active enrollment in the Alzheimer's Disease Initiative (ADI), Community Care for the Elderly (CCE), and Home Care for the Elderly (HCE) state funded programs.

Case management is not a required service for clients with an active enrollment in Older Americans Act or Local Services Programs. If case management is provided under OAA Title IIIB for clients enrolled to receive OAA registered services or LSP, then all case management requirements apply.

The purpose of case management is to coordinate the delivery of community care services in accordance with the following principles:

- A. Gatekeeper:** The case manager is the community care service system "gatekeeper" with the knowledge and responsibility to link clients' needs to the most beneficial and least restrictive array of community services and resources.
- B. Client Centered:** Case management is client centered. Case managers shall make every effort to link clients with appropriate formal and informal support, regardless of the agency or organization offering the services and advocate on the client's behalf to help the client to receive the assistance needed.
- C. Limiting Services:** Case managers should not limit services only to those services offered by their agency.
- D. Coordination:** Case managers should ensure full coordination of services provided by various agencies and individuals and pay attention to the scheduling of services in the home of the client.
- E. Linking Services:** Case management is the link between social services programs, home and community-based service providers and health care delivery systems, such as physicians, hospitals, health maintenance organizations (HMOs) and nursing homes.
- F. Informal Support Systems:** Case management provides the contact through which the family, caregivers, neighborhood help organizations and volunteer services assist the client. The case manager is a developer of informal support systems, one of the most necessary and productive components of long-term care. Case managers should actively pursue informal resource development.

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- G. Assistance to Families:** Case managers assist clients' families as well as clients. Allowing for legally competent clients to choose who participates in decisions about their care, case managers will encourage families to be involved and link them with respite care resources as needed.

- H. Family Training:** Case managers should encourage family members to receive training in caregiving methods.

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Goals of Case Management

The goals of case management are the following:

- A. Self-Sufficiency:** To coordinate services that assist clients in becoming more independent, remaining in the least restrictive environment, and attaining or maintaining the highest level of physical, mental and psychosocial well-being.
- B. Quality Assurance:** To ensure effective and efficient client care through the following activities by:
 - 1. Initiating or terminating services;
 - 2. Increasing or decreasing services;
 - 3. Assessing client needs in a comprehensive manner;
 - 4. Determining client satisfaction with services;
 - 5. Planning and arranging for appropriate services (duration, scope, frequency) provided to clients within a reasonable time and that produce effective results;
 - 6. Coordinating services through community care service systems and eliminating unnecessary overlap of services, as possible; and
 - 7. Documenting gaps between services that are needed and those presently being received for planning and budgeting purposes.
- C. Continuum of Care:** To provide access to holistic care, ranging from services in the home to institutional care.

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Role of the Case Manager

Role of the Case Manager

Basic Functions and Responsibilities: Functions and responsibilities of the case manager include the following:

- A. Investigating Community Resources:** The case manager is responsible for knowledge about all formal and informal community resources to coordinate client services.
- B. Receiving and Documenting Referrals:** The case manager is assigned referrals for case management services.
 - 1. Receiving:** The case manager shall complete an initial comprehensive assessment using the 701B.
 - 2. Documenting:** The 701B is entered in CIRTS and any handwritten notes on the paper assessment form must be entered in the appropriate CIRTS field, and a priority score and rank are generated. Referrals to other agencies shall be documented.
- C. Networking with other Agencies:** The case management agency shall develop a network with other agencies to assist clients in obtaining needed services.
 - 1. Networking:** This network will provide valuable information, save valuable time coordinating client services and prevent service duplication.
 - 2. Referring:** The case manager is responsible for making referrals when appropriate. This may include such agencies or offices as Department of Children and Families (Food Stamps), Social Security Administration or Veterans Administration.
- D. Completing the Client Assessment:** The case manager shall act as an assessor and complete the Comprehensive Assessment (DOEA 701B). The assessment will determine the client's level of functioning, existing resources, and gaps in service provision (see Assessment Instructions 701D for details).
- E. Developing a Care Plan:** If the client is determined eligible for services after the comprehensive assessment is completed, a care plan and confidential file must be developed for each client. The case manager shall use the uniform care plan (DOEA 203A and additional pages DOEA 203B) to develop with the client, caregiver and/or designee, ways to address service needs.

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- F. Arranging Needed Services:** The case manager shall complete the care plan within two weeks after completion of the client assessment. The case manager must arrange needed services offered by agencies in the community care service system and organize informal sources.
- G. Referring to Other Sources:** Services not arranged through agency contracts should be obtained through referrals to other community resources. Referrals may be made to volunteer agencies, informal networks and proprietary agencies that charge fees.
- H. Providing Follow-up:** The case manager or case aide must conduct a follow-up contact on service arrangements and referrals within two weeks following such arrangements to ensure that services have begun.
- I. Communicating with Other Agencies:**
- 1. Agency Involvement:** It is very important for all agencies involved to know when a client's needs change or when an agency, for whatever reason, modifies its services.
 - 2. Assistance:** Some agencies may be able to assist or know of other resources to help the client.
 - 3. Staffing:** One way to ensure communication and coordination of services is to meet on a regular basis with other agencies for case staffing.
- J. Documenting Case Activities:** A good case record serves as an invaluable aid in rendering services to the client and documenting the outcomes. The record serves as the tool for relevant information regarding the client's progress. The case manager has the responsibility for the following:
- 1.** Initiating and maintaining the case record;
 - 2.** Documenting pertinent information in the case record and updating the record when conditions change or following periodic contacts with the client; and

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3. Writing in a fashion to enable an independent reviewer to fully understand the client's status and services and obtain a good overview of case management. Legibility of handwriting or use of word processing, along with a legend of abbreviations used, is vital to a good case record. (See the Case Record Section of this chapter for required documentation.)

K. Contacting the Client to Review and Monitor the Care Plan: The case manager must make a home visit to review the care plan at least every six months, or more frequently, based upon the individual client's needs and program requirements.

1. **Continuity of Care:** The case manager will oversee the care plan for continuity of services and changes in the client's functioning that warrant increases, decreases, or other changes in the recommended care plan.
2. **Care Plan Review:** The review is not a complete reassessment, but a review of service goals and changes in the client's status that may warrant modification to the care plan. The case manager will discuss any changes in the care plan with the client, caregiver and/or designee for acceptance prior to changes in service provision. The case manager will verify service quality and client satisfaction.

L. Client Reassessment: For case management, as well as planning and coordination purposes, the case manager must perform a face-to-face client reassessment at least once every year.

1. **Reassessment Form:** The case manager shall complete the Comprehensive Assessment (DOEA 701B) in accordance with the instructions in the Client Assessment section of this chapter.
2. **Reassessment Results:** Reassessment results are to be used to evaluate and modify the care plan, if needed.

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- M. Discontinuing or Modifying Services:** The decision to discontinue or modify services shall include the client, family members or caregiver, after a review and update of the client's situation.
- 1. Improvement of Condition:** If the client's health or functional status improves, then the case manager shall modify the care plan, accordingly, accommodating assistance from family members or other community supports. If formal services are no longer needed, the case manager shall terminate services.
 - 2. Deterioration of Condition:** If the client's health deteriorates to the extent that more extensive care is needed, then the case manager shall assist the person in locating the most appropriate, least restrictive and most cost-effective alternate living arrangement.
 - 3. Client Behavior Problems:**
 - a.** The case manager may close the case when the client exhibits either of the following behaviors:
 - i.** Refuses to continue services; or
 - ii.** Is uncontrollable, uncooperative, or combative.
 - b.** The case manager will document in the case narrative circumstances of the situation and the progression of the behavior problems.
 - 4. Documentation:** The case record must reflect adequate documentation for service modification or termination. The client must be notified in writing 10 calendar days in advance of the termination of services, except in the case of death, the client moving out of the service area, the client moving to an assisted living facility or nursing home, or the client requesting the termination.
- N. Referrals to Protective Services (Florida Abuse Hotline):** Agency staff or their subcontractors must report any suspicions of abuse, neglect, or exploitation to the Florida Abuse Hotline.
- 1. Florida Statutes:** The Florida Abuse Hotline was established by Section 827.07, F.S., to record all such incidences.

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2. **Hotline:** On-call coverage for reporting of abuse, neglect or exploitation of disabled or infirmed, aged adults is provided 24 hours a day, seven days a week by the Florida Abuse Hotline staff at a toll-free number: 1-800-96 ABUSE (1-800-962-2873).
3. **Investigation:** Each complaint of alleged abuse, neglect or exploitation accepted by the hotline is phoned to the designated Adult Protective Services investigator in the respective district for contact and action.

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RECOMMENDED STAFFING AND CASELOAD STANDARDS:

Listed below are recommended staffing, caseload and case manager supervision standards:

- A. Caseload:** A caseload consists of those clients determined eligible and receiving case management services.
 - 1. Average Caseload:** DOEA suggests maintaining a caseload of 60-70 clients per case manager full time equivalent (FTE).
 - 2. Over Average Caseloads:** Caseloads exceeding 100 clients per case manager require a waiver from the Area Agency on Aging (AAA).
- B. Case Manager Supervisor:** Case manager supervisors may be established in larger agencies employing five or more case managers.
 - 1. Supervisor's Caseload:** The case manager supervisor may handle a small number of cases, not to exceed half of the size of a case manager's caseload (30-35 clients).
 - 2. Alternate Supervision:** In smaller projects, supervision may be provided by the project director or other project staff with direct service experience.

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JOB DESCRIPTION INCLUSION REQUIREMENTS:

B. Case Manager:

- 1. Major Functions:** Major functions of the case manager's job description are:
 - a. Referral and Assessment:** Receives referrals and completes initial assessments and annual reassessments.
 - b. Information:** Provides information as needed to involve the client, caregiver and/or designee in the care plan.
 - c. Care Plan:**
 - i.** Develops care plans, arranges for and follows-up on services provided; and
 - ii.** Reviews care plans with other professionals involved with service provision.
 - d. Follow-up:** Provides follow-up as needed.
 - e. Home Visits:** Makes home visits.
 - f. Case Records:** Maintains individual case records.
 - g. Informal Support Network:** Develops informal support network (relatives, volunteers, friends, etc.) when there is no caregiver or when additional help is needed.
 - h. Expanded Support Network:** Builds an expanded support network with members of the clients immediate community.

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2. Major Duties: Case managers' major duties are as follows:

Client Assessment: After the new client is released and it is determined that funding is available to provide services, the case manager will schedule a face-to-face visit with the client to complete the Comprehensive Assessment (DOEA 701B). The form will generate a priority score and rank to prioritize the client in comparison with all other clients waiting for services. If the applicant can be served, the Comprehensive Assessment will be completed within 14 business days after receiving the referral. In all cases, the Comprehensive Assessment (701B) will be completed face-to-face with the client before services are begun.

- a. Care Plan Development:** Develops care plan in conjunction with the client, caregiver and/or designee, obtaining the client's concurrence and signature or that of the client's representative, if the client is unable to sign the care plan. If the client is legally incompetent, his/her guardian must sign the care plan.

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- b. Care Plan Review:** Reviews care plan with supervisor at initial development. This may be a team activity for subsequent reviews.
- c. Services:** Arranges for services and coordinates service delivery.
- d. Respite Care:** Arranges respite care for caregivers as needed. Refers caregivers to, or arranges for, counseling/support groups to relieve the stresses of the caregiver role.
- e. Training:** Encourages and may arrange for caregivers, family members or friends to attend training where possible.
- f. Client Reassessment:** Completes written client reassessment at least annually and more frequently if conditions warrant.
- g. Client Record:** Completes and maintains a client record with progress reports and forms related to service provision and ongoing documentation.
- h. Supervisory Role:** May supervise other personnel.
- i. Other Duties:** Performs other duties as necessary.

3. Minimum Qualifications: A case manager must meet one of the following qualifications:

- a.** A bachelor's degree in social work, sociology, psychology, nursing, gerontology or a related social services field; or
- b.** Year for year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA.

C. Case Aide:

1. Major Functions:

- a.** Case aides are para-professionals who complement or supplement the work of case managers. The case aide service is not a stand- alone service and is only provided in conjunction with the provision of case management.

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- b.** Case aide activities are billed as case aide services and not case management services.

2. Major Duties:

- a.** Assist with the implementation of care plans;
- b.** Assist with accessing medical and other appointments;
- c.** Perform follow-up contacts. This may include the monthly contact with the HCE caregiver;
- d.** Oversee quality of provider services;
- e.** Deliver supplies and equipment;
- f.** Assist with paying bills;
- g.** Assist the client or caregiver in compiling information and completing applications for other services and public assistance;
- h.** Facilitate linkages of providers with recipients via telephone contacts and visits;
- i.** Determine client satisfaction with services provided;
- j.** Arrange, schedule and maintain scheduled services;
- k.** Document activities in the case record;
- l.** Reconcile and voucher activities;
- m.** Assist with HCE monthly contact to confirm caregiver eligibility; and
- n.** Record telephone and travel time associated with billable case aide activities.

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3. Provider Qualifications:

- a. Minimum qualifications for case aides include a high school diploma or General Educational Development (GED) diploma.
- b. Job related experience may be substituted for a high school diploma or GED diploma upon approval of the AAA.

D. Case Manager Supervisor:

1. Major Duties::

- a. **Supervision:** Supervises case managers and case aides.
- b. **Care Plans:** Reviews care plans at initial development, and as necessary, ensures follow-up on all care plans.
- c. **Reviews, Reassessments, Case Records:** Ensures completion of semiannual reviews and annual reassessments for clients and that appropriate case records are maintained.
- d. **Service Delivery:** Ensures that providers deliver services as scheduled, within specified time frames and without negative incident.
- e. **Coordination:** Resolves service delivery problems and ensures coordination among community care providers.
- f. **Problem Resolution:** Resolves problems between the case manager and client or caregivers.
- g. **Quality Assurance:** Reviews service provision to ensure effective and efficient client care.
- h. **Home Visits:** Makes random client home visits for the following objectives:
 - i. To ensure that service plans are followed;
 - ii. To become familiar with the client's environment; and
 - iii. To ensure accuracy of case recordings.

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- i. **Respite Care:** Ensures that respite care is arranged for caregivers as needed.
- j. **In-Service Training:** Arranges for in-service case manager training.
- k. **Informal Support Systems:** Ensures that case managers are actively developing informal support systems among clients' neighbors and community volunteers.
- l. **Caregiver Training:** Ensures that caregivers, family members or friends receive training where possible.

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IN-SERVICE TRAINING PROGRAM:

- A. Program Development:** Each provider agency shall develop an in-service training program for case management staff.
- B. Minimum Standards:** Each provider agency shall conduct at a minimum an annual in-service training of six hours and will document the duration and content in case management staff records.
- C. Description and Allocation of Funds:** Each provider agency shall describe and allocate budget funds for training in the provider application.
- D. Minimum Standards:** Training will include, at a minimum, the following topics:
 - 1. Overview:** Overview of community care services;
 - 2. Relationship:** Relationship of case management to the community care services system;
 - 3. Completion of Forms:** Use and completion of assessment instruments and care plans;
 - 4. Interviewing:** Interviewing skills and techniques;
 - 5. Record Keeping:** Record-keeping procedures;
 - 6. CIRTS:** Client Information and Registration Tracking System (CIRTS) procedures;
 - 7. Aging Network Overview:** Overview of the aging network (AAA, DCF, AHCA, DOEA and other agencies) and the agency's relationship to the community care service system;
 - 8. Caregiver Training:** Caregiver training regarding responsibilities and resource development techniques;
 - 9. Coordination Training:** Interagency coordination and informal network development training; and
 - 10. Adult Protective Services (APS) Training:** Training on the Abuse Registry Tracking Tool (ARTT) and the APS Referrals Operations Manual.

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Client Assessment

PURPOSE:

A. Client Assessment Purpose:

1. **Areas of Need:** A comprehensive assessment of the client's condition and changes in that condition revealed during assessment and/or reassessment shall identify areas of need where services and/or informal networks should be developed;
2. **Planning and Budgeting:** Assessment information evolves into the development of profiles on client impairments and service needs, which are useful in planning and budgeting for those needs.

B. Assessment Forms:

1. Assessment forms are used to conduct client assessments for all DOEA programs. The assessment forms are listed below:
 - a. Screening Form (DOEA Form 701S)
 - b. Condensed Assessment (DOEA 701A)
 - c. Comprehensive Assessment (DOEA 701B)
 - d. Congregate Meals Assessment (DOEA 701C))
2. **Assessment Instructions (DOEA 701D)** Specific and detailed guidance for completing the assessment forms are included in the Assessment Instructions (DOEA 701D).
3. **Development of Care Plan:** The case manager utilizes the information gathered through the assessment in the development of a client-centered care plan. The final notes and summary section of the Comprehensive Assessment (DOEA 701B) is a summary of all assessment information and will assist the case manager in developing the client's care plan.

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- C. Reassessments:** After the initial assessment, annual assessments are referred to as reassessments.
- 1. Definition of Annual:** 365 days after the prior assessment through the end of the month. Reassessments may be completed up to 30 days prior to clients' annual reassessment due date
 - 2. Example:** If the prior assessment is July 14, 2016, then the annual reassessment must be completed between the dates of June 14, 2017, and July 31, 2017.
- D. Client Not Capable of Providing Information:** If a client is unable to provide information for the assessment due to illness or impairment, the case manager must attempt to obtain the information from the caregiver and/or designee.
- E. Assessment Face-to-Face Requirement:** Initial assessments and reassessments must be administered face-to-face with the client using a **new** Comprehensive Assessment (DOEA 701B).
- F. Sharing of Completed Assessments:** All DOEA-funded program agencies shall utilize assessments completed by other agency staff that have been trained and certified to complete the assessment forms.
- G. Changes in Client Condition:** If the client's condition changes during the year and significantly affects the client's functional status, then the case manager shall review the impact of this change and complete a new face- to-face comprehensive assessment.
- 1.** The case manager shall make appropriate notations in the case record and revise the care plan accordingly.
 - 2. Examples of Significant Changes:**
 - a.** Changes in health status such as an accident or illness;
 - b.** Change in living situation;
 - c.** Changes in the caregiver relationship;
 - d.** Loss, damage or deterioration of the home living environment;

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- e. Loss of spouse, family member or close friend; or
 - f. Loss in income.
- 3. **Face-to-Face Requirement:** The case manager will conduct a face-to-face interview with the client and complete a new assessment to document the significant changes in the client's condition(s).
- 4. **Assessment Training and Certification:** Staff must have received training and certification on completing the assessment forms prior to conducting client assessments.

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Client Assessment

CONDUCTING THE INTERVIEW

INTERVIEWING TECHNIQUES:

A. Establishing Rapport:

1. **Interview Relationship:** The assessor must make every effort to establish a good interviewing relationship and environment by providing warmth, genuineness and empathy.
2. **Respect and Dignity:** The assessor must treat the applicant/client with dignity and respect.
3. **Hints:** The assessor should refer to “Assessor/Case Manager Skills” in the Assessment Instructions (DOEA 701D) for hints in establishing rapport.

B. Applicant/Client Involvement:

1. **Privacy:** In most cases the applicant should be interviewed alone.
2. **Involvement of Others:** A caregiver and/or designee may need to be present to provide the assessment information if the applicant/client is confused, very ill or otherwise unable to provide the necessary information. However, the assessor must try to involve the client as much as possible in the interview.

C. Statement of Interview Intent: The assessor will state that the intent of the interview is to obtain specific information to:

1. Determine what type of assistance the person may need; and
2. Ensure that all eligibility criteria are met.

D. Confidentiality: The assessor will inform the client that the data collected will be kept confidential; however, with his/her written consent, there may be situations when information will need to be shared with another agency to obtain services that will be of assistance. It should be understood by clients that failure to provide informed consent may preclude referral to another service agency. However, the client’s refusal to consent to sharing his/her information with another agency does not prohibit the client’s receipt of services from the interviewing agency. All HIPAA regulations (the federal Health Insurance Portability and Accountability Act of 1996) will be followed always. (Refer to Section III, Case Management Requirements ter—Case Record for more information on confidentiality).

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ASSESSMENT SCORES:

Two scores are produced when the completed DOEA 701B is entered in CIRTS.

- A. Risk Score:** This score indicates the likelihood that the individual will go into a nursing home.
1. There are questions within the Assessment Instrument, which add value to the risk score, measuring the client's frailty.
 2. The risk score can change after the client begins to receive services due to changes in the client's medical and physiological condition. Nevertheless, as frailty normally increases with age, the risk score tends to increase over time.
 3. This score has values that range from 0-100.
- B. Priority Score:** This score indicates the client's need for services.
1. Both the client's frailty and the resources available to meet his/her needs are calculated.
 2. Greater frailty adds to the score, while the available resources subtract from the score.
 3. The priority score tends to decrease as the client receives services.
 4. This priority score is indicated as part of a range of -1-5, with the lowest value being Rank 1.

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Client Assessment

ASSESSMENT INSTRUCTIONS - DOEA 701D (Instructions for 701A, 701B, 701S, 701C):

Instructions for completion of the DOEA forms 701A, 701B, 701S and 701C assessment instruments are included in DOEA Form 701D. These 701A, 701B, 701S, and 701C forms are incorporated by reference in Rule Chapter 58A-1, Administration of Federal Aging Programs.

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CARE PLANNING AND SERVICE ARRANGEMENT

- A. Case Manager:** The case manager uses the care plan for the following tasks:
- 1. Information Organization:** To organize service information related to client problems/gaps; and
 - 2. Documentation:** To document the plan of action to address client problems and needs through the development of service solutions that meet the client's needs.
- B. Care Plan Inclusions:** The care plan should prescribe the following services:
- 1. DOEA Funded:** Services provided through DOEA funded programs; and
 - 2. Non-DOEA Funded:** Services funded outside of DOEA or informal services provided by the caregiver and/or designee.

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DEVELOPMENT OF THE CARE PLAN:

- A. General:** The care plan development is:
- 1. Mutual Endeavor:** A mutual endeavor between the case manager, the client, caregiver and/or designee, and the caregiver and other family members; and
 - 2. Roles:** Recognition of the roles and contributions of family members.
- B. Client or Caregiver/Case Manager Expectations:** The following applies to the client, caregiver and/or designee and case manager:
- 1. Written Consent:** The client, caregiver and/or designee, if the client is unable, must be involved in the care plan development and must provide written consent to the plan.
 - 2. Expectations:** To avoid possible false expectations on the part of the client, caregiver and/or designee, the case manager shall explain, during the initial interview, that services will be planned, and provided as feasible, in keeping with the care plan goals.
- C. Time Frame:** The case manager must complete the care plan within 14 business days after completion of the client assessment. The client shall receive a copy of the care plan.
- D. Care Plan Consultation:** The case manager may consult with individuals, such as the client's physician, nurse, hospital discharge planner or other specialized medical staff, as possible, to ensure appropriate care planning.
- E. Client-Centered Care Planning:** Case managers shall perform the following client-centered tasks regarding care planning:

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1. **Case Manager Task:** Case managers shall concentrate on assisting clients to identify:
 - a. What the client identifies as problems;
 - b. What solutions are available to alleviate the problems; and
 - c. Whether the solutions are possible or feasible.
 2. **Commitment:** The client's commitment to the plan is crucial as well as the commitment of the caregiver and/or designee.
 3. **Case Manager Role:** The case manager should use communication skills to enable the client to perform the following care planning tasks (or the caregiver and/or designee in the absence of client capability):
 - a. Understand goals;
 - b. Appraise resources; and
 - c. Decide on a course of action.
 4. **Case Manager Identification of Goals:** In some instances, case managers may identify additional goals that they should discuss with the client and, if agreeable, add to the care plan.
- F. Consideration of Most Appropriate Resources:** In completing the care plan, the case manager shall consider the most appropriate resources to provide the services outlined in the care plan. The client must be given the opportunity to participate in the selection of service providers.
1. **Non-DOEA Services:** Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/employee assistance programs, private insurance, association, religious/other and local government.
 - a. **Service Development:** These services can and should be developed to effectively address client needs as an alternative to purchased services from providers of DOEA funded services.

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- b. **Preservation of Funds:** Case managers shall emphasize using informal resources, whenever possible, to preserve program funds for clients with the most critical needs.
 - c. **Other Resources:** The case manager and client shall consider informal resources, such as faith-based organizations and civic groups, in the development of the care plan.
 - d. **Examples:**
 - i. A concerned friend or family member can sometimes arrange to provide homemaker or personal care assistance.
 - ii. A faith-based organization can sometimes provide meals or transportation services.
- DOEA Funded Services:** Other services come from the service providers in the local community care service system, which are funded through the Department.
- Resource Directory:** The case manager should have access to a local community care service system directory, and the statewide aging resource center database to assist individuals in selecting and arranging for services.
- Client Refusal:** If a client refuses a service(s) recommended by the case manager, the case manager shall document the refusal in the case narrative notes in the client's case file. The case manager may periodically suggest adding the needed service.

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REVIEW AND EVALUATION OF SERVICES:

- A. 14-Day Follow-Up Contact:** The case manager or case aide must telephone or visit the client within 14 business days following the ordering of services to determine the following:
- 1. Service Satisfaction:** Is the client satisfied with the services? If not, why?
 - 2. Quality of Service:** Is the client satisfied with the quality of the services performed? If not, why?
 - 3. Interviewer:** The individual conducting the interview is:
 - a.** Not required to observe the service being performed; but is
 - b.** Encouraged to observe services being performed and conduct discussions with the service worker, if there is any indication that this action would be beneficial in determining the quality of services (e.g., the client expresses dissatisfaction with the way the service is performed).
- B. Quality Assurance (QA) Interviews:** Quality assurance interviews should rate the following subject areas at a minimum:
- 1. Rapport:** Service worker's rapport with the client. Does the service worker communicate effectively with the client (no language barriers)?
 - 2. Service Worker Attitude:** Service worker's attitude towards job performance. How does the service worker approach the job? Is he/she positive, negative, enthusiastic? Other observations.
 - 3. Service Worker Compliance:** Service worker's compliance with assigned duties. Are all services being completed as assigned?
 - 4. Service Worker Dependability:** Service worker's dependability regarding the work schedule. Does the service worker arrive timely; arrive when expected by the client; stay as planned in the care plan?
 - 5. Client Evaluation:** Client's evaluation and assessment of the service provided. Is the client satisfied with the services received?
 - 6. QA Interview Format:** Agencies may devise their own formats for the quality assurance interview.

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REVIEW AND UPDATE OF THE CARE PLAN:

A. Care Plan Review: Case manager responsibilities are as follows:

- 1. Semiannual Review:** The case manager shall conduct a care plan review and home visit at least semiannually and more frequently, if necessary, depending upon the changes in the client's condition.
 - a. Definition of Semiannual:** 180 days after the initial service delivery through the end of the month.
 - b. Example:** If the initial service date is July 23, 2014, then the case manager must complete the semiannual review by January 31, 2015.
 - c. Sample Review:** The case manager shall review a sample of service delivery logs during the semi-annual review to ensure services were delivered per the care plan, and that the service delivery logs indicate all tasks performed during the service period.
- 2. Review Schedule:** The case manager shall establish a care plan review schedule for home visits and face-to-face contact with each client based on this standard.
- 3. Continuity of Services/Changes in Client Status:** The case manager will monitor for continuity of services and changes in the client's functional status, which warrant the following changes in the recommended care plan:
 - a. Additional services;**
 - b. Reduction in services; and**
 - c. Any other changes.**
- 4. Review Parameters:** The review is not a complete reassessment but a review of problems/gaps and changes in the client's functional status that warrant modification of the care plan.
- 5. Review Date:** The review date will be posted on the care plan form along with the case manager's initials.

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- B. Care Plan Update to Case Narrative:** The case manager's responsibilities for case narrative are as follows:
- 1. Address Goals:** Address each service need listed on the care plan in the case narrative after the semiannual visit.
 - 2. Progress/Barriers:** The case narrative shall describe progress or barriers encountered.
- C. Review Outline:** The care plan review will comply with the following guidelines:
- 1. Review Date:** The case manager shall visit the client at least semiannually and review the care plan.
 - 2. Service Needs:** The case manager and client will discuss the following:
 - a.** Continuation of current services in relation to the client's identified needs; and/or
 - b.** Need for additional services due to changes in condition; and/or
 - c.** Acknowledgement of improvements and the corresponding changes in or termination of specific services.
 - 3. Plan for Services:** The case manager will perform the following tasks regarding client services:
 - a.** Review services provided;
 - b.** Discuss any changes that need to be made with the client, caregiver and/or designee; and
 - c.** Revise the care plan, as needed.

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CASE CLOSURE/SERVICE TERMINATION:

- A. Procedures:** Procedures shall be developed to discontinue services to clients when their condition has either improved or declined sufficiently that services are no longer effective or appropriate.
- B. Case Closure:** An individual's case may be closed for services for any of the following reasons:
- 1. Change in Condition:** The client's condition has declined to the extent that he/she can no longer be safely maintained in the home.
 - a. Hospitalization:** In the case of hospitalization, the case manager shall maintain contact with the client and hospital social services worker to assist in planning for the client's discharge.
 - b. Other Placements:** If the client is discharged to a location other than home (i.e. nursing home, assisted living facility, adult family care home or other placement), the case manager shall maintain contact with the client for a three-month period or until such time it is evident that return to the home is no longer possible. Follow-up with the placement facility staff may be completed by correspondence or telephone.
 - 2. Move Out of County/Service Area:** The case manager shall arrange to transfer client records upon request and communicate with service providers in the client's new area.
 - 3. Client Death:** The case manager shall close a case upon the death of a client.
 - 4. Client Ineligibility:** The case manager shall close cases when clients become technically or financially ineligible for services.
 - 5. Services No Longer Needed:** The case manager shall close cases when services are no longer needed such as the following:
 - a. Improved Condition:** The client's functional status has improved so that services are no longer required.
 - b. Other Sources Available:** The client's family or other persons are available to assist the client.

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- c. **Transfer to Another Program:** The client is transferred to another program.
- d. **Client Request:** The client requests that services be terminated.

C. Responsibilities in Case Closures:

- 1. **Case Manager:** The case manager shall record a brief explanation of the termination reason and the effective date in the case record.
- 2. **Case Management Agency:** The case management agency shall develop and implement the following:
 - a. **Written Notification:** To provide advance written notification to clients when terminating services; and
 - b. **Grievance Rights:** To provide information to clients regarding their right to appeal the decision except in the following situations:
 - i. The client has moved out of the service area;
 - ii. The client requested termination;
 - iii. The client has been placed in an assisted living facility or nursing home; or
 - iv. The client has died.
 - c. **Notification Timeframe:** The timeframe for notification shall be established in conjunction with the case management agency's grievance procedures.

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PURPOSE OF CASE RECORD:

A. The purpose of the case record is two-fold:

1. **Single Location:** To keep information about the client in a single location; and
2. **Client Information Retrieval:** To keep the information filed in an orderly fashion for retrieving all pertinent information on a client.

B. **Case Record Information:**

The case record contains current client information. This information is the basis for continuing or adjusting the client's care plan and the basis for review. The case record contains the following:

1. **Prioritization Screening (DOEA Screening Form 701S):** A completed prioritization form for clients released from an assessed priority consumer list prior to receiving services in a case managed program.
2. **Comprehensive Assessment (DOEA 701B):** A completed 701B, as well as at least one prior year assessment.
3. **Care Plan Form:** Current and accurate care plan form(s), covering at least the past two years. The form(s) should be signed and dated annually and should reflect the initials and dates of semiannual or more frequent care plan reviews.
5. **Grievance Procedures:** A current notice of grievance procedures signed and dated by the client, applicable to terminations, suspensions, or reductions in service.
6. **Case Narrative:** A current and accurate case narrative. A current detailed case narrative showing all contacts with the client, and the caregiver, and notes regarding the client's progress toward achieving care plan outcomes.
7. **HCE Financial Worksheet:** A financial worksheet for HCE clients. A current and correct form should be included.
8. **Co-pay Assessment Form:** A co-pay assessment form for CCE and ADI clients. A current and correct form should be included.
9. **Specific Forms:** Program specific forms for CCE, ADI, HCE or OAA. Forms for individual programs should be included.

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10. **Other Information:** Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.
 11. **Choice & Options:** Documentation of the choices and options given to the client.
- C. Case Record Information:** When clients request service from an agency, they give the agency the right to receive information about their condition. This information enables the case manager to perform the following tasks:
1. **Service Planning/Provision:** Plan for and provide appropriate and timely services; and
 2. **Update Client Information:** Update information for current and future delivery of services.
- D. Retention of Case Record:** Client case records shall be retained for a period of six (6) years after case closure or longer, if required by federal regulations.
- E. Care Plan:** *The case record is the basis for the following regarding care plans:*
1. Continuance/Adjustment: **Continuance or adjustment of the client's care plan; and**
 2. **Quality Assurance:** The basis for reviewing the client's situation.

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CONTENT OF THE CASE RECORD:

The case record shall contain the following items:

- A. Assessment:** Completed client assessment form(s):
 - 1. A completed prioritization form for clients released from an assessed priority consumer list prior to receiving services in a case managed program (**DOEA 701S, 701A, 701B and/or 701C**, as appropriate);
 - 2. Any assessments completed to document a significant change in the client's condition; and
 - 3. Annual Reassessments.
- B. Care Plan:** Completed care plan - DOEA Forms 203A and 203B - with updates and review dates indicated.
- C. Case Narrative:**
 - 1. **All Case Narratives:** Each narrative entry shall be signed and dated by the case manager who performed the activity. Case narrative entries made by a case aide shall be signed and dated by the aide.
 - a. Case management or case aide services are documented with the actual units of services provided, as well as the time spent on the activity. For billing of case management or case aide services, the time spent in direct service with or on behalf of a client is accumulated daily. The cumulative amount of time per service is totaled for the day and minutes are rounded up to the nearest quarter of a unit.
 - b. Service logs documenting the delivery of other services provided may be kept in the client file or may be kept in separate files.
 - 2. The case narratives for **Adult Protective Services High-Risk Referrals** require the following additional documentation:
 - a. The specific services authorized and the specific service dates for services provided during the 72 hours following the referral must be recorded. This includes non-DOEA services. If services were delayed or not provided, the reason why must be stated, and all actions taken to provide service must be recorded.

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- D. Co-pay Assessment Form:** Copy of the co-pay form for CCE and ADI clients.
- E. Home Care for the Elderly (HCE) Financial Worksheet:** Copy of the HCE financial worksheet shall be included for HCE clients.
- F. Physician's Assessment/Order:** Copies of the physician's assessment and order if the following services are provided:
 - 1. Home Health Aide;
 - 2. Skilled Nursing;
 - 3. Occupational Therapy;
 - 4. Physical Therapy; and
 - 5. Speech Therapy.

The original physician's order shall be filed at the provider location with a notation of the physician's order in the case narrative.

- G. Specific Forms:** Program specific forms for CCE, ADI, HCE or OAA. Forms for individual programs should be included.
- H. Grievance Procedures:** If necessary, a current notice of grievance procedures signed and dated by the client, applicable to terminations, suspensions, or reductions in service.
- I. Other Information:** Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.
- J. Choice and Options:** Documentation of the choices and options given to the client.

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STANDARDS FOR SECURITY AND PRIVACY OF CASE RECORDS:

- A. Locked Files:** Client records shall be kept in a locked file within the agency.
- B. Client Informed Consent:** The case manager must inform clients of the following:
 - 1. Purpose:** Purpose for which the information is collected; and
 - 2. Manner of Usage:** How it will be utilized, maintained and disseminated.
- C. Information Obtained:** The case manager shall inform applicants/clients that information obtained about them is:
 - 1. Required** to provide services;
 - 2. Confidential** and protected from loss, defacement and unauthorized access, and
 - 3. Available for review** by applicants/clients and/or their representative.
- D. Case Record Review:** The client and representative/guardian have the right to review the client's case record.
 - 1. Case Manager Responsibility:** The case manager shall review and update the case record before releasing it for the client's review.
 - 2. Case Manager Availability:** The case manager shall be available to discuss the contents of the case record with the client, if requested.
 - 3. Method of Case Record Review:** Active case records shall not be mailed to clients. The client may review the record in the case manager's office or, if homebound, request that an authorized staff person bring it to the client's residence for review.
 - 4. Case Record Copy:** The case manager may provide one copy of the case record to the client.

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- E. Electronic Records:** The 21st Century Cures Act, Section 12006 requires an Electronic Visit Verification (EVV) system for Medicaid-funded personal care services.

The EVV system must verify the following:

- Type of service performed,
- Individual receiving service,
- Date of service,
- Location of service delivery,
- Individual providing service, and
- Time the service begins and ends.
- Verification of attendance

The Department authorizes, but does not require, the contractor to create and retain electronic records and to use electronic signatures to conduct transactions necessary to carry out the terms of its agreement. A contractor that creates and retains electronic records and uses electronic signatures to conduct transactions shall comply with the requirements contained in the *Uniform Electronic Transaction Act*, s. 668.50, Fla. Stat.

Vendor systems must be able to provide a verification method that produces an audit trail confirming the client service was performed. For example, an electronic time stamp initiated by the client (i.e., telephonic or via service app) can verify attendance of an individual providing the service in lieu of a "wet" signature.

Electronic records must be fully auditable; are subject to Florida's Public Records Law, Chapter 119, F.S.; must comply with Section 29, Data Integrity and Safeguarding Information; must maintain all confidentiality, as applicable; must be retained and maintained to the same extent as non-electronic records are retained and maintained; and must be provided to clients in non-electronic format, upon request.

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CASE NARRATIVE GUIDELINES:

General Guidelines:

- A. Reflection of Activity:** Case narratives are completed to reflect activity that relates either directly or indirectly to the implementation of the care plan.
- B. Framework:** The reviewer should be able to determine the following as it relates to the care plan:
 - 1. Is the care plan valid?
 - 2. Are the services appropriate?
 - 3. Are the services responsive to the client's needs in both duration and intensity?

CASE Narrative:

- A.** Record the status of all active care plan problems in the case narrative after each contact with the client.
 - 1. If no changes are identified, enter a statement covering multiple problems such as, "The client's needs remain the same and all services are continued."
 - 2. Make sure the problem number on the most recent care plan corresponds with the problem number entry which updates the case narrative. There is no need to rewrite the problem statement in the narrative. See the example below:

Problem Statement Entry from Care Plan: Client is unable to get in and out of the bathtub safely

Case Narrative Entry Indicating Status of the Problem:

Through home modification services, Ms. Smith could retrofit her bathroom so that she can safely get in and out of the bathtub. She can take a bath daily and her caregiver helps her to wash her hair and back. The modifications to her bathroom and assistance from her caregiver are appropriate now.

- B.** The case narrative describes the client's progress and challenges or barriers that hinder the desired outcomes in the care plan.

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1. The narrative reflects services consistent with the needs and service gaps identified in the care plan and provide reasons for variances
2. The case narrative entries may reference specific care plan and assessment summary entries.
3. Case narrative entries should document the date of the contact, the type of contact (Office Visit - OV, Telephone Call - TC, Field Visit - FV), and the person making the contact

C. Case Narrative Sections: Case narratives shall consist of the following two sections:

1. **Section 1—Contact Summary:** The following information shall be included in the contact summary:

a. Date of Contact

b. Type of Contact:

<u>Contact:</u>	<u>Abbreviation:</u>

i.. Office Visit	OV
ii. Telephone Call	TC
iii. Field Visit	FV
iv. Home Visit	HV

1. **Staff Name:** Name of staff making the contact and person contacted.

D. Section 2—Narrative: A summary of data shall include the following:

1. **Client's Progress:** The client's progress towards goals.
2. **Care Plan:** Pertinent data related to the care plan and/or the client's overall situation.
3. **Follow-Up Activity:** Documentation of contacts and other action performed for the client. This includes contacts with external entities and persons as well as agency staffing, or other activities performed within the agency that relate directly to the client. Dates of follow-up activity must be documented.

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4. **Service Barriers:** Problems encountered in service delivery.
 5. **Special Circumstances:** Unique circumstances affecting the case.
 6. **Care Plan Semiannual Review Contacts:** Each active problem listed in the care plan addressed for each client semiannual care plan review contact.
 7. **Initial Entries:** Initial entries should reflect the following elements:
 - a. **Available Resources:** Available resources are explored, including involvement of client's family and friends.
 - b. **Client Goals:** Provider is advised of the client's goals (for arranged or referred service only).
 - c. **Consistency:** Service provision is consistent with the care plan.
 - d. **Variances:** Variances from the care plan are addressed including reasons for the change.
 - e. **Other Data:** Any other appropriate data is included.
 8. **Assessment Case Notes:** The following applies to case notes taken during the assessment process:
 - a. **Assessment Notes:** Notes taken on the assessment form at the annual assessment or reassessment shall generally serve as case notes for the assessment visit. Any specific information about the client, his/her needs, surroundings, the assessor's observations of the situation, or other information not captured on the assessment form, should be noted in the narrative for the visit, along with the date and the purpose of the visit.
 - b. **Case Note File Entry:** Notes written about the client's problems and needs on the assessment form do not have to be rewritten in the case narrative.
 9. **Ongoing Narrative:** Ongoing narrative must reflect the following:
 - a. **Appropriateness:** That services as well as the duration and intensity, continue to be appropriate for meeting the client's ongoing needs.

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- b. **Service Consistency:** That services continue to be consistent with the care plan and are delivered in accordance with program policy.
 - c. **Adjustments Needed:** Adjustments to be made to the plan based on new information received.
 - d. **Problem Status:** The status of each active problem listed on the care plan:
 - i. **Care Plan Semiannual Review Standard:** The case manager shall address each problem in case notes at least semiannually following initial client contact.
 - ii. **Tracking:** For tracking ease, the problem number on the most recent care plan shall correspond with the problem number entry that updates the case note.
 - iii. **Progress/Barriers:** Case notes shall describe progress or additional problems encountered in achieving desired outcomes stated on the care plan.
 - e. **Other Data:** Include any other data appropriate to the client's situation.
 - f. **Client's Satisfaction:** Include how satisfied the client or caregiver is with the services being provided.
 - g. **Termination:** Circumstances for termination.

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Section IV: Grievance Proceedings

GRIEVANCE PROCEEDINGS:

Please refer to Appendix D, “Minimum Guidelines for Recipient Grievance Procedures” included in this Handbook.

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Section V: Attachment 1

Case Management Program Comparison

PROGRAM	ELIGIBILITY	ASSESSMENT
ADI	<u>TECHNICAL CRITERIA:</u> Diagnosis or suspected diagnosis of a memory disorder which interferes with ADLs and IADLs <u>FINANCIAL CRITERIA:</u> None	Screening Form (701S) and/or Comprehensive Assessment (701B)
CCE	<u>TECHNICAL CRITERIA:</u> •Age: 60 + •Functional Impairment <u>FINANCIAL CRITERIA:</u> None	Screening Form (701S) and/or Comprehensive Assessment (701B)
HCE	<u>TECHNICAL CRITERIA:</u> •Age: 60 + •At risk of NH placement •Living with an adult caregiver who is: 1 18 years or older; 2 Willing and able to provide and assist in arranging services; & 3 Willing to qualify as a caregiver. <u>FINANCIAL CRITERIA:</u> • Receiving the following benefits: 1 SSI; 2 Medicaid; 3 Medicaid Waiver; 4 QMB; or 5 SLMB. OR •Determined ICP eligible	Screening Form (701S) and/or Comprehensive Assessment (701B)
LSP	Follow the criteria for CCE or OAA, as specified in the contract agreement	Follow the criteria for CCE or OAA, as specified in the contract agreement.
OAA	<u>TECHNICAL CRITERIA:</u> •Age: 60 + •Assessed to be functionally impaired for in-home services •Emphasis placed on low-income minorities, older individuals residing in rural areas and individuals with limited English-speaking proficiency <u>FINANCIAL CRITERIA:</u> None	Condensed Assessment (701A) or Congregate Meals Assessment (701C)

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Section V: Attachment 1

Case Management Program Comparison

	PROGRAM				
	ADI	CCE	HCE	LSP	OAA
CARE PLAN	<u>Uniform Care Plan:</u> 1 Indicate review date and initial. 2 Review semiannually. need . 3. List service(s) and provider(s): A DOEA funded; and B Non-DOEA funded. 3 State frequency of services. 4 State needed services and actual services available. 5 Indicate service(s): A Start date; B End date; 8 Include client, caregiver, and case manager signatures. 9 Update at next care plan semiannual review visit for changes. 10 List frequency of case management as a service.	<u>Uniform Care Plan:</u> 1 Indicate review date and initial. 2 Review semiannually. 3 List service(s) and provider(s): A DOEA funded; and B Non-DOEA funded. 4 State frequency of services. 5 State needed services and actual services available. 6 Indicate service(s): A Start date; B End date; 7 Include client and case manager signatures. 8 Update at next care plan semiannual review visit for changes. 9 List frequency of case management as a service.	<u>Uniform Care Plan:</u> 1 Indicate review date and initial. 2 Review semiannually. 3 List service(s) and provider(s): A DOEA funded; and B Non-DOEA funded. 4 State frequency of services. 5 State needed services and actual services available. 6 Indicate service(s): A Start date; B End date; 7 Include client, caregiver, and case manager signatures. 8 Update at next care plan semiannual review visit for changes. 9 List frequency of case management as a service.	Follow the criteria for CCE or OAA, as specified in the contract agreement.	For case managed clients, follow the standards for CCE.

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Case Management Program Comparison

PROGRAM	CASE NARRATIVE	FORMS	GRIEVANCE	HANDBOOK
ADI	Case narratives should include: 1 Telephone contacts. 2 Home visits. 3 Case staffing. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Care plan semi annual reviews. 7. Units of service for provision of case management.	Forms utilized: 1 Intake and Assessment 2 Care Plan 3 Co-Pay Assessment Form	Grievance Procedures: 1 Apply to Provider Agency 2 Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
CCE	Case narratives should include: 1 Telephone contacts. 2 Home visits. 3 Case staffing. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Care plan semiannual reviews. 7 Units of service for provision of case management.	Forms utilized: 1 Intake and Assessment 2 Care Plan 3 Co-Pay Assessment Form	Grievance Procedures: 1 Apply to Provider Agency 2 Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
HCE	Case narratives should include: 1 Telephone contacts. 2 Home visits. 3 Case staffing. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Care plan semi-annual reviews. 7 Units of service for provision of case management	Forms utilized: 1 Intake and Assessment 2 Care Plan 3 HCE Financial Worksheet	Grievance Procedures: 1 Apply to Provider Agency 2 Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
LSP	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Department of Elder Affairs Programs and Services Handbook
OAA	For case -managed clients, follow the standards for CCE.	Forms Utilized: 1 Intake and Assessment	Grievance Procedures: 1 Apply to Provider Agency 2 Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook

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Section V: Attachment 2

Care Plan (DOEA Form 203A)

Page _____ of _____ Case Manager: Provider #: Worker ID:						Client: DOB: SSN: Caregiver/Designee:				Care Plan Date: Care Plan Review Date:			
Services Needed						Services Planned							
Date	Service	Units	Type	Frequency	End Date	Program	Units	Type	Frequency	Start Date	End Date		
Provider: DOEA Funded Source: (1) OAA, (2) CCE, (3) HCE, (4) ADI, (5) LSP, (6) Other (Specify)						Provider: Non-DOEA Funded Source: (1) Family and Friends (2) Local Government, (3) Faith Based, (4) Other Non-Profit Association							
DOEA Funded Care Plan Total Cost:			Non-DOEA Funded Care Plan Total Cost:			Care Plan Total			Co-Pay Amount (circle CCE or ADI)				
I have participated in developing this care plan through discussion regarding my assessed needs, and the services and service providers available to help meet those needs. I understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. I authorize the provider to release information concerning the services I receive under all programs to the Florida Department of Elder Affairs.													
Client:		Caregiver and/or Designee:				Date		Case Manager:		Date:			

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Section V: Attachment 3

Care Plan Instructions

I. OVERVIEW:

Introduction: This Attachment describes how to develop a care plan. The care plan form, DOEA Form 203A (and DOEA Form 203B for additional pages), is designed to assist the case manager in developing and documenting service needs, community resources available to meet needs and costs associated with care.

Guiding Principles: Several principles guide the care plan development:

- A.** Every client must have a current care plan that addresses problems identified by the assessment.
- B.** The care plan is based on an assessment as well as observations made between reassessments. It is a holistic evaluation of the client's situation, regarding transportation, finances, medication, mental health, substance abuse, etc.
- C.** The care plan provides a clear picture of the client's needs and identifies services that will be provided to meet the identified needs. It specifies service interventions, frequency and intensity offered..
- D.** The care plan will include DOEA-funded services, services provided by insurance companies, family caregivers, local United Way entities, health care taxing districts and non-DOEA funded services and activities provided by community resources, volunteers, friends and family.
- E.** The client's coping skills and adaptability are assets and should be considered in developing the care plan.
- F.** Client choice and autonomy are important and should be considered in the care planning process.

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II. CARE PLANNING CONCEPTS:

A. General Concepts:

1. Effective care planning is:
 - a. Client-focused;
 - b. Derived from the assessment;
 - c. A team effort with the client, caregiver and/or designee and case manager, and
 - d. Conscious of the cost of care and the safety of the client.
2. The resulting care plan will:
 - a. Respond to the appropriate amount of care required by the client, caregiver and/or designee, allowing for choices;
 - b. Be proactive when possible and preventive in nature;
 - c. Commit a variety of providers to provide services;
 - d. Include DOE A and non-DOEA funded services and activities, and

B. The Four Steps in Developing a Care Plan:

1. Use the assessment information.

Develop the care plan with the client, caregiver and/or designee within 14 business days after the completed assessment. Begin the care plan by reviewing the client's assessment and identifying the appropriate services required by the client. All issues identified should be addressed by the care plan, even if services/resources are not currently available to meet all needs. The following information should be gleaned from the assessment summary:

- a. Functional deficits, problems and health conditions, including aspects of medication management and nutrition;
- b. Coping skills, adaptability and preferences;

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- a.** Supports the client currently has in place, as well as current and potential service gaps;
 - b.** Caregiver issues, and
 - c.** Environmental issues.
- 2.** Actively Involve the Client, Caregiver and/or Designee and Existing Support Systems.

The existing persons/resources providing help to the client will be supported by planned services, not replaced. DOEA and non-DOEA services/resources will fill in gaps in the client's present support system. Throughout the planning process and as service provision continues, the client, caregiver and/or designee will help to evaluate how effective the services/resources are and plan together for needed changes.

- 3.** Apply Professional Knowledge and Judgment in Using Community Resources.

The goal is to help elders to age in place with security, purpose and dignity in an elder-friendly environment. Thus, it is important to know what services and activities are available in the community to support elders.

- a.** Learn as much as possible about the client's situation, including caregivers, employee assistance programs, insurance, etc. With input from the client, caregiver and/or designee, the case manager can determine if the client can participate in his or her own care, including whether the client can pay for some of the services.
 - b.** Find out what coping skills the client has and the client's adaptability. Then, decide how much care the client needs, the services the client will receive, and the client's choice in service providers.
 - c.** The client should be empowered to choose the services that best meet his/her needs, from service providers of his/her choice. Services should be scheduled in a delivery method that complements the client's lifestyle. However, when clients need more assistance with managing their care and handling their activities of daily living, it is important to:
 - i.** Identify help to be provided by family, volunteers, and others;

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- ii. Consider which DOEA and non-DOEA funded services and activities are available to best meet the client's needs, and
 - iii. Consider all options, including insurance, employee assistance, and faith- based programs.
- d. Become familiar with the services and community resources available. The following are suggested ways to learn what is available:
 - i. Talk with veteran case managers;
 - ii. Use the resource directories produced by organizations and associations in the area, telephone directories, and web resources;
 - iii. Check with local employers and review insurance coverage;
 - iv. Contact health care taxing districts, (local government entities which collect funds for a specific cause, such as health care);
 - v. Contact participants in the local service network, following agency protocols, such as Senior Centers, Area Agencies on Aging, Community Care for the Elderly provider agencies, Elder Helplines and FL Department of Children and Families, and
 - vi. Consider all sources of help including families, friends and volunteers; churches, temples, synagogues or other religious groups; local service clubs and civic organizations; and local taxing districts.
- e. Develop a comprehensive list of possible resources. Learn the specifics of services offered by each provider and be aware of eligibility requirements for each.
- f. Identify a key person and a backup contact with each provider.
 - Write down phone numbers and when key persons are available.
 - i. Use available services, including services covered by insurance companies and employee assistance programs.
 - ii. Consider how to enhance the client's quality of life within the context of his or her life situation.

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4. Apply Client Choices and Reflect the Client's Preferences:
 - a. Client and caregiver directed options: Involving the client, the caregiver and/or designee allows for autonomy and choice. Autonomy is self-determination and freedom from unnecessary dependency and having choices in available services and providers. The following guidelines will help:
 - i. Find out from the client, the caregiver and/or or designee what amount of help is acceptable.
 - ii. Case management is a required service. Do not mandate other services as a condition for opening the case, if a client does not want a service.
 - iii. Provide enough information about available services and provider options so that the client, the caregiver and/or designee can make an informed decision.
 - iv. Do not arrange for others to perform activities that the client, the caregiver and/or designee can do.
 - v. Exhibit cultural and linguistic sensitivity when working with clients, the caregiver and/or designee and family members.
 - vi. Remember the client, the caregiver and/or designee have the right to accept or decline services, providers or other care arrangements.
 - b. Discuss the following topics with the client, caregiver and/or designee:
 - i. Assessment results: Explain the assessment result. The assessment results allow the case manager to assist the client to identify service needs and resources that help the client remain living safely in the least restrictive setting, appropriate to the individual's needs.
 - ii. Client goals: Document the client's preference in services, providers, and scheduling.
 - a). Discuss the client's coping skills and adaptability to determine how to fill in gaps.

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- b). Discuss the client's preference of care to determine desired results.
 - c). Understand what the client would like to achieve. What problems does the client currently communicate the need to overcome?
 - iii. Expectations about services: Inform the client, the caregiver and/or designee of both DOEA and non-DOEA services and resources available.
 - a) Inform the client, the caregiver and/or designee that programs have lists of service providers from which clients may choose.
 - b) Discuss the frequency and duration of services to be arranged and the alternatives.
 - c). Encourage the client, the caregiver and/or designee to participate in decisions and arrange services per those which are acceptable and appropriate.
 - d) Ask the client, the client's caregiver and/or designee to identify resources they would like to use.
 - e) Emphasize that priority is given to the frailest and that resources are limited.
 - iv. Cost of care: Discuss service costs, co-pay (CCE and ADI only), and the possibility of Medicaid eligibility.
 - v. Quality assurance: Inform the client, the caregiver and/or designee that within two weeks following the start of services, a telephone call or visit will be made to determine if services are being provided as planned and if the client is satisfied with services, or if the client wishes to change providers.
 - a) Additional contacts may be made as needed, based upon the client's needs.
 - b) Explain to the client, caregiver and/or designee that there may be changes, reductions, or terminations in services at the time of the review, based upon the client's needs

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and achievement of specific goals

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-
- c) Talk with the client, caregiver and/or designee to determine the effects of service delivery in meeting established needs.
 - d) Document all telephone contacts and visits in the case narrative.
 - vi. Client rights: Give the client a copy of the grievance procedures. Explain the client's right to appeal care plan decisions, changes in services, or termination of services.
 - c. A well-developed care plan shall:
 - i. Address all aspects of the client's care. It represents the client, caregiver and/or designee, and professional worker's understanding of the situation, based upon the client's needs;
 - ii. Represent the case manager's best professional, objective, and independent judgment, based upon the client's needs;
 - iii. Reflect the client's health conditions, problems/services needed, challenges and barriers to problem resolution, outcomes to be attained, and DOEA and non-DOEA funded services and activities provided;
 - iv. Reflect the client's preferences and choice of providers in a document unique to the client;
 - v. Serve as the information base to measure progress and revise services;
 - vi. Exhibit the caregiver's and/or designee's contributions, maximize other non-DOEA funded services and be used to estimate the cost of needed services and activities.

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III. COMPLETING THE CARE PLAN FORM:

Complete all sections of the care plan. The following information explains how each section is completed.

A. General Information:

1. Client Name

2. Social Security Number (SSN)

- a. The nine-digit number is a unique identifier for each client and is used for tracking and comparing information.
- b. The client is not required to provide the SSN, but is encouraged to do so for staff to screen for Medicaid eligibility and possible referral to the Department of Children and Families for services.
- c. The client must be informed that disclosure of the SSN is voluntary and will be used for referral and screening for Medicaid in accordance with Title XIX of the Social Security Act.
- d. If a pseudo identification number (ID) was used on the Assessment Form, the same number should be used on the Care Plan Form. Directions for creating a pseudo ID are found in the DOEA Form 701D Assessment Instructions.

3. Case Manager Name

4. Provider

The provider code is unique for each individual provider within a PSA. The first digit of the provider code usually corresponds to the PSA code.

5. Care Plan Date:

The date the care plan form is prepared is a reference point for determining care plan review dates. Each time the assessment is reviewed, the case manager shall review the care plan form and make necessary changes or begin a new form. The care plan must be updated annually in CIRT, at the time of reassessment.

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- a. To update the Care Plan annually in CIRTS, terminate all current service lines, effective the date of the annual reassessment. Enter a new service line for each service determined appropriate based on the annual reassessment using the following day's date. If it is determined that the services will continue as they did the previous year, the same information regarding units, type, and frequency may be added in the corresponding columns.

6. Care Plan Review Dates:

- a. Review the care plan every six months or more frequently, if the case manager and supervisor deem it necessary to meet the needs of the client.
- b. Enter the date and reviewer's initials for each review.

B. Health Conditions and Service Impact:

1. Identify the health conditions documented in the assessment and list them in this section. If more than three conditions exist, list the three which are most problematic to the client.
2. Conditions which affect the individual's ability to perform activities of daily living determine the degree of frailty and should be included in the care plan.
3. Identify the most appropriate service impact for each health condition and write the corresponding number(s) next to each health condition. Four service impact possibilities are listed on the form.

C. Problems and Gaps/Adaptability and Coping Skills/Challenges and Barriers:

1. Review information provided in Sections D and E on the assessment to identify problems. Information will indicate the client's ability to functionally perform tasks or to complete moderately complex tasks necessary to maintain a healthy and independent life and the amount of assistance the client receives from others.
2. List all problems, including medication management and nutritional considerations in the case narrative. ,
3. Challenges and barriers indicated in the assessment help to explain why the problem exists.

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4. Activities of daily living (ADL) and instrumental activities of daily living (IADL) the client cannot perform independently may cause problems, unless the individual has developed methods of coping and adapting.
5. Adaptability and coping skills are ways to compensate for deficits and are resources and assets.
 - a. Resources and assets documented on the assessment summary describe how the client overcomes deficits.
 - b. The use of assistive devices is one means of adapting and employing coping skills.
 - c. Doing activities of daily living in an unconventional or creative way or allowing others to do certain chores or parts of chores are methods of coping.
 - d. When the individual can use adaptability and coping skills to overcome challenges and barriers, problems may be alleviated or minimized.
6. Gaps (need for assistance) exist when problems have been identified, and challenges and barriers cannot be overcome through adaptability or coping skills. Gaps determine service needs.

D. Service/Activity:

1. Identify the specific service or activity to address the gap (assistance needed) related to each problem documented in Sections D and E of the assessment.
2. List both DOEA funded and non-DOEA funded services and activities on the care plan.
3. Services arranged by the case manager or case aide and provided by non-DOEA funded sources must be listed in the care plan.
4. In addition, services which exist at the time of the assessment, not arranged by a member of the case management staff, and provided by non-DOEA funded sources, must be listed in the care plan.
5. Document on the care plan and in the case narrative when a change in the client's service needs or a change in providers occurs.

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6. Indicate the date of the change and any unit rate changes on the care plan. Also, notify service providers in writing when changes in service are needed.
7. Updates are based on changes in the client's health conditions and other circumstances.

E. Frequency:

1. Record the frequency for services.
 - a. Frequency is how often a service is planned. It is the number of hours, meals, or other units per week, month and year.
2. Because of budget restraints and other barriers, services documented on the care plan as needed may not be the same as the services that are planned.
 - a. Needed services represent the frequency of recommended services necessary to address the client's needs to obtain the desired outcomes stated in the care plan.
 - b. Planned services represent the frequency of services, which are planned to be provided.
 - c. For the care plan to be an accurate reflection of the client's situation, it must be acknowledged that sometimes problems cannot be fully addressed.
 - i. Thus, recognize unmet needs/services needed on the care plan and document them in the case narrative.
 - ii. Document all efforts to secure non-DOEA funded services in the case narrative.
 - iii. Enter the begin date and end date for the needed and planned services.
 - iv. The begin date for needed services must be equal to or prior to the begin date of planned services.

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3. When necessary, write “PRN” or “as needed” next to the amount of service noted on the care plan to indicate temporary changes may occur. (“PRN” is the abbreviation for the Latin “pro re nata,” which means “as needed” or “when necessary”).
 - a. Note temporary changes in the case narrative and indicate when these temporary services are terminated.
 - b. Record permanent changes to the care plan on the form and enter them in CIRTS.
4. Document in the case narrative the reason changes occur in the frequency or duration of planned services, indicating the date of the change. Notify the service providers in writing when changes in frequency are being made.

F. Desired Outcomes:

1. Document in the case narrative the desired outcome established for the client based upon the individuals overall status, not select problems. In most situations, the desired outcome is either short-term or long- term.
2. **Short-term outcomes** address immediate concerns.
 - a. The short-term outcome is that the individual’s situation is stabilized and acute episodes or nursing home placement can be delayed or prevented.
 - b. For instance, after relocation, hospitalization, or incapacitation of a caregiver, a client may require temporary assistance to obtain necessary access to community resources.
 - c. Assistance may be needed immediately, but not for an extended period.
3. **Long-term outcomes** address concerns that have long range implications and will exist into the future.
 - a. The long-term outcome is that the individual’s situation will be maintained or improved by with assistance and that an acute episode or nursing home placement will be delayed or prevented.

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- b. When a client's situation is stable, the goal is to help keep the individual as safe and healthy as possible. An example is an individual who has arthritis. Heavy chores may be difficult, but the person can manage small tasks, if paced appropriately throughout the day.
 - c. Assistance should support the individual's abilities and offer relief from activities that might not be safe, such as cleaning the bathtub, but also allow the person to be as active as possible.
 2. **Both short-term and long-term outcomes** address stabilization of a situation and concerns for the future.
 - a. The overall outcome is that the individual's immediate concerns are addressed, and plans are made to address long-range implications.
 - b. An example is an individual who has a recent hospital discharge and needs assistance with personal care needs. Personal care assistance will be required temporarily. However, due to health conditions, the individual is no longer able to drive. The need will be long-term for transportation.
- G. **Non-DOEA Funded/DOEA Funded and Provider:** Document the planned number of hours or other service units in the appropriate column.
1. Write "ND" for Non-DOEA funded and "D" for DOEA funded. Include the corresponding number for the source.
 - a. Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.
 - b. DOEA-funded sources include Older Americans Act (OAA), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Alzheimer's Disease Initiative (ADI), and Serving Health Insurance Needs of Elders (SHINE). "Other" in this section of the form refers to:
 - Local Service Programs (LSP)
 - Respite for Elders Living in Everyday Families (RELIEF)
 - Long-Term Care Ombudsman Council (LTCOC).

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The provider refers to the source and the funding method.

2. The following are some examples:

Non-DOEA Funded	Example
Family and friend	Child, granddaughter, niece, neighbor
Local Government	Board of County Commissioners, taxing entities, County Human Resources, City Government, County Taxing District (Health Care Taxing District in Palm Beach) Medicare, Medicaid
Associations/Religious/Other	American Diabetes Association, Lutheran Social Services, United Health Maintenance Organization, Volunteer, IBM Corporation, Employee Assistance Program, Private Insurance
Other Non-Profit	United Way, Habitat for Humanity, Food Bank
Long-term Insurance	Benefits covered under long term care
DOEA Funded Provider:	Funding Source:
Older Americans Act (OAA)	Federal
Community Care for the Elderly (CCE)	State
Alzheimer's Disease Initiative (ADI)	State
Home Care for the Elderly (HCE)	State
Local Services Program (LSP)	State
Respite for Elders Living in Everyday Families (RELIEF)	State
Serving Health Insurance Needs of Elders (SHINE)	Federal

Assistance may be needed immediately, but not for an extended period.

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H. Date Services Start (S) and Ended (E):

1. Indicate the date each service began or ended in this column.
2. If a service or activity exists prior to DOEA involvement and is planned to continue, but the date the service began is not known, use the same entry as the problem date for the services begin date.

I. Date Problem Resolved (RS) or Revised (RV):

1. Document in the case narrative, the date and “RS” when the problem is resolved, and services are no longer needed.
 - a. For example, if the client's problem was an inability to hear because of a lost hearing aid, then replacing the hearing aid resolves the problem and no further service is required.
 - b. Once a resolved or revised date is posted, the problem need not be tracked in the case narrative unless the problem recurs.
2. Document in the case narrative the date and “RV” when a problem, frequency, service, or desired outcome is revised.
 - a. If the client began receiving two hours a week of personal care services on 8/14/15 and this service was revised to three hours a week on 12/22/15, the care plan would be updated to show the date of the revision.
 - b. Make a corresponding entry in the case narrative to describe the reason for the revision and any other details about the revision that occurred.

J. Unit Cost/Individual Purchase:

1. Enter the approved unit rate for the corresponding DOEA-funded service on a service cost calculation form .
 - a. The approved rates are based upon those included and approved in the area plan.

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- b. For an example of a non-DOEA service: If the daughter provides personal care, use the approved DOEA-funded rate for personal care as the non-DOEA funded resource value.
 2. If the service is not a service provided by DOEA and the unit rate is not known, a fair market value will need to be computed. There are three suggested ways to figure the needed value:
 - a. Call at least three sources of the service or activity in the area and average their cost. For example, if three sources of a service charged \$5.00, \$6.00 and \$7.00 per unit, then the fair market value for the service would be \$6.00, ($5+6+7=18$, divided by 3).
 - b. Use CIRT's average actual rates.
 - c. Use market rate surveys as a basis for the determination that suggested rates are reasonable.
 3. Enter the individual purchase cost of the item, service or activity, if unit cost does not apply.
- K. **DOEA-Funded Monthly Care Plan Cost:** Enter the total amount for all DOEA-funded care plan services documented in the Monthly Cost/Value column.
- L. **Co-Pay Monthly Amount:** Multiply the monthly co-pay amount by twelve, i.e., $\$27.00 \times 12 = \$324.00$.
- M. **Care Plan Total:** Enter the total amount of the care plan, including costs, value of resources and the co-pay amount.
- N. **Signature:**
1. Sign on the case manager line as the individual developing the care plan.
 - a. The client is to sign the care plan when it is first done, and then once yearly, when reassessed.
 - i. Clients do not have to sign the plan each time there is a revision.
 - ii. Clients must be made aware of and have an opportunity to discuss all revisions.

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- iii. There must be documentation that the client agrees with the revisions.
 - b. If the client is unable to sign the care plan, note that on the signature line.
- 2. The client's caregiver and/or designee should sign the form when it is first completed and once yearly, when the client is reassessed.
 - a. Note "HCE" next to the caregiver's signature if the individual is an HCE caregiver.
 - b. The caregiver and/or designee does not need to sign the care plan each time there is a revision, however, the caregiver and/or designee must be informed of revisions.
- 3. By signing the care plan, the client acknowledges that he or she has participated in discussions about assessed needs, has helped to develop the care plan, has been given choices to address service needs, and agrees with the care plan provisions.
 - a. Additionally, the client acknowledges that a grievance review can be requested if there is unacceptable change, reduction or termination of services.
 - b. Information must be provided to the client in a language the client can understand and articulate.

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IV. ORGANIZING THE CARE PLAN:

List each problem (short or long-term) in chronological order, including information from the assessment summary related to its challenges and barriers, and the client's coping skills and adaptability in the client's case narrative.

:

A. Long-Term Problems:

1. These problems will likely not improve and may require services over a long period, i.e., more than 6 months, and may have to be changed or updated throughout the year.

Example: Long-Term Problem

Health Condition: The client has emphysema and difficulty breathing when performing activities.

Service Impact on Health Condition:

Number "2" was selected as the condition may be maintained with intervention.

Problem: Challenges and barriers to problem resolution are the client's lack of stamina and strength to do more than light housekeeping.

Service: Homemaker services are needed.

2. Each change or update is shown on a new line of the care plan form.

B. Short-Term Problems:

1. These problems will usually improve or be resolved over a short period and will not require as many changes or updates during the year.
2. Thus, the "Date Service Began/Ended" column is used most.

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Examples: Short-Term Problem

Health Condition: The client has severe arthritis and is limited in her ability to perform physical activity.

Service Impact on Health Condition:

Number “3” was selected as the condition may decline with intervention.

Problem: Challenges and barriers to problem resolution are the client’s inability to safely get in and out of the bathtub and the caregiver’s frailty.

Service: Home repair service is needed to make the bathtub accessible by installing grab bars

C. When revising a care plan,:

1. Identify every new entry with the problem number of the original problem statement.
2. Record a date for each revision followed by “RV” in the “Date Problem Resolved or Revised” column.
3. If the problem is resolved, record the date of resolution and “RS.”

Examples: Long-Term Problem:

Health Condition: The client has renal cancer, kidney and bladder failure, incontinence problems and is very weak from dialysis. In addition, the client has uncontrolled diabetes.

Service Impact on Health Condition: Number “3” was selected as the condition may decline with intervention.

Problem: Challenges and barriers to problem resolution are the client’s inability to drive to the doctor or get around without assistance. The client is also unable to properly manage her health care needs.

Service: Transportation and home health care are needed services.

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CARE PLAN UPDATES:

- A.** Review and update the care plan semiannually.
 - 1.** The care plan may be updated more frequently depending upon the client's need for more frequent reviews, such as following a hospitalization, loss of a spouse or a physical move.
 - 2.** During the care plan review, discuss with the client the services provided and determine whether these services meet the client's needs or if changes are required.
 - 3.** Review the options and provide choices for the client.
 - a.** Are there new problems that need to be addressed?
 - b.** Additional problems identified should be added to the care plan.
- B.** Enter "same" or "no change" if some of the columns on the care plan are still accurate and do not need revising or updating, whichever method used. Only the initials of the case manager and review date are required.
- C.** The care plan for each active client will be updated in CIRTSS at least annually.

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CASE NARRATIVE:

Problem Statement Entry from Care Plan: Client is unable to get in and out of the bathtub safely

Case Narrative Entry Indicating Status of the Problem:

Through home modification services, Ms. Smith could retrofit her bathroom so that she can safely get in and out of the bathtub. She can take a bath daily and her caregiver helps her to wash her hair and back. The modifications to her bathroom and assistance from her caregiver are appropriate now.

The case narrative describes the client's progress and challenges or barriers that hinder the desired outcomes in the care plan.

- The narrative reflects services consistent with the needs and service gaps identified in the care plan and provide reasons for variances.
- The case narrative entries may reference specific care plan and assessment summary entries.
- Case narrative entries should document the date of the contact, the type of contact (Office Visit - OV, Telephone Call - TC, Field Visit - FV), and the person making the contact.

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SUMMARY:

The essence of good care planning is the inclusion of the client at the center of the planning and selection process. All services and activities revolve around the client and flexibility is the key to effective care planning. The role of the caregiver is paramount to the client's care and the planning process. The caregiver and/or designee must be included in the care planning process. The care planning process must be broad enough in scope to look at the abilities of the client, the support of the caregiver and/or designee, and the resources of the community.

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Section VI: Incident Reporting Requirements

Incident Reporting Requirements for Alzheimer's Disease Initiative (ADI), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Local Service Programs (LSP), and Older Americans Act (OAA) service contracts

The Contractor shall notify the Department immediately but no later than forty-eight (48) hours from the Contractor's awareness or discovery of conditions that may materially affect the Contractor's or Subcontractors ability to perform the services required to be performed. Such notice shall be made orally to the Department's Contract Manager (by telephone) with an email to immediately follow *including the Contractor's plan for provision of services*.

The Contractor shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96-ABUSE). As required by Chapters 39 and 415, F.S., this provision is binding upon the Contractor, Subcontractors, and their employees

The reporting requirements are associated with any conditions that may materially affect the Contractors or Subcontractors ability to perform the services required to be performed.

Such conditions include, but are not limited to the following:

- Meal site closure or suspension of services;
- Provider terminations; or
- Building or service site issues.

These incident reporting requirements are in addition to the requirements set forth by Chapters 39 and 415, F.S., related to "professionally mandatory reporters" and the required reporting of suspected abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline.

Chapter 3

Title III and Title VII of the Older Americans Act (OAA)

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Section I: Purpose, Goals, Legal Basis and Legal Authority

PURPOSE, GOALS, LEGAL BASIS AND LEGAL AUTHORITY OF TITLE III AND TITLE VII OF THE OLDER AMERICANS ACT PROGRAM AND SERVICES:

The purpose, goals, legal basis and legal authority of Title III and Title VII of the Older Americans Act (OAA) program and services are outlined in this chapter under “Service Requirements” in separate sections with similar headings. These sections are as follows:

- A.** General Policies
- B.** Area Agencies on Aging
- C.** Service Providers
- D.** OAA, Title IIIB—Supportive Services
- E.** OAA, Title IIIC—Nutrition Program Policies
- F.** OAA, Title IIID—Disease Prevention and Health Promotion Services Program
- G.** OAA, Title IIIB—Multipurpose Senior Centers
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- I.** OAA, Title VII—Vulnerable Elder Rights Protection Activities

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PURPOSE OF TITLE III OF THE OLDER AMERICANS ACT AND LEGAL AUTHORITY

Purpose of the Chapter: This chapter expresses general policy guidance for the administration of the Title III, OAA program in Florida. All subrecipients of Title III, OAA funding will be held accountable for adherence to these policies.

PURPOSE OF TITLE III (as stated in the OAA) AND LEGAL AUTHORITY:

- A.** It is the purpose of Title III to encourage and assist state agencies and Area Agencies on Aging (AAAs) in entering cooperative arrangements for:
 - 1.** Planning and delivering aging programs and services;
 - 2.** Concentrating resources to develop greater service capacity; and
 - 3.** Fostering the development and implementation of comprehensive and coordinated systems to provide supportive services and multipurpose senior centers for older individuals:
 - a.** Attain and maintain maximum independence and dignity in a home environment and the capability of self-care with appropriate supportive services;
 - b.** Remove individual and social barriers to economic and personal independence;
 - c.** Provide a continuum of care;
 - d.** Secure the opportunity to receive managed in-home and community-based long-term care services; and
 - e.** Encourage and assist public and private entities that have unrealized potential for meeting the service needs of older individuals to assist on a voluntary basis.

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- B.** Agencies include State Units on Aging, such as the Department of Elder Affairs (DOEA). Other agencies include:
1. Area Agencies on Aging;
 2. Agencies that administer home and community-based care programs;
 3. Indian tribes, tribal organizations, and native Hawaiian organizations;
 4. Voluntary organizations or other private sector organizations providing supportive services, nutrition services and senior centers; and
 5. Organizations representing or employing older individuals or their families.
- C.** Specific legal authority for the provisions of this act is as follows:
- Older Americans Act, Title III, Part A—General Provisions; Purpose; Administration, Sections 301 through 316
- 42 U.S.C. 3021 through 3030c
- Older Americans Act, Title III, Section 307(a) (10)—direct service provision by AAA
- 45 CFR, Part 74—Suspension/Termination of AAA
- 45 CFR, Parts 81 and 90—Title VI of the 1964 Civil Rights Act —Non-discrimination
- 45 CFR, Part 84—Section 504 of the 1973 Rehabilitation Act—Nondiscrimination—disability
- 45 CFR, Part 1321—Hearings
- 45 CFR, Parts 1321.11(a), 1321.53—AAA Role
- Administrative Procedures Act, Section 120.57(2), F.S.

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DESIGNATION OF PLANNING AND SERVICE AREAS (PSAs) FOR PROGRAM ADMINISTRATION:

- A. The Department, as Florida's State Unit on Aging, has designated eleven (11) Planning and Service Areas:

PSA: Counties Included in each PSA:

1. Escambia, Okaloosa, Santa Rosa, Walton
2. Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, Washington
3. Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
4. Baker, Clay, Duval, Flagler, Nassau, St. Johns, Volusia
5. Pasco, Pinellas
6. Hardee, Highlands, Hillsborough, Manatee, Polk
7. Brevard, Orange, Osceola, Seminole
8. Charlotte, Collier, Desoto, Glades, Hendry, Lee, Sarasota
9. Indian River, Martin, Okeechobee, Palm Beach, St. Lucie
10. Broward
11. Miami-Dade, Monroe

- B. It is the policy of DOE A to maintain the integrity of these boundaries for all program planning and administration. The Department shall set specific objectives, in consultation with the AAAs, for each PSA to ensure that services, which are Title III-funded, will be targeted to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. The state will provide written descriptions of how specific program development, advocacy, and outreach efforts focused on the needs of these individuals must be undertaken.

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- C.** Under federal regulations, any unit of general purpose local government, region within a state recognized for area-wide planning, metropolitan area, or Indian reservation may make application to be designated as a PSA.
- D.** If the Secretary of the Department finds that an AAA has failed to comply with federal or state laws, including the area plan requirements of this section, regulations or policies, the state may withhold a portion of the funds to the AAA available under this title.
- E.** The Secretary of the Department shall not make a final determination to withhold funds under paragraph (D) without first affording the AAA due process in accordance with procedures established by the Department.

At a minimum, such procedures shall include:

- a. Providing notice of an action to withhold funds;
 - b. Providing documentation of the need for such action; and
 - c. Conducting a public hearing concerning the action at the request of the AAA.
- F.** If the Department withholds the funds, it may use the funds withheld to directly administer programs under this title in the PSA served by the AAA for a period not to exceed 180 days, except as provided in section G, below.
- G.** If the Department determines that the AAA has not taken corrective action, or if the Department does not approve the corrective action, during the 180-day period described in section F above, the Department may extend the period for not more than 90 days.
- H.** The Department shall establish and follow appropriate procedures to provide due process to affected parties, if it initiates an action or proceeding to:
 - 1. Revoke the designation of the AAA under section OAA 305(a);
 - 2. Designate an additional PSA in the state;
 - 3. Divide the state into different PSA; or
 - 4. Otherwise affect the boundaries of the PSAs in the state.

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- I. The procedures described in Section H above shall include:
 - 1. Providing notice of an action or proceeding described in Section H;
 - 2. Documenting the need for the action or proceeding;
 - 3. Conducting a public hearing for the action or proceeding;
 - 4. Involving AAAs, service providers, and older individuals in the action or proceeding; and
 - 5. Allowing an appeal of the decision of the Department in the action or proceeding to the Assistant Secretary of the Administration for Community Living.

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DESIGNATION OF AREA AGENCY ON AGING:

- A. The Department shall designate an AAA whose responsibility shall be to develop a plan for the PSA.
- B. The designated AAA shall be one of the following:
 - 1. An established office on aging operating within the PSA;
 - 2. Any office or agency of a unit of general purpose local government which is designated to function only for serving as an AAA by the chief elected official of the governmental unit;
 - 3. Any office or agency designated by the appropriate chief elected officials of any combination of units of general purpose local government to act only on behalf of such combination for this purpose; or
 - 4. Any public or non-profit private agency in a PSA or any separate organizational entity within such agency which can and will engage only in the planning of a broad range of supportive and nutrition services for the elderly, under the supervision of the Department.
- C. If a multipurpose agency is designated as the AAA, all responsibilities for OAA Title III programs must be delegated to a sole organizational unit which has full authority and capability to prepare and administer the area plan.
- D. A regional or local agency of state government may not be designated as an AAA.
- E. If a new AAA is to be designated, the "right of first refusal" shall be given to a unit of general purpose local government if:
 - 1. The boundaries of such a local governmental unit are reasonably contiguous with the PSA; and
 - 2. There is an office or agency designated by the chief elected official for serving as the area agency.
- F. If a new area agency is to be designated and the appropriate unit of general purpose local government chooses not to exercise its right as stated in this section, preference shall be given to an established office on aging, if applicable; otherwise, designation may be from any other agency permitted in this section.

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- G.** In accordance with federal regulations, designation of an AAA is presumed to be continuous unless withdrawn for cause or voluntarily discontinued. A competitive Request for Proposal (RFP) process will be used to identify the organization best qualified to be the designated AAA whenever an AAA is designated.
- 1.** The Department of Elder Affairs (DOEA) will develop the RFP.
 - 2.** A recommendation will be made to the DOEA Secretary based on the bid review team's evaluation.
 - 3.** The actual designation will be made by the DOEA Secretary, as the director of the state unit on aging.
 - 4.** The contract with the new AAA will not be awarded until an area plan is submitted and accepted.

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RESCINDING DESIGNATION OF AN AREA AGENCY ON AGING:

- A.** In accordance with Section 430.04, F.S., the Department of Elder Affairs has the authority to rescind designation of an AAA whenever, after reasonable notice and opportunity for a hearing, it finds that:
 - 1.** An AAA does not meet the requirements of the Code of Federal Regulations; or
 - 2.** An area plan or plan amendment is not approved by the Department; or
 - 3.** There is substantial failure in the provision or administration of an approved plan to comply with provisions of the OAA, as amended, the applicable federal regulations, state statutes or administrative rules; or
 - 4.** Activities of the AAA are inconsistent with the statutory mission prescribed in the OAA.
- B.** At least 90 days prior to the intended action of rescinding the designation of the AAA, and after the AAA has been afforded due process to correct deficiencies, the DOEA Secretary will be responsible for determining the relevant facts and circumstances which warrant such action and prepare a written notification to the agency announcing the intention to rescind designation. The notification shall be delivered to the executive director of the AAA and the board of directors by U.S. Certified Mail, return receipt requested, or by hand delivery. The notification shall contain the following:
 - 1.** A statement of the basis for the decision to withdraw the designation as an AAA, including the citation of specific legal or contractual provisions that were allegedly violated;
 - 2.** Information on the facts, circumstances, and evidence which substantiate the decision;
 - 3.** Information on the technical assistance given by DOEA staff to identify and help with corrective action for deficiencies of the AAA;
 - 4.** The effective date of the proposed rescinding of designation; and

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5. A statement that the AAA may:
 - a. Submit further information to justify its position;
 - b. Review any pertinent evidence on which the withdrawal is based;
 - c. Attend a public hearing conducted by the Department involving the rescinding of its designation.
- C. DOEA shall conduct a public hearing within 30 days of the notice of the intent to rescind designation. The public hearing shall be noticed in the Florida Administrative Weekly to allow participation by the AAA, service provider, older individuals, and other interested parties.
- D. DOEA shall render a final written decision within 30 days after the public hearing. A copy of the hearing record will also be provided to the AAA in accordance with Chapter 120.57(2)(b) F.S. If DOEA upholds its original decision to rescind designation of the AAA, the decision shall include the reasons and the following information:
 1. A statement of the AAA's right to request a hearing regarding the adverse decision in accordance with Chapter 120.57, F.S.;
 2. A statement of the AAA's right to request an appeal regarding the adverse decision with the Assistant Secretary of the ACL.
- E. If the AAA requests a hearing, DOEA shall withhold rescinding designation until the hearing decision is rendered.

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CONTINUITY OF SERVICES:

- A.** In the event the Department, as the State Unit on Aging, withdraws an AAA's designation or an AAA voluntarily withdraws, the Department shall:
 - 1.** Require the AAA to provide a written plan for the continuity of services in the affected PSA for the Department's approval and implementation;
 - 2.** Designate a new AAA in a timely manner; and
 - 3.** Obtain the transfer of program, financial and property records, both current and prior years, including all documentation of service provider contracts from the AAA.
- B.** If necessary, to ensure continuity of services, for a period up to 180 days after the effective date of the withdrawal of the designation of AAA, the Department may:
 - 1.** Perform the responsibilities of the AAA; or
 - 2.** Assign the responsibilities of the AAA to another agency in the PSA.
- C.** The 180-day period may be extended by the Assistant Secretary of the ACL under 45 CFR 1321, if requested by the Department.

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ROLE OF THE SERVICE PROVIDER:

Each service provider is responsible for:

- A.** Planning and conducting activities as indicated in the area plan in accordance with the approved service provider application or other contract documentation;
- B.** Establishing priorities and methods for serving older persons with greatest economic or social need with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. Such methods must conform to state and AAA policies; and
- C.** Familiarizing its staff with this policy handbook and referenced authorities and for carrying out all activities in compliance with federal and state statutory and regulatory requirements

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COORDINATION WITH THE COMMUNITY CARE FOR THE ELDERLY (CCE) PROGRAM:

Requirements for coordination between OAA and CCE programs:

- A.** The AAA is responsible for ensuring that the planning and administration of the OAA program is coordinated with the CCE program.
- B.** At the service provider level, the OAA program and CCE program shall be effectively coordinated to maximize benefits to older persons.

COORDINATION WITH MEDICAID CAPITATED LONG-TERM CARE PROGRAMS:

Requirements for coordination between OAA and Medicaid capitated long-term care programs:

- A.** Consumers shall not be dually enrolled in an OAA Program and a Medicaid capitated long-term care program, except for consumers in need of OAA Legal Assistance services and OAA Congregate Nutrition Services, including transportation to and from congregate meal sites. If the MLTC consumer participates in recreational activities at the meal site, the provider shall not bill the service to the OAA Program.
- B.** The Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) Program enrollee referral process, listed below, is a provider reference for OAA providers and managed care plans (MCPs) regarding a SMMC LTC enrollees' access to OAA congregate nutrition services.

SMMC LTC Enrollee Referral Process

- A.** SMMC LTC MCPs must coordinate with local OAA nutrition service providers in each of the planning and service areas (PSAs) to access congregate nutrition services, and transportation to congregate meal sites, if needed. Coordination includes contacting the service provider, with the enrollee's documented consent (to be maintained by the MCP).
- B.** The nutrition service provider will access the enrollee's current assessment information from CIRTIS and prioritize the enrollee for services. In addition to frailty, priority is based upon OAA targeting criteria. The MCP must ensure the enrollee has a current "701B assessment" in CIRTIS upon making the referral.
- C.** The nutrition services provider will notify the SMMC LTC MCP case manager prior to release of an SMMC LTC enrollee from the OAA congregate nutrition services priority list. If an individual is receiving OAA congregate meal services prior to Enrollment Management System (EMS) release, then there will be no interruption in the individual's OAA services. The priority list for OAA congregate nutrition services is managed by the local OAA provider.
- D.** The SMMC LTC MCP case manager must provide the completed "DOEA Congregate Meal Nutrition Services Referral Form #243" to the nutrition service provider, (to be maintained by the nutrition service provider). The nutrition service provider will contact the enrollee to begin services.

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COORDINATION OF SUPPORTIVE SERVICES FOR MENTALLY IMPAIRED AND PHYSICALLY IMPAIRED OLDER PERSONS

Requirements for coordinating supportive services are as follows:

- A.** Area plans shall address the coordination of supportive services.
- B.** At the service provider level, the OAA program shall provide coordination and cooperate with local community mental health provider agencies, and agencies assisting individuals with physical disabilities, making referrals as needed.

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COOPERATION WITH ADULT PROTECTIVE SERVICES:

Area Agencies on Aging and service providers shall cooperatively respond to requests for assistance from the Department of Children and Families (DCF) Adult Protective Services (APS) staff and assist as appropriate with efforts to prevent adult abuse, neglect, or exploitation. Priority for services shall be given to victims of abuse, neglect, or exploitation. Activities related to DCF APS referrals shall be done in accordance with the APS Referrals

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LICENSURE AND SAFETY REQUIREMENTS FOR PROVIDERS:

Each service provider must meet existing state and local licensure, certification, and safety requirements for the provision of services. Each service provider is responsible for determining the requirements applicable in the area(s) it serves.

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REASONABLE ACCESS TO INFORMATION AND REFERRAL SERVICES: A statutory requirement, applicable to all AAAs, is the obligation to ensure that all older persons in the PSA have reasonably convenient access to information and referral services. Each area plan requires an assurance concerning these essential services.

Requirements for Information and Assistance:

- A.** All providers of OAA, Title III services are to be responsive to requests for assistance from older persons or on behalf of older persons and provide comprehensive information on the full range of available public and private long-term care programs, options, services providers, and resources within a community, that can meet the needs inferred from the contact (phone, email, walk-in, etc.), including information on the availability of integrated long-term care services, and federal or state programs that provide supports through home and community-based services programs.;
- B.** Assess the problems and capacities of the individuals;
- C.** Link individuals to the opportunities and service that are available;
- D.** To the maximum extent practical, ensure that the individuals receive the services needed by adhering to established follow-up procedures when necessary;
- E.** Serve the entire community of older individuals, particularly;
 - Older individuals with greatest social need;
 - Older individuals with greatest economic need; and
 - Older individuals at risk for institutional placement.
- F.** Each AAA shall ensure that up-to-date resources of agencies and organizations targeting services to elders, persons with disabilities and caregivers, is maintained and made available to the community. Agencies and organizations listed in the statewide aging resource database shall meet the criteria that guide the inclusion and exclusion of providers in the Aging and Disability Resource Center (ADRC) resource directory.
- G.** This policy refers to an administrative or advocacy response to a request for assistance and is considered an administrative function rather than a direct community service.
- H.** All providers of OAA, Title III services are to be responsive to opportunities to advance public knowledge about the OAA program by public presentations (speaking to groups, appearing on television or radio shows, or press releases). Such public information should acknowledge the financial support provided by OAA, Title III for community programs serving older persons.

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LEADERSHIP AND ADVOCACY:

All providers of OAA, Title III services undertake the inherent obligation to provide area or community leadership on aging issues and to serve as the advocate and focal point for the elderly within the community in cooperation with agencies, organizations, and individuals participating in activities under the area plan monitoring, evaluating, and commenting upon all policies, programs, hearings, levies, and community actions which affect the elderly. "Advocacy" is initiating positive changes in public or private policies and attitudes towards older persons, acting to improve, modify, or eliminate situations which adversely impact on lives of older persons, or expressing support for older persons and their interests. Advocacy activities may be broadly supportive of the general interests of older persons or may involve specific activities on behalf of individuals.

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RESTRICTIONS ON LOBBYING:

Federal regulations provide restrictions on the use of OAA, Title III funds for lobbying or political advocacy. In general, the restrictions apply to attempts at influencing elections, partisan contributions, and the introduction or enactment of legislation and legislative liaison activities. Unallowable lobbying with federal funds includes such activities as direct electioneering or participation in campaigns, direct lobbying to politically influence federal or state legislation, and efforts to generate concerted public action on a legislative issue. (The detail of these restrictions is contained in 29 CFR Part 93, 2 CFR Part 200, and 45 CFR Part 93))

CLIENT CONFIDENTIALITY:

Confidentiality Requirements:

- A.** All providers of OAA, Title III services are responsible for maintaining confidentiality of information obtained in the delivery of services. No information about an older person, or obtained from an older person by a service provider, AAA, or the state agency may be disclosed in a form that identifies the person, without the informed consent of the person or of his or her legal representative, unless disclosure is required by court order, operations, payment and treatment, or for program monitoring by authorized federal, state, or local monitoring agencies. It should be understood by older persons that failure to provide informed consent may preclude referral to another service agency.
- B.** Specific policies regarding confidentiality include:

 - 1.** Information contained in the DOEA Client Information and Registration Tracking System (CIRTS) will be disclosed only in accordance with established DOEA procedures.
 - 2.** Neither the state, nor a state agency, may require any provider of legal assistance under Title III to reveal any information that is protected by the attorney-client privilege.
 - 3.** Information may be disclosed to the public by the state agency or the state only if such information could be disclosed under Section 652 of Title 5, U.S.C., by an agency of the United States.
 - 4.** The minimum requirement for safeguarding files and records is a locked cabinet or file.

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COMMUNITY PARTICIPATION:

One of the primary features of the OAA, Title III program is county and community involvement in the planning and funding of the system of services for older persons. Each service provider must seek to expand the sense of community participation by expanding the use of volunteers, by involving qualified local persons in both policy making or advisory capacities, by collecting and analyzing information on the needs, opinions and preferences of older persons, by employing qualified staff from local sources, and by securing the required non-federal financial share (local match).

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TARGETING ECONOMIC OR SOCIAL NEEDS AND OUTREACH EFFORTS:

Targeting Methodology:

- A.** Older Americans Act, Title III funding provides services to persons 60 years of age or older, regardless of income or assets. The OAA mandates that preference be given to providing services to older individuals with the greatest economic or social needs and individuals at risk of institutional placement, with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency and older individuals residing in rural areas.
- B.** Each AAA's area plan shall include objectives and a methodology by which providers will address the targeting requirement.
- C.** AAAs shall ensure that service providers have approved written procedures for prioritizing individuals to receive services when resources are insufficient to meet the demand for services. Examples of indicators which may be used for identifying older persons with a high probability of service need are:
 - 1.** Functional impairment or disability;
 - 2.** Inadequate housing and environment;
 - 3.** Homebound;
 - 4.** Living alone;
 - 5.** Low-income minority;
 - 6.** Limited English proficiency;
 - 7.** Isolation and lack of access to social and recreational activities;
 - 8.** Caregiver "burn out," or
 - 9.** High-risk nutritional status.

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Outreach Efforts: Outreach is an access service, and is defined as a face-to-face, one-to-one intervention with clients initiated by the agency for the purpose of identifying potential clients or caregivers and encouraging their use of existing and available resources.

Agencies must ensure that outreach efforts are conducted to identify older persons with the greatest economic or social needs, with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas, and to inform these elders of the availability of supportive and nutrition services. For additional information, see the outreach service description in Appendix A.

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NON-DISCRIMINATION POLICIES:

All providers of OAA services shall make every effort to actively recruit and employ qualified older persons and undertake the responsibility to administer their programs in compliance with federally mandated non-discrimination policies. Specific requirements are:

Legal Authority for Non-Discrimination Policies:

- A.** Non-discrimination based on race, color or national origin (45 CFR Part 80 and 81); Title VI of the Civil Rights Act of 1964, as amended.
- B.** Non-discrimination based on handicap in programs or activities receiving federal financial assistance (45 CFR 84),

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Affirmative Action Plans:

- A.** To ensure equal employment opportunity for minorities, women and persons with disabilities, each provider of OAA, Title III services must develop and adhere to an affirmative action plan.
- B.** Affirmative action plans are to address agency policies relating to:
 - 1.** The recruitment, hiring, placement, training and education of employees;
 - 2.** The dissemination of policies;
 - 3.** The identification of the responsible official of the agency;
 - 4.** The design of an effective program for monitoring status and progress in equal employment;
 - 5.** A grievance procedure for applicants or employees; and
 - 6.** The Americans with Disabilities Act.

STAFF TRAINING:

AAA and Service Provider Responsibilities:

- A.** Each AAA is to identify annual training requirements and sources of funding for training for:
 - 1.** Service provider staff;
 - 2.** AAA staff;
 - 3.** Board of directors; and
 - 4.** Advisory council.
- B.** Service provider applications shall address staff development and training, indicating the pre-service, orientation, and in-service training to be provided and the sources of funding.

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CONFLICT OF INTEREST:

Conflict of Interest Standards:

- A.** "Conflict of interest" is a situation wherein a person may be perceived as having private interests or multiple public agency duties and responsibilities, which may interfere with the ethical conduct of duties and responsibilities being rendered to an agency funded with OAA, Title III funds.
- B.** Because of the potential for "conflict of interest," AAAs and service providers must adhere to the following minimum policies regarding board of directors' voting membership:

 - 1.** No DOEA employee may be a member;
 - 2.** No AAA or provider may employ, in any capacity, any member of its governing board or any family member of a person on the board (i.e., brother, sister, child, parent, grandparent or spouse); and
 - 3.** No AAA may make a sub-grant or subcontract with any service provider, if a member of the AAA's board is also a member of the provider's staff, board of directors or advisory council.
- C.** No AAA or service provider will give preference for services to older individuals because of a contract or commercial relationship that is carried out to implement Title III, unless stipulated by OAA or DOEA contracts or policies.
- D.** Voting members of the AAA's Board of Directors shall not include a member of the AAA's Advisory Council.

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Area Agencies on Aging

PURPOSE: This section provides policy and guidance on the role and responsibilities of the AAAs in Florida. The policies apply to the AAAs as recipients of OAA, Title III funds and provide guidance for AAAs in managing the network of service providers in the PSA.

Area Agency on Aging Authority and Capacity:

- A.** The AAA is a public agency or non-profit, private corporation designated by the State Unit on Aging to carry out the provisions of the OAA, as amended, at the sub-state level. The AAA serves as the advocate for older persons and is the agency responsible for fostering the development of a comprehensive and coordinated system of service delivery for older persons in the PSA.
- B.** The OAA and federal regulations provide guidance on the types of agencies that may be designated to perform AAA functions and provide specific procedures to be followed in the process of designating a new AAA.
- C.** There will be only one AAA designated in each PSA.
- D.** If a multi-purpose (umbrella) agency is the designated AAA, all authority and responsibility for AAA functions must reside in a single organizational unit of the multi-purpose agency.
- E.** The designated AAA must have sufficient legal authority and administrative capacity to plan, coordinate, implement, and supervise the area plan for the PSA.
- F.** The board of directors of the AAA is the legally recognized entity designated as the AAA. The responsibility, accountability, and liability for the prompt and complete execution of contractual obligations to DOEA or other agencies rest with the board of directors.
- G.** Each AAA must have written procedures for complying with its statutorily mandated functions. All policy and procedures must be approved by the AAA board of directors and shall be made available for review by DOEA staff upon request.

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ROLE OF THE AREA AGENCY ON AGING (AAA):

Each AAA is responsible for the following activities:

- A.** Planning, coordinating, administering, and assessing a comprehensive and coordinated system of services to older persons in the PSA. The AAA is limited to engaging in only those activities which are consistent with its statutory mission prescribed in the OAA or policies prescribed by the state, which is given authority and responsibility "to develop policies governing all aspects of programs operated under Part 1321 grants to state and community programs on aging" in 45 CFR, Parts 1321.11(a) and 1321.53.
- B.** Hiring qualified staff at sufficient capacity to develop the area plan and to perform the functions of an AAA as prescribed in federal and state regulations and in this handbook.
- C.** Selecting, administering, and evaluating a network of service provider agencies which are responsible for the provision of services to older persons. Specific objectives must be established by the AAA for providing services to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- D.** Ensuring the use of outreach efforts that will identify eligible individuals, with special emphasis on older individuals who have the greatest economic or social need, particularly low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- E.** Establishing priorities and methods for serving older persons with greatest economic or social need with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- F.** Conducting annual evaluations of the effectiveness of outreach efforts in reaching low-income minority persons and older persons living in rural areas.
- G.** Identifying, allocating and coordinating available resources to achieve the most effective program for older persons.
- H.** Developing program activities to provide the types of services most needed and provide them in the locations most appropriate to serve those older persons in greatest economic or social need.

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- I.** Conducting advocacy activities including:
 - 1.** Soliciting comments from the public on needs of older persons through public hearings.
 - 2.** Representing the interests of older persons to local officials and public and private agencies and organizations.
 - 3.** Monitoring, evaluating, and, where appropriate, commenting on all policies, programs, hearings, levies, and community actions which affect older persons.
 - 4.** Carrying out activities in support of the Long-Term Care Ombudsman Program in the PSA.
- J.** Engaging in efforts directed at furthering research projects or innovative approaches to service delivery.
- K.** Conducting outreach activities to identify older Indians in the PSAs and informing such older Indians of the availability of assistance under the OAA, if there is a significant population of older Indians in the PSA.

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DIRECT PROVISION OF SERVICE BY THE AREA AGENCY ON AGING (AAA):

- A.** Area Agencies on Aging will not directly provide supportive, nutrition, or in-home services, except as specifically approved by the Department.
 - 1.** Any AAA wishing to provide direct service must determine the basis for the exception by a review of Section 307(a)(8) OAA, and submit a written request for exception. Such requests for exception must:
 - a.** Include the basis for the exception which is either:
 - i.** Based on the need to assure an adequate supply of the service; and/or
 - ii.** Based on the service being directly related to the AAA's administrative functions; and/or
 - iii.** Based on the service being provided more economically, and with comparable quality, by the AAA
 - b.** Include verifiable evidence and documentation to support such a request for exception;
 - c.** Include precise measurable objectives for the proposed service;
 - d.** Include a plan for an objective economic evaluation of the exception, which will address a comparative analysis of the AAA provided direct services and equivalent services as rendered through a service provider agency;
 - e.** Be routed to DOEA; and
 - f.** Be approved by the DOEA in writing.
 - 2.** Approval by DOEA for an AAA to perform direct services will be valid for not more than one area plan cycle. During the cycle, the AAA must work with local service providers to develop the capacity to perform the service if the exception no longer meets the criteria cited in A 1 above.
- B.** Provision of direct services by the AAA will not be incorporated in the area plan without specific prior approval of the DOEA.

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POLICY ON AAA STAFFING AND ORGANIZATION:

- A.** Each AAA will have an active, functioning, policymaking board. For AAAs that are free-standing, private, non-profit agencies, this is the board of directors. For AAAs that are within a multipurpose agency, there must be an equivalent multi-member policymaking body.
- B.** Each member of the policy making board must reside and/or work in the PSA. The board of directors should be representative of all geographic areas of the PSA to the degree feasible.
- C.** Each AAA must have a qualified full-time employee designated as the AAA executive director, or an equivalent title. Section 20.41 (7) F.S. requires the AAAs appoint an executive director in consultation with the Secretary of the Department of Elder Affairs. The individual must have complete authority over staff and routine activities of the AAA. "Full-time" is defined as having no conflicting or competing duties, responsibilities, or assignments and a normal scheduled workweek of not less than 40 hours. "Qualified" is defined as meeting the education, experience, and training specified for the position. The following are minimum qualifications for the AAA executive director:
 - 1.** Bachelor's degree from an accredited college or university in public administration, social work, or a related academic area, with a minimum of five years of professional and/or administrative supervisory experience in social, economic, health, or rehabilitative services. A Master's degree can substitute for one year of the required work experience.
 - 2.** Professional or non-professional work experience may be substituted for the required college on a year for year basis.
 - 3.** Extensive experience in project management and/or community organization and planning related to elderly services is preferred.
- D.** Each AAA must have:
 - 1.** A qualified, full time person responsible for the financial activities of the AAA;
 - 2.** A qualified, full time person responsible for the program activities of the AAA;
 - 3.** A qualified person responsible for the planning activities of the AAA;

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4. A qualified person responsible for the monitoring activities of the AAA;
 5. A designated person responsible for the advocacy activities of the AAA; and a designated person for the Client Information and Registration Tracking System (CIRTS) administration.
- E.** The AAA is responsible for transmitting information about information and assistance and case management services to the Elder Helpline and other applicable agencies when such information is made known to the AAA. Each AAA must designate a resource staff person who is responsible for disseminating information. The information must be maintained in a current Information and Referral (I & R) directory and be available to Elder Helpline staff. The AAA must also list its agency in the area telephone directory under "Area Agency on Aging."
- F.** Each AAA is responsible for developing written documentation, approved by the board of directors, supporting each of these personnel requirements:
1. Job descriptions must be established for each position funded by Title III, OAA, and associated unpaid positions.
 2. The minimum education, training, experience, and qualifications necessary for each position must be established.
 3. A salary range for each position must be established. Salary ranges must be reasonably consistent with equivalent positions in state government (i.e., positions with similar duties and responsibilities and similar training, education, and experience qualifications).
 4. An approved organizational chart or charts illustrating the structure and relationship of positions, units, supervision, and functions must be developed.
 5. Personnel policies, which are incorporated into agency operating procedures, must be developed which address, at least, the following topics:
 - a. Employee recruitment and hiring;
 - b. Lines of authority and supervision;
 - c. Work schedules and hours of operation;
 - d. Employee compensation;

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- e.** Employee fringe benefits;
 - f.** Incentive compensation (2 CFR Part 230);
 - g.** Employee evaluation and promotion;
 - h.** Leave;
 - i.** Confidentiality and privacy;
 - j.** Employee discipline and termination;
 - k.** Employee grievance procedures;
 - l.** Accidents, safety, and unusual incidents;
 - m.** Transportation/travel;
 - n.** Employee conduct;
 - o.** Employee pre-service and in-service training and staff development;
and
 - p.** Procedures for selecting the AAA executive director.
- G.** Each AAA shall give preference to qualified persons age 60 and over when hiring to fill OAA-funded positions.

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AREA AGENCY ON AGING ADVISORY COUNCIL:

Advisory Council Requirements:

- A.** Each AAA must establish an advisory council to advise the AAA on matters relating to the development and coordination of services for older persons. .
 - 1.** The council shall advise the agency relative to:
 - a.** Developing and administering a DOE A approved area plan, and operations conducted under the plan;
 - b.** Conducting public hearings;
 - c.** Representing the interests of older persons; and
 - d.** Reviewing and commenting on community partner organization policies, programs, and actions that affect older persons with the intent of assuring maximum responsiveness to older persons.
 - 2.** **Council Composition:** The council shall include older individuals and representatives of older individuals who will enhance the role of the AAA in developing and administering a department-approved area plan. The advisory council shall be made up of:
 - a.** Older individuals, age 60 and older, including minority individuals and older individuals residing in rural areas who are clients or who are eligible to participate in OAA programs. (More than 50 percent of the membership must be 60 years of age or older);
 - b.** Family caregivers of individuals, age 60 and older, including minority individuals and older individuals residing in rural areas;
 - c.** Representatives of older individuals;
 - d.** Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);
 - e.** Representatives of supportive service provider organizations,
 - f.** Persons with leadership experience in the private and voluntary sectors;
 - g.** Local elected officials; and

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h. The public.

B. Review and Approval at the Local Level of the Multi-Year Area Plan:

- 1.** The AAA advisory council must have the opportunity to provide input into the development of the multi-year area plan. The signature of the advisory council chairperson is required prior to the plan's submission to DOEA.

C. Review and Approval at the Local Level of the Area Plan Update:

- 1.** The AAA advisory council must review and sign-off on the area plan annual update. The signature of the advisory council chair is required prior to the annual update's submission to DOEA.

D. The advisory council must review and approve the AAA's area plan as a prerequisite for the plan's submission to DOEA.

E. The AAA advisory council acts in an advisory capacity only, and is not authorized to establish policy or make decisions concerning the OAA, Title III program.

F. The following additional guidelines apply to the AAA advisory council:

- 1.** Membership selection should closely represent the demographics of the PSA. All counties in the PSA must be represented to the extent possible.
- 2.** The following individuals may not be voting members of the AAA advisory council:
 - a.** DOEA employees;
 - b.** AAA employees and members of the AAA's board of directors;
 - c.** Employees of service provider agencies under the area plan;

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- d.** Members of the boards of directors of service provider agencies operating under the area plan; and
 - e.** Immediate family members of an AAA employee (i.e., spouse, parent, grandparent, child, brother, or sister).
- 3.** In any instance where the AAA's advisory council membership conflicts with the preceding membership guidelines, the AAA must prohibit the identified member(s) from voting on any issue and act to comply with the guidelines within 90 days of discovery.
- 4.** The AAA's advisory council must develop, adopt, and maintain by-laws. These by-laws must be available to the public. They must, at a minimum, specify the purposes and procedures of the advisory council, the number of members, terms of membership, procedures for selection of members, and frequency of meetings. By-laws must also contain specific policies and procedures to identify and eliminate or reduce potential conflict of interest in council membership.
- 5.** AAA advisory council meetings must be held at least quarterly. Minutes of the proceedings of the meetings shall be accurately recorded, promptly transcribed, and distributed to the membership, including ex-officio members.
- 6.** Copies of the by-laws and minutes of advisory council meetings must be available for review by the Department and the public.
- 7.** Non-voting membership or ex-officio members may be chosen to provide technical expertise or broad program insight.

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PUBLIC INFORMATION:

Public Information Requirements - Each Area Agency on Aging (AAA) shall:

- A.** Develop a public information program that routinely provides the news media with information about programs, activities, and needs of older individuals throughout the PSA.
- B.** Ensure providers receive relevant information contained in policy, technical assistance, and informational issuances of the AAA and DOEA, including this handbook, fiscal administration manuals, and their revisions.
- C.** Adopt a policy of freedom of dissemination of information. The area plan, program and financial reports, and other documents not subject to confidentiality restrictions shall be available to the public for review upon request. All federal and state policies and procedures must also be available to the public for review upon request. Such information is to be available at reasonable times in the administrative offices of the AAA for review by interested persons upon specific request, including news media representatives. Each AAA must develop procedures for responding to requests for information under this policy.
- D.** Adopt procedures for responding to requests for copies of documentation. A reasonable amount, not to exceed the actual cost, may be charged for making copies to satisfy requests for information from outside the Florida aging network.
- E.** Provide positive program publicity at the AAA and provider levels to enhance community support of, and cooperation with the objectives of the OAA, Title III program.
- F.** Ensure that the public information policy maintains confidentiality regarding persons who are clients or applicants for services.

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***AAA ADVOCACY, PROGRAM DEVELOPMENT, OUTREACH AND LEADERSHIP
ROLE:***

Each AAA is statutorily mandated to represent the views, concerns, and interests of older persons with the greatest economic and social needs, with attention to low income minority older individuals within its geographic area of responsibility. The AAA must establish policies and procedures and execute its duties and responsibilities with due consideration for the views of older persons, groups representing older persons, elected officials, social, civic, and community organizations and agencies, as well as the public. The AAA must develop the area plan with reasonable opportunity for public input and must act to effectively obtain the views of older persons on the community's need for services. The AAA must also have procedures for prompt responses to requests for information from citizens, older persons, or media representatives. Specific responsibilities of the AAA for advocacy and program development are included in the OAA. It should be noted, however, that lobbying or political advocacy using federal funds is prohibited.

Program Development and Coordination Requirements—Each AAA shall:

- A.** Ensure, through management leadership activities, effective program development and coordination to ensure a more efficient, complete, and comprehensive service delivery system. These activities include technical assistance, training, advocacy, public information, inter-agency communication, community participation, and coalition building;
- B.** Establish cooperative agreements and understandings with community service agencies not under the area plan to extend, expand or improve services available to older persons;
- C.** Develop service provider agency capacity to perform services under the area plan efficiently, effectively and economically;
- D.** Plan realistic initiatives for program development and coordination, which will achieve measurable results within a defined time;
- E.** Establish, in accordance with the OAA, Section 306(a)(b)(H), effective procedures for coordination with specified federally-sponsored programs; and
- F.** Enter arrangements, as specified in the OAA, with organizations providing day care services for children to provide opportunities for older individuals to aid or assist, on a voluntary basis, in the delivery of such services to children.

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PROVIDER APPLICATION AND REVIEW PROCESS:

- A. Each AAA must establish written procedures for accepting applications for funding from current or potential service provider agencies.
- B. The Department will provide a standardized service provider application (SPA) to be used by AAAs to develop area-specific service provider applications. This application will incorporate the essential elements needed to support a contract under the area plan for OAA, Title III funding.
- C. Implement the approved area plan through contracts with service provider agencies.
- D. Establish written policies, procedures, criteria, and standards for purchasing and procurement of goods and services on an open and competitive basis.
- E. To obtain OAA, Title III funds to provide services under the area plan, an applicant agency shall submit a SPA or an equivalent proposal to the AAA, in accordance with directions provided by the AAA.

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- F.** Any local public agency or any private nonprofit agency or organization incorporated under the laws of the State of Florida is eligible to apply for OAA, Title III funding. Private, profit-making agencies are eligible to apply for OAA, Title III funding, but in accordance with Chapter 287, F.S., may not receive advance funding for contractual services. A regional or local agency of the state may not be a service provider under an area plan.
- G.** The framework for the SPA is developed by the Department and includes the basic requirements, instructions and formats for requesting funds to provide DOEAF-funded services administered by the AAA. The SPA is intended to serve as a guide for the AAA in the development of PSA-specific applications to address local needs and initiatives. Approval and oversight of the AAA's service provider application process is the responsibility of the AAA board of directors.
- H.** The minimum standards for handling service provider applications for funding under the area plan are as follows:
- 1.** The AAA must be responsive to requests for technical assistance concerning the application process on a basis that is fair to all applicants.
 - 2.** Applications received must be evaluated to ensure that they meet minimum criteria. Each application must include the following:
 - a.** A proposal of supportive or nutritional services consistent with the proposed area plan or Request for Proposal (RFP);
 - b.** Meaningful and realistic program objectives which comply with DOEAF minimum service standards and policies;
 - c.** A realistic plan on how the service needs of low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas will be met, ensuring that services will be provided to them in accordance with their needs, rather than in proportion to their percentage of the population served.
 - d.** incorporation of reasonable, necessary and allowable budget information in agreement with DOEAF grants accounting standards;
 - e.** A proposal including cost effective services in a defined geographic service area;

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- f.** A proposal including sufficient staff qualified by experience, education, and training to ensure proper and efficient program and fiscal accountability;
 - g.** Verifiable assurances that the providers' activities will be operated in accordance with OAA, Title III regulatory requirements; and
 - h.** Responsiveness to the instructions contained in the service provider application.
- 3.** The AAA will determine the number of copies to be submitted and whether the use of a "draft" application for prior review and critique will be required.
- 4.** The AAA will perform a critical review of each application accepted.
- 5.** Each applicant will be provided information regarding the discrepancies noted by a separate written critique.
- 6.** AAAs are urged to meet with the applicants to discuss the review and evaluation findings.
- 7.** In the event the AAA receives applications from more than one provider agency proposing to provide essentially the same services, the AAA may apply the following considerations in its evaluation process:
 - a.** Prior experience of the applicant in providing supportive or nutrition services for older persons;
 - b.** Extent of community support and local funding for the applicant; and
 - c.** Recommendation of the AAA advisory council because of a qualitative and quantitative review and comparison of all applicants.
- 8.** The AAA shall notify unsuccessful applicants and inform them of their right to obtain a hearing in accordance with procedures approved by the AAA's board of directors.
- 9.** In those cases, where the accepted application contains weaknesses, discrepancies, or omissions, the AAA will arrange a meeting with the potential provider agency. The AAA is responsible for coordinating and conducting the meeting. The AAA will clearly identify all revisions required to make the application "approvable" and ensure the service provider understands the requirements and time frame for accomplishment.

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- 10.** The service provider must complete all revisions noted by the AAA and respond within the negotiated time frame with a fully acceptable application.
- C.** The AAA is responsible for assuring that each application approved for OAA, Title III funding conforms to the applicable statutory and regulatory requirements.

Note: Approval of AAA contracts and policies and procedures is the responsibility of the AAA board of directors.

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REQUEST FOR PROPOSAL (RFP) AND INVITATION TO BID (ITB):

- A.** The AAAs must competitively bid contracts for DOEAF-funded services at least every six years in accordance with applicable state and/or federal regulations. The “Request for Proposal” or the “Invitation to Bid” may be used by the AAA to obtain proposals for purposes of gaining economy, efficiency and effectiveness in the delivery of services to older persons.
- B.** Each AAA shall have specific policies and written competitive solicitation procedures to ensure all interested agencies are offered a fair opportunity to submit responsive proposals. Approval and oversight of the AAA’s competitive solicitation process is the responsibility of the AAA board of directors.

TECHNICAL ASSISTANCE AND TRAINING:

AAA and DOEA Requirements Regarding Technical Assistance and Training:

- A.** Each AAA must provide an on-going program of technical assistance and training, both programmatic and financial, to service providers under the area plan. The AAA may provide technical assistance by verbal and written communications, during on-site visits, at training or workshop sessions, or during other conferences and meetings.
- B.** Each AAA must provide technical assistance to applicants, potential service providers, other agencies and organizations of the PSA, and the public concerned with the needs of older persons.
- C.** Technical assistance may result from specific requests or may result from an apparent need for such assistance based on reports, assessments, inquiries, or other information received by the AAA.
- D.** The AAA may request technical assistance from the Department in responding to policy issues and inquiries that cannot be addressed locally.
- E.** The AAA must develop an annual pre-service and in-service training plan. The plan must address topics appropriate to the AAA staff, board, advisory council and provider agencies. The required ADRC operations pre-service and in-service training may be incorporated into this annual training plan.
- F.** The AAA is required to offer at least quarterly training for new case managers of any DOEA-funded program. As applicable, the topics must include:
 - 1. DOEA Care Plan and Certification;
 - 2. Adult Protective Services (APS) Reporting Requirements;
 - 3. DOEA APS Referral Tracking Tool; and
 - 4. DOEA APS Referrals Operation Manual. Other training topics may include:
 - 1. DOEA Policy Notices and Transmittals;
 - 2. DOEA Programs and Services Handbook Overview;
 - 3. Aging Network Overview;
 - 4. CIRTIS Data Entry and Reporting Requirements;
 - 5. Record-Keeping Requirements; and
 - 6. Confidentiality Requirements.

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- G.** All aging network staff responsible for conducting screening and assessments using the Department Screening (701S), Condensed Assessment (701A), Congregate Meals Assessment (701C), and the Comprehensive Assessment (701B) must be trained and certified as required by DOEA policy.

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ENSURING QUALITY OF SERVICE:

AAA Requirements Regarding Quality of Service Provision:

- A.** Each AAA shall establish procedures to assure quality of services delivered. Service providers under the area plan must indicate in their application the methods to be used to assure delivery of high quality services. In addition to an internal evaluation and the use of management controls designed to verify the quantity, quality, economy, and appropriateness of service, each provider must establish procedures to solicit the views of older persons regarding services rendered.
- B.** Each AAA must determine the adequacy of the methods and procedures used by service providers to obtain the views of clients about the quality of service. The area plan is to include any standards, criteria, or specific procedures which are to be used by service providers in evaluating quality of service. The AAA may provide policy guidance to assure impartiality, anonymity, and adequacy of a service satisfaction sample. The AAA may also specify appropriate policy requiring service providers to measure evidence of service dissatisfaction. The AAA will monitor a service provider's methodology for determining client satisfaction.

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AAA COORDINATION WITH OTHER STATE/FEDERAL DOEA FUNDED PROGRAMS:

Each AAA must be aware of other state/federal programs, their activities and level of participation in the PSA. These programs include:

- A. Adult Care Food Program
- B. Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program.
- C. Emergency Home Energy Assistance for the Elderly Program (EHEAP)
- D. Local Services Program (LSP)
- E. Long-Term Care Ombudsman Program (LTCOP)
- F. Medicaid Home and Community-Based Services (HCBS) Programs
 - a. Statewide Medicaid Managed Care Long-term Care Program (SMMC LTC)
 - b. Program of All-Inclusive Care for the Elderly (PACE)
- G. Senior Community Service Employment Program (SCSEP) (OAA Title V)
- H. Senior Corps (Foster Grandparents, Senior Companion, and Retired Senior Volunteers), AmeriCorps, and Learn and Serve America.
- I. Serving Health Insurance Needs of Elders (SHINE) Program
- J. Office of Public and Professional Guardian (OPPG)

When coordinating with any of the programs listed above, the AAA shall illustrate in the area plan the services to be funded in the PSA. Planning for services in the PSA shall integrate the OAA and other DOEA-funded programs. For additional information see DOEA's Summary of Programs and Services.

AAA COORDINATION WITH TITLE V, OAA PROGRAM:

Each AAA must be aware of the SCSEP (OAA Title V) program, including the number and distribution of the subsidized positions in the PSA, and document the support provided to the aging network and the services supporting older persons that are attributable to the Title V, Senior Community Service Employment Program.

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SUPPORT FOR ELDERLY INDIVIDUALS WITH ALZHEIMER'S DISEASE AND RELATED MEMORY DISORDERS:

Each AAA must include initiatives relating to support for individuals with Alzheimer's disease and related memory disorders. The AAA must develop service provider capacity to support this initiative. Information regarding Florida's Alzheimer's Disease Initiative is contained in Chapter 5 of this Handbook.

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PURPOSE AND LEGAL AUTHORITY

This section provides policy guidelines applicable to service provider agencies under the OAA, Title III. Supplemental requirements for nutrition service providers are contained in Section 5 of this chapter. Special requirements applicable to acquisition, renovation, and construction grants for multipurpose service centers are contained in Section 9 of this chapter.

SPECIFIC LEGAL AUTHORITY:

Older Americans Act, Title III, Part A—General Provisions; Purpose; Administration, Sections 301 through 316 42 U.S.C. 3021 through 3030c-1

Older Americans Act, Title III, Part A, Section 306(a)(b)(H) 42 U.S.C. 3026

Older Americans Act, Title III, Part B, Section 321 42 U.S.C. 3030d

Older Americans Act, Title III, Part C, Subpart 1, Section 331 42 U.S.C. 3030e

Older Americans Act, Title III, Part C, Subpart 2, Sections 336, 337, 339 42 U.S.C. 3030e, f, g

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SERVICE ELIGIBILITY FOR OLDER AMERICANS ACT PROGRAMS:

The provider of a Title III, OAA service, is under obligation to ensure that each client receiving a service is eligible for the service. A brief description of eligibility criteria is provided in this section for selected services.

Recipient Eligibility Criteria:

- A. Title III B, Supportive Services**, require that service recipients be 60 years of age or older except for Information, Caregiver Training/Support, and Education/Training services, regardless of income, assets, or ability to pay. Although services are provided at no cost, voluntary contributions are accepted. Priority for services must be targeted to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- B. Title III C1, Congregate Meals** - Persons eligible to participate in the congregate meals program at no cost, with the opportunity to contribute to the cost of meals include:
 - 1.** Persons 60 years of age or older and their spouses of any age;
 - 2.** Disabled persons under 60 years of age who reside with persons over 60 years of age and accompany the eligible older client to the site;
 - 3.** Disabled persons under 60 years of age who reside in housing facilities occupied primarily by older persons and at which congregate nutrition services are provided, when the participation of such individuals does not pose a threat to the well-being of the older clients and when such participation does not prevent the participation of older persons and their spouses; and
 - 4.** Persons under 60 years of age on days they provide meal related volunteer services when the participation of such individuals does not prevent the participation of older persons and their spouses.

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- C. Title III C2, Home Delivered Meals**—Persons eligible to participate in the home delivered meals program at no cost, with the opportunity to contribute to the cost of meals include:
1. Persons age 60 years or older who are disabled, homebound, or isolated and who have no one available to aid with meal preparation.
 2. The spouse of the recipient, regardless of age or condition; and
 3. A disabled person under age 60 years who resides with an eligible client, whom the disabled person is dependent upon for care.
- D. Title III D, Disease Prevention and Health Promotion Services**
1. Persons 60 years of age or older.
 2. Services are targeted to persons residing in medically underserved areas.
- E. Title III E, National Family Caregiver Support Program**—Services are provided to family caregivers of older individuals who are 60 years of age or older and grandparents or older individuals who are relative caregivers of children not more than 18 years old or individuals with a disability. Grandparents or older individuals who are relative caregivers of children must be 55 years of age or older.
- F. Title VII, Vulnerable Elder Rights Protection Activities**- Elder abuse, neglect, and exploitation prevention services are delivered to individuals, regardless of age.

COUNTING PERSONS SERVED:

Methodology for Counting Persons Served:

- A. One of the more difficult concepts in service delivery for many providers is planning for and counting the persons served. This is because of two complicating factors – unduplicated persons and period of service. For the federal annual report, the time frame is October 1 through September 30, and the contract time frame is January 1 through December 31.
- B. Service provider agencies are expected to serve older persons of a county, multi-county area, or a community within a county. The service area contains a certain number of older persons. The service provider agency must know the relative impact being made in that service area. It is important to know whether provider programs and services are reaching 3% or 30% of the older persons in the service area. This factor is labeled as the number of unduplicated older persons served by the provider. There must be a beginning and ending point for counting these persons. The beginning may be calendar year, fiscal year, contract year or any other understood period. **Each person is counted only once during the period.** The number of unduplicated persons served by the provider is the number of different persons served, whether they obtain one unit of one service (e.g., one meal); many units of one service (e.g., many meals); or several units of multiple services (e.g., 240 hours of Homemaker service and 100 Home Delivered Meals). Counting begins anew when a new period starts (e.g., a new contract period).
- C. The concept of unduplicated persons is also applied to specific services. For service providers delivering multiple services, this means that planning for each service must include an estimate of the number of unduplicated older persons by each service during a given time. An example would be “Homemaker services will be provided over the year to 110 persons for 4,800 units of service (hours).”
- D. For most services the count of unduplicated persons increases rapidly early in the period, then the rate of increase reduces sharply. This contrasts with the number of units of service, which are relatively constant throughout the year. Note that adding the separate counts of “unduplicated persons” by each service is not a source to obtain information on the “unduplicated persons served by the provider.” Combining these separate counts of unduplicated persons will not provide the correct count for the provider agency because the same individual is likely to receive multiple services.

SERVICE STANDARDS:

Service Standard Requirements:

- A.** For each service, there is a service standard which prescribes the quality requirements and performance criteria applicable to the services. These standards are contained in Appendix A of this handbook. Additional Title III C standards are in Section 5 of this chapter. Each service standard includes a definition of the service, unit of service, goal of service, and standards for the service.
- B.** Program, fiscal, contract review, or monitoring/quality assurance visits may involve a review of local procedures and activities to assure that minimum service standards are understood by service provider staff and that each service delivered meets or exceeds the quality standards expected.

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REVIEW OF AREA PLAN:

- A. Each service provider agency must be knowledgeable regarding the concepts and planning factors contained in the AAA's area plan for the PSA.
- B. Providers must deliver services in accordance with the area plan.
- C. Providers should attend public hearings on the area plan and express their views regarding its contents. This helps to ensure that the area plan represents the best approach to a comprehensive and coordinated system of service delivery to older persons.

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COMMUNITY SUPPORT:

Community Support Standards:

- A.** One of the unique features of the OAA, Title III program is the deliberate intent to involve community participation in all aspects of service. Each service provider must be able to document community support and participation in the planning and delivery of services.
- B.** Community support includes, but is not limited to, the following:
 - 1.** Inviting the public's input into local service delivery planning efforts;
 - 2.** Volunteer recruitment efforts; and
 - 3.** Soliciting local government officials and the private sector for cash and in-kind contributions to support programs and services.

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BUILDING COMMUNITY SERVICE SYSTEMS:

Improvement and Expansion of Services Available to Older Persons:

- A.** OAA, Title III providers shall try to improve and expand the services available to older persons. One method of accomplishing this task is to obtain additional sources of funding for services, such as discretionary grants for specific service, research, training, or demonstration projects. Grant funding may be available from private charitable foundations or other public programs. Service providers should be alert for such opportunities and submit responsive proposals.
- B.** In those instances, where the OAA, Title III service provider is not the CCE program provider, operating procedures shall be established to ensure coordinated service delivery at the community level. Each OAA, Title III provider shall have arrangements for individual referrals between agencies and for cooperative agreements to ensure that there is no overlapping of service responsibilities or duplication of effort in services to the frail elderly.
- C.** Each OAA, Title III service provider shall also have cooperative arrangements with community mental health provider agencies for appropriate linkages and referrals of older persons.
- D.** Each OAA, Title III service provider shall be responsive to CARES and Department of Children and Families staff involved in SSI-related services and adult protective services.
- E.** Each OAA, Title III service provider shall function as an advocate for the elderly in the community.
- F.** Each OAA, Title III service provider shall also function as a focal point for the concerns of older persons in inter-agency coalitions developed to stimulate community change (e.g., housing, zoning, transportation, health care planning, and accessibility for persons with disabilities).

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ASSESSMENT OF COMMUNITY SERVICE NEED:

- A.** The AAA is responsible for comprehensive planning to meet the needs of elders in the PSA. Each service provider has an obligation to identify and report unmet needs, analyze service delivery, and offer constructive comments or suggestions to the AAA. An efficient, effective and economical service delivery system can be developed through this shared responsibility.
- B.** Each service provider must be thoroughly informed about the needs in the community for services to older persons, both in quantitative and qualitative terms. The AAA is a source of statistical, demographic, and needs indicator information. In many instances, service provider agencies may also perform needs assessment surveys or obtain information from waiting lists, key informants, and public input. Studies done by public planning agencies, community service agencies, or commercially oriented information sources such as the chamber of commerce may be of use. The service provider should use research from a variety of sources so that community needs can be assessed from several viewpoints.
- C.** Service providers must plan service delivery based on sound, factual data-making informed judgments about service needs in the community using accurate descriptions of existing resources, and forecasts of future trends. The service providers' assessments of community need for services to older persons should explain why certain services are necessary and confirm the AAA's analysis of need.

SERVICE DELIVERY STRATEGIES and TARGETING OBJECTIVES:

- A.** Each service provider must be able to assess service needs in the community, analyze possible responses to the current service need, and develop a service delivery strategy based on the most effective use of available resources.
- B.** In developing a strategy for service delivery, service providers must analyze how service delivery can be provided most successfully. The provider should consider such basic concepts as single or multiple service sites and in-home service delivery or service delivery at an operating site or senior center (or combinations of these methods). Some services require specialized training or licensing for provider staff while other services can use volunteers with only limited training. Some services may require an approved facility (e.g., Adult Day Care); other services may require access to transportation and escorting services to be feasible (e.g., Congregate Meals). Efforts by the provider at the strategy stage can be a solid basis for cost effective and efficient service delivery.

Selection of Specific Services to be Offered:

- A.** After assessing service needs of the community and carefully developing the strategy of service delivery, the service provider must consult with the AAA to determine the specific services that are to be offered in the community. There must be a rationale for selecting the services to be offered; and, by the same token, each service provider must have a basis for deciding which services are not to be available and a reasonable explanation why they are not available. This step involves the hard decisions necessary to maximize the impact of the limited public programs available for services to older persons. Service providers must address the basic decision of providing a wide or narrow range of services for older persons. A wide range of various services allows the service provider to offer a continuum of services, but, only a limited quantity or frequency of each service. A narrow range of services permits a greater impact, more intensity or more frequent services, but offers few service options.
- B.** In planning the array of services to be offered, service providers must be able to justify the rationale for selecting which services will be available. This is the process of finding the best service array for the provider, the community and for older persons. These difficult decisions involve both the AAA and the service provider working together. The service array decisions should be based on sound logical analysis, and should be periodically reviewed to assure that the choices in effect are still clearly the best options for that specific community and service provider.

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- C. Each service provider in consultation with the AAA must set a specific targeting objective for the provision of services to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for services rather than in proportion to their percentage of the population. The targeting objective shall specify the number of individuals in these groups to be served on an annual basis.

ALLOCATION OF RESOURCES:

Allocation of Resources Requirements:

- A.** The allocation of resources is the responsibility of the service provider. It is understood, however, that the AAA will be accountable for final decisions in these matters.
- B.** Each service provider has a limited amount of resources to be used for service delivery. After selecting the service array, the next decision is to allocate resources, at least tentatively, for maximum benefit and impact.
- C.** The resource allocation activity also involves decisions as to the number, qualifications and training necessary to ensure adequate staff is available for service delivery.

SERVICE PREFERENCE AND ASSESSMENT OF INDIVIDUAL NEEDS:**Service Preference and Individual Needs Assessment:**

- A. Statutory Requirement:** Service preference in OAA, Title III programs refers to the statutory requirement that services will be provided to older individuals with preference given to those with greatest economic and/or social needs. Attention shall be given to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. They shall be served in accordance with their need for service instead of their proportion in the population. Service providers should consider the following in serving targeted populations:

1. Targeted community outreach;
2. Strategic location of service sites;
3. Specialization in types and methods of services offered; and
4. Selection of responsive and sensitive staff.

In areas where a substantial number of persons are of limited English proficiency, the services of workers who are fluent in the language spoken by a predominant number of such older individuals (Spanish, Creole, etc.) shall be provided. In addition, the AAA shall ensure that assistance is made available to older individuals with limited English proficiency to facilitate their access to and participation in services under Title III. The AAA shall also provide guidance to providers under the area plan on awareness of cultural sensitivities, considering linguistic and cultural differences.

- B. Local Procedures:** Each service provider, in its application, must describe the local methods and procedures for carrying out the statutory and area plan requirement for giving preference to those older persons of greatest economic or social need, with special attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- C. Intake Process:** Older persons referred for services or who request services shall be screened by service provider during an intake process. The screening process is intended to ensure that the targeted populations are given preference without excluding others from participating in service to the extent services are available.

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- D. Evaluation of Economic and/or Social Status:** A service provider must evaluate an individual's economic or social status in a non-threatening, non-invasive manner, and with the utmost respect for an individual's right to privacy. Service providers must devote special attention to the selection and training of staff assigned to perform this function. The intake procedures must be non-discriminatory, appropriate to determine the individual's need and priority to services, and applied consistently to all applicants. The intake process must be flexible enough to adapt to a homebound person; a patient awaiting hospital discharge; persons of widely varying ethnic, cultural, and language characteristics; or persons with widely varying disabilities.
- E. Prioritization of Individuals:** Staff should use expertise and sound judgment in prioritizing individuals. It may be appropriate during the screening/intake interview to inquire about sources of income, levels of financial resources, and informal support systems to explore eligibility for other types of economic or supportive services, such as Food Stamps, Supplemental Security Income, Medicaid, low-income housing, or Low-Income Home Energy Assistance programs.
- F. Preference for Services:** Preference for services may be given to those persons of greatest social or economic need, with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas if the service is available and appropriate to the specific needs of the individual. The service provider may limit or restrict services, even to individuals who are judged to be in a group to receive preference, if the service is not deemed necessary or appropriate. For example, not all persons of greatest economic or social need should be provided such in-home services as homemaker or home-delivered meals.
- G. Asset, Income, and Contributions Prohibition:** Service providers are cautioned that decisions regarding service provision cannot be based on a determination of assets or income, nor on a required amount or frequency of contributions.
- H. Discretionary Service Provision:** The service provider may perform or deliver services to the extent of the agency resources and service capacity for those individuals judged to need services, but who do not qualify for preference in service delivery. If there is no availability of a specific service, the provider should refer the person to another community resource, or utilize an assessed consumer prioritization list, if appropriate.

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- I. **Timely Assessment of Need for Services:** Each service provider must have reasonable local procedures to handle requests for service based on urgent need (e.g., discharge from a hospital to home) and a methodology for timely assessment of the need for services.

- J. **Procedure for Handling Clients with Special Behaviors:** Each service provider must have reasonable, written local procedures to handle situations involving unruly, disruptive, abusive or belligerent persons receiving services. The local procedures should ensure that the rights of all individuals are protected and that services are delivered in a non-discriminatory manner. An advisory council may provide the appropriate mechanism to make recommendations in these situations.

SUBCONTRACTS FOR SERVICES:

Subcontracting Requirements:

- A.** The AAA may allow a service provider under the area plan to subcontract with another agency to deliver one or more specific service(s).
- B.** Service providers are responsible for exercising independent judgment in the selection of the subcontractor that can best meet the service needs of the older persons within the service area.
- C.** As required under the area plan, the service provider, as the prime contractor, must perform the following tasks prior to subcontracting for specific services:
 - 1.** Identify in the provider application the intention to subcontract one or more specific services, identify the service(s) to be subcontracted, the amount of funds dedicated to subcontracted services, and the units of service to be provided by the subcontractor.
 - 2.** Adhere to the policies of the AAA regarding competitive bidding or non- competitive negotiations. Competitive procurement must be conducted a minimum of every six years.
 - 3.** Resolve, to the satisfaction of the AAA, the following requirements:
 - a.** Non-federal financial participation;
 - b.** Methodology for contributions;
 - c.** Methodology for reporting the number of unduplicated persons and units of service;
 - d.** Methodology for CIRTS reporting; and
 - e.** Audit trail for financial transactions.
- D.** If the service provider intends to subcontract with a profit-making organization, prior approval must be obtained from the AAA before contract execution.

REFERRALS FOR SERVICES:

Service Provider Requirements:

- A. Knowledge of Available Services:** Service provider agencies must be aware of the service array available in the community from both public and private agencies and organizations.
- B. Inability to Provide Services:** When an older person cannot be served because of the nature of the service need or the lack of service capacity within the provider's available resources, efforts shall be made to offer an appropriate referral to another agency.
- C. ELDER HELPLINE:** When a service provider receives a referral from the ELDER HELPLINE, the provider shall respond to that referral within 14 business days or sooner, as established in the service provider's policies and procedures, in an effective, and appropriate manner.

ORGANIZING THE AGENCY:

Service Provider Agency Organization Requirements:

- A. Nonprofit, Charitable Agencies:** Service provider agencies, if not public agencies, must be incorporated under the laws of Florida. Throughout the remainder of this section, the usage will refer to a service provider as if it were a nonprofit, charitable agency.

Public or For-Profit Agencies: For service providers that are public agencies or profit-making agencies, it is understood that the general policies expressed may in some cases require adaptation depending on the type of agency.

- B. Incorporation:** Incorporation requires that a charter, board of directors and by-laws be developed and application for incorporation be made to the Secretary of State. To retain status as a corporation, an annual report must be filed, and a fee paid to the Secretary of State.
- C. IRS Tax Code:** Nonprofit agencies should seek recognition from the Internal Revenue Service under Section 501C (3) of the IRS Tax Code as charitable organizations.
- D. Board of Directors:** The recruitment and selection of a well-qualified, highly motivated, and broadly representative board of directors is crucial to the effectiveness of the service provider agency. Members of the board of directors are ultimately responsible for the success or failure of the enterprise. Their expertise and qualifications should encompass a wide range of business management, administrative, and technical skills.
- E. Organizational Structure:** The organizational structure of the OAA, Title III service provider agency should be determined and displayed on one or more organizational charts. These are sketches or diagrams, which show lines of authority and responsibility from the board of directors. Organizational charts should also delineate all job titles and positions including unpaid volunteers, the advisory council, lines of supervision, and any coordination linkages within the organization.

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- F. Principle Person Responsible:** Each service provider's board of directors must establish procedures for selection of the principal person responsible for accomplishment of service under the area plan. Qualifications will be disclosed in the written personnel policies as required in the service provider application. **NOTE:** The term "Executive Director" used in this chapter refers to the principal person responsible for the OAA, Title III program, unless the context indicates otherwise.
- G. Oversight Responsibility:** Each AAA will have oversight responsibilities regarding the required qualifications, the selection process, and the ultimate selection of any executive director with responsibility for OAA, Title III service delivery under the area plan. Oversight refers to supervision and review of the qualifications and selection process. The AAA's oversight responsibility also applies to a reviewing the qualifications of the executive director when a new service provider agency under the area plan is selected.
- H. Acting Executive Director:** At any time, there is a vacancy for an executive director, the service provider must delegate an "acting" executive director. An "acting" executive director may not serve for **more than 120 calendar days** without prior written approval of the AAA.
- I. Executive Director Compensation:** The AAA must establish a consistent and uniformly applied policy limiting the salary range of the executive director to be paid with OAA, Title III funds.

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PERSONNEL POLICIES:

Service Provider Personnel Policies Requirements:

- A. Written Personnel Policies:** Each service provider must develop written personnel policies covering, at least, the topics identified in the provider application. These policies must receive approval of the board of directors (or equivalent policy- making board).
- B. Current Personnel Policies:** Personnel policies must be current and may be prepared and published in booklet form. Personnel policies will be adhered to in all activities and practices of the agency.
- C. Employee Benefits:** The benefits and privileges available to employees including “fringe benefits” must be explicitly stated in the written personnel policies.
- D. Continuity of Care:** Each service provider will ensure that personnel policies do not have an adverse impact on the availability of supportive and nutrition services during holiday periods.

STAFF POSITION DESCRIPTIONS AND QUALIFICATIONS:

Service Provider Staff Descriptions and Qualifications Requirements:

- A. Written Job Descriptions:** Each service provider must develop written job descriptions for each position used in service delivery in the OAA, Title III program, including unpaid (volunteer) positions. Each job description should include the following elements:
1. Job title;
 2. Position description;
 3. List of duties;
 4. Identification of how the position is supervised and by whom;
 5. Identification of other lines of authority; and
 6. Minimum training, education, and experience required.
- B. Functions, Responsibilities, and Tasks:** All significant functions, responsibilities, and tasks to be undertaken by the service agency must be allocated to specific position descriptions.
- C. Salary Pay Range:** Each position paid by OAA, Title III funds must have a written salary/wage pay range giving minimum and maximum amounts. The salary/wage range must be reasonably related to the training, education, experience, and responsibilities for the position. The salary/wage range documentation must be approved by the board of directors (or equivalent policy making board) and must be used in planning the provider budget information.
- D. Consideration of Older Workers:** When preparing the minimum training, education, and experience portion of a position description, service providers are urged to develop the requirements so that older workers may qualify for employment based on experience rather than formal education or specific training.

STAFF SELECTION, TRAINING AND EVALUATION:

Staff Selection, Training and Evaluation Requirements:

- A. Staff Recruitment:** Recruiting, hiring, and retaining qualified staff to fill the positions represented by the written job descriptions is the responsibility of each service provider.
- B. Training and Staff Development:** Training and staff development is a major function of each service provider. In the service provider application, there must be a staff development and training plan to address the full range of training needs for the OAA, Title III program. All new staff will need at least a brief orientation to the agency, its community role, its service and resource development activities, and its staff functions. Certain activities will require new employees to undergo pre-service training or supervised training on-the-job prior to assumption of job responsibilities. Regular ongoing in-service training needs will vary with the provider's activities and the services being offered. Training workshops and activities must be documented in employees' files.
- C. Employee Performance:** Each service provider must have a methodology for evaluating employee performance at least annually. Evaluations must be documented and kept confidential.
- D. Non-discrimination Requirements:** Each service provider must ensure that employment practices are in accordance with non-discrimination requirements.

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MANAGING SERVICE PROVIDER ACTIVITIES:

Service Provider Management Activities:

- A. Written Operating Procedures:** Each service provider must have clearly written operating procedures to guide staff, including volunteers, in their tasks of delivering services.
- B. Insurance Coverage:** Each service provider must obtain reasonable and adequate insurance, including general liability coverage, directors and officer's insurance and worker's compensation insurance. The board of directors shall determine the types of insurance coverage and amounts based on the functions and activities of the agency and prudent business judgment.
- C. Bond Coverage:** Each service provider must obtain bonding coverage for individuals who handle cash or cash equivalent in the performance of their assigned tasks.
- D. Financial and Compliance Audit:** Each service provider under OAA, Title III must obtain the services of an independent auditor for a financial and compliance audit.
- E. Record Retention:** Each service provider must act to assure that all program, financial, and property records, supporting documents, statistical reports and other documentation pertaining to OAA, Title III funding will be retained for a period of six years after termination of the annual contract. If an audit has been initiated and the audit findings not resolved at the end of six years, the records must be retained until resolution of the audit findings.
- F. Record Transfer to AAA:** Each service provider must transfer all current and prior years' program, financial and property records to the AAA in the event of suspension, termination, or non-renewal of funding to the service provider agency.
- G. Record Disposal:** Disposal of records after the six years' retention period will be in accordance with the state and federal policies and procedures approved by the AAA, as applicable.
- H. Licensure Requirements:** Service providers must fully comply with all applicable state and local licensure, health, fire safety, and sanitation requirements.

DATA COLLECTION AND REPORTING:

Data Collection and Reporting Requirements—Each Service Provider Must:

- A. Promulgate** clear and adequate procedures to collect information and compile reports. Accurate, verifiable information is essential for program, financial and client reporting.
- B. Retain** records in enough detail to record services performed, expenditures made, and clients served. Reports submitted must be timely, accurate, and verifiable.

MEASURING RESULTS AND MAKING ADJUSTMENTS:

- A. Self-Assessment:** Service providers should frequently compare actual units of service delivered with planned units of service and compare planned number of unduplicated persons with actual number of unduplicated persons served. This tracking of units and unduplicated persons, by service, is to ascertain that the projections made in the application were realistic and that service levels are appropriate.
- B. Optimum Level of Service Delivery:** Each service provider is accountable for the optimum level of service delivery and must ensure that levels of service delivery are reasonably uniform throughout the year (or contract period).
- C. High Level of Service Delivery:** A high level of service delivery early in the period, which cannot be sustained, may cause a reduction in service availability late in the period. The reduced service level may result in anxiety, frustration and potential harm to older persons receiving services.
- D. Low Level of Service Delivery:** Low levels of service delivery at the onset, building to excessive levels at the end of the period, are a poor use of resources and an indicator of poor management practices. This situation may result in having clients who have demonstrated needs being unable to obtain services.
- E. Seasonal Fluctuations:** Many service providers do experience seasonal fluctuations in levels of service delivery. However, care must be taken not to utilize resources inefficiently in low service delivery periods or develop unrealistic service expectations in peak periods.

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- F. Tracking Actual Performance:** Service providers shall track actual performance and propose adjustments to the AAA.

Adjustments: Adjustments may be necessitated by the following changes in circumstances:

1. Priority of needs for service (e.g., greater need for Homemaker than anticipated due to high number of hospital discharges);
2. Unavailability of local resources, such as trained, qualified staff to perform the service (e.g., vacancies for Home Health Aide, or extended sick leave for the staff person doing Counseling);
3. Financial resource allocation (e.g., increased costs for Transportation, unplanned use of paid staff for Home Delivered Meals); or
4. Environmental factors (e.g., loss of donated meal site for Congregate Meals or weather conditions reducing attendance at Congregate Meals).

- G. Technical Assistance:** After the service provider has determined the causes of over/under service utilization, appropriate adjustments within funding, staff, and management resources available to the service provider, technical assistance should be requested from the AAA concerning the revision of service objectives.

- H Management Cycle:** Service provider agencies must complete the management cycle by utilizing actual performance information as a starting point for developing the service provider application for succeeding years.

- I. Management of Financial Affairs:** The service provider must manage the agency's financial affairs so that expenditure of OAA, Title III funds is at a rate commensurate with service delivery. Each service provider, working with the AAA, must ensure the optimal use of OAA funds to meet the needs of elders.

VOLUNTEER SERVICE:

Use of Volunteers and SCSEP Participants:

- A. Maximization of Volunteers:** Each service provider can maximize its service delivery capacity using volunteer resources. Non-profit agencies will need the services of dedicated volunteers to serve on the board of directors and any local citizens' advisory council. Volunteers may be recruited, trained, and utilized in many roles within the service delivery system.
- B. Volunteer Resources:** Service provider agencies should plan and develop volunteer resources. This requires a concerted effort to:
1. Develop jobs/duties suitable for volunteers;
 2. Recruit and provide orientation to volunteers with appropriate interview and placement activities;
 3. Provide pre-service training, on-the-job training, and annual in-service training;
 4. Training on prevention of elder abuse, neglect, and exploitation, shall be included during the initial training session;
 5. Provide supervision;
 6. Evaluate the volunteer's performance; and
 7. Provide appropriate recognition.

Volunteer activities should be recorded and quantified into hours and value to the provider agency. When calculating the dollar value for volunteer hours, the hourly rate published by the independent sector should be used as a standard.

- C. SCSEP Workers:** When possible, work with the local Senior Community Service Employment Program (SCSEP) by serving as a host site for program participants.
- D. Volunteer Activity Report:** Area Agencies on Aging are required to submit an OAA Annual Volunteer Activity Report (VAR) electronically. Service provider agencies shall request and receive technical assistance from AAA for the VAR. The Department of Elder Affairs Office of Volunteer & Community Services (OVCS) is available to provide additional interpretation if needed. The AAA should forward the request to OVCS for review and a response.

DETERMINING CLIENT SATISFACTION:

Client Satisfaction:

- A. Service Delivery and Quality Goals:** The underlying goal of service delivery is to meet the need of the older person for supportive and nutrition services. The ultimate test for service quality is the level of client satisfaction with the service as delivered, and whether the older person's perceived need for service is being met.
- B. Determining Client Satisfaction:** Each service provider must have a mechanism for objectively determining the level of client satisfaction or dissatisfaction with the services delivered. Each service provider must indicate in the service provider application the methods to be used to ensure a high level of participation in determining satisfaction with the services delivered. Such methods may include the following:
1. Suggestion boxes;
 2. Client interviews;
 3. Surveys;
 4. Questionnaires;
 5. Agency or site visits;
 6. Advisory councils;
 7. Public meetings; and
 8. Other methods for obtaining feedback on quality of services.

Strengths and Weaknesses of Survey Methodology: Service providers should be knowledgeable about the strengths and weaknesses of each of the survey methods undertaken.

Evidence of Client Dissatisfaction: Service providers should be alert for evidence of "dissatisfaction" with services delivered (e.g., anonymous complaints, "no-shows," service drop-outs, and, in the nutrition program, plate waste).

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Special Efforts to Determine Client Satisfaction: Any method for obtaining views of older persons must recognize the special needs of individuals who are homebound, hearing or visually impaired, mobility challenged, or those affected by language, ethnic, or cultural barriers. Special efforts must be undertaken to include representation from these groups in surveys.

- C. Sample Survey Requirement:** Each service provider is required to periodically and systematically survey a sample of older persons being served to objectively determine the level of client satisfaction. The information obtained is to be used to improve services and must be made available to AAA monitoring staff as requested.
- D. Advisory Council:** Service providers with multiple service sites are encouraged to create an advisory council, inclusive of older people, to advise on matters concerning service delivery and advocate on behalf of older persons in the community. Client satisfaction results shall be reviewed by the service provider's advisory council. Based on these reviews, the advisory council should make any necessary recommendations to improve Title III services

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DOCUMENTATION AND REPORTING OF UNUSUAL INCIDENTS:

Unusual Incident Reporting and Documentation Requirements—Each AAA and Service Provider shall:

- A.** Notify the Department immediately but no later than forty-eight (48) hours from the Contractor's awareness or discovery of conditions that may materially affect the Contractor's or Subcontractors ability to perform the services required to be performed. Such notice shall be made orally to the Department's Contract Manager (by telephone) with an email to immediately follow *including the Contractor's plan for provision of services*.
- B.** Maintain files on unusual incidents (e.g., an accident, exposure to bloodborne pathogens, injury, illness, altercation involving services or clients, and other reportable conditions as specified by the Department by contract);
- C.** Have written procedures to investigate, report, and record unusual incidents;
- D.** The Contractor shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96-ABUSE). As required by Chapters 39 and 415, F.S., this provision is binding upon the Contractor, Subcontractors, and their employees.
- E.** The reporting requirements are associated with any conditions that may materially affect the Contractors or Subcontractors ability to perform the services required to be performed. Such conditions include, but are not limited to the following:
 - Meal site closure or suspension of services;
 - Provider terminations; or
 - Building or service site issues.

These incident reporting requirements are in addition to the requirements set forth by Chapters 39 and 415, F.S., related to "professionally mandatory reporters" and the required reporting of suspected abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline.

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SUPPORTIVE SERVICES:

This section sets forth the OAA requirements for Title IIIB supportive services. Title IIIB supportive services are defined in Appendix A, Service Descriptions and Standards.

PURPOSE AND LEGAL AUTHORITY:

Supportive Services Requirements:

- A. Priority Supportive Services:** The Older Americans Act requires each state to ensure that an adequate proportion of the amount allocated to a PSA for OAA, Title IIIB supportive services be expended to deliver the following three categories of service:
- 1. Access Services:** Services such as Transportation, Outreach, Information and Referral, and Case Management;
 - 2. In-home Services:** Services including Homemaker, Home Health Aide, Home Repair, Companionship, Telephone Reassurance, Chore, Respite and other supportive services for families of elderly victims of Alzheimer's disease and other neurological and organic brain disorders of the Alzheimer's type; and
 - 3. Legal Assistance:** The area plan must contain assurances that AAAs will give priority to legal assistance related to income, health care, long term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.
- B.** The AAA must award Title IIIB supportive service dollars to fund the priority areas in Part A above within the PSA in the following minimum funding percentages:
- 1.** Access Services - 20 percent
 - 2.** In-home Services - 8 percent
 - 3.** Legal Assistance - 1 percent
- C.** DOEA may waive the percentage funding requirement in Part B above if the AAA demonstrates that services being furnished in the area are sufficient to meet the need. The procedures required for waiver are set forth in the OAA Section 306(b)(2)(A) through (D).

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- D.** Other services the area agencies may support with Title IIIB funds include the following:
- 1.** Companionship, Counseling, Emergency Alert Response System, Education/Training, Employment, Escort, Housing Improvement, Health Support, Interpreting/Translation, Material Aid, Recreation, Shopping Assistance, or Telephone Reassurance.
 - 2.** Case Management for clients requiring in-home and community-based services such as Adult Day Care, Chore, Homemaker, Home Health Aide, Personal Care, Respite, or Therapies.
 - 3.** Acquisition, alteration, renovation, or construction of facilities to serve as multipurpose senior centers.

Legal Authority:

Older Americans Act, Title III Grants for State and Community Programs on Aging; Part B—Supportive Services and Senior Centers, Section 321

Older Americans Act, Title III, Part B, Section 306(b)(2)(A) through

(D) 42 U.S.C. 3030d

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NUTRITION PROGRAM POLICIES

Purpose:: To set forth policies and procedures governing the operations of nutrition services under Title IIIC of the OAA.

Purpose of Nutrition Awards or Contracts: The AAA may award nutrition service funds received under Title IIIC for the provision of nutrition services that assist older individuals in Florida to live independently, with better health through improved nutrition and reduced isolation. Nutrition services are provided through programs coordinated with nutrition-related supportive services and include the procurement, preparation, transport, and service of meals; nutrition education; nutrition screening; nutritional assessment, and nutrition counseling. In making these awards, the AAA must ensure that congregate and home-delivered meals are provided to eligible individuals based on their assessment of need.

LEGAL BASIS: The legal basis for Title IIIC nutrition programs is found in the OAA of 1965, as amended, Title III Grants for State and Community Programs on Aging; Part C, Nutrition Programs.

SPECIFIC LEGAL AUTHORITY:

Older Americans Act, Title IIIC Subpart 1, Section 331 42 U.S.C. 3030e

Older Americans Act, Title IIIC, Subpart 2, Sections 336, 337, 339 42 U.S.C. 3030f, g, g-21

The National Nutrition Monitoring and Related Research Act of 1990 (Public Law 101- 445)

U.S. Department of Health and Human Services Public Health Service Food and Drug Administration, Food Code

<http://www.fda.gov/food/foodsafety/retailfoodprotection/foodcode/default.htm>

U.S. Department of Agriculture (<http://www.usda.gov>)

Americans with Disabilities Act – 42 U.S.C. 12101

Healthy People 2020 (<http://www.healthypeople.gov/>)

Dietary Guidelines (<http://www.health.gov/dietaryguidelines>) Chapter 509.039, Florida Statutes – Food Manager Certification

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SPECIFIC LEGAL AUTHORITY:

Older Americans Act, Title IIIC Subpart 1, Section 331 42 U.S.C. 3030e

Older Americans Act, Title IIIC, Subpart 2, Sections 336, 337, 339 42 U.S.C. 3030f, g, g-21

The National Nutrition Monitoring and Related Research Act of 1990 (Public Law 101- 445)

U.S. Department of Health and Human Services Public Health Service Food and Drug Administration, Food Code
<http://www.fda.gov/food/foodsafety/retailfoodprotection/foodcode/default.htm>

U.S. Department of Agriculture (<http://www.usda.gov>)

Americans with Disabilities Act – 42 U.S.C. 12101

Healthy People 2020 (<http://www.healthypeople.gov/>)

Dietary Guidelines (<http://www.health.gov/dietaryguidelines>)

Chapter 509.039, Florida Statutes – Food Manager Certification

Chapter 64E-11, Florida Administrative Code - Food Hygiene

Chapter 468.509 Florida Statutes - Dietitians/Nutritionist

Chapter 64B8 Florida Administrative Code – Dietitians/Nutritionist

DASH Diet (<http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/index.htm>)

SELECTION OF NUTRITION PROGRAM SERVICE PROVIDERS:

Selection Criteria:

A. General Rules:

1. An AAA may make awards for congregate and home-delivered nutrition services to a provider that furnishes either or both services. Providers must meet the requirements of this part.
2. Contracts are awarded through a competitive process. Such process shall include evaluation of each bidder's experience in providing services to older individuals.

B. Existing Congregate and Home-Delivered Nutrition Program Providers:

Each AAA will give primary consideration where feasible, in contracting for the provision of congregate and home delivered meals to organizations which:

1. Have demonstrated an ability to provide quality congregate and home delivered meals efficiently and reasonably; and
2. Have furnished assurances to the AAA that the organization will maintain efforts to solicit voluntary support and that funds made available under this title to the organization will not be used to supplant funds from non-federal sources.
3. Make every attempt to efficiently and responsibly meet the cultural and/or ethnic culinary needs of participants of congregate and home delivered meals.

C. Service Area and Selection of Nutrition Providers:

Each nutrition service provider under an area plan shall operate within the boundaries of the area established in the award document. A nutrition service area must be of sufficient size for:

1. Economical delivery of meals;
2. Efficient provision of nutrition education, outreach, nutrition counseling; and
3. Coordination and linkage of nutrition activities with related services programs in the service area.

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D. Selection of Nutrition Providers within a Service Area: Awards shall be made to congregate nutrition service providers serving an annual average of at least 100 meals per day, five or more days a week within the designated service area, but not necessarily at each site.

1. AAA approved exceptions for providers operating in sparsely populated rural areas include:

Provision of:

- a. Less than 100 meals per day; and
- b. Meals at least five days a week at sites throughout the service area, but not necessarily five days a week at each site.

NOTE: Providers operating in a sparsely populated rural area must provide outreach as set forth in this handbook (See Appendix A, Service Descriptions and Standards.)

2. A provider of nutrition services shall target older persons in greatest economic and social need; low-income older individuals; including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.

E. Nutrition Provider's Responsibilities When Establishing New C-1 Sites:

1. Obtain AAA approval for establishment of additional C-1 sites, which can include the use of local restaurants.. When there is a break in service at an existing C-1 location, the Nutrition Provider must notify and receive approval from the AAA in order for the C-1 site to resume services and billing.
2. Determine interest and capability of the potential site. .
3. Determine the number of meals per day, week or month that will be available to C-1 recipients.
4. Establish written policies and procedures in accordance with the Program and Services Handbook and applicable state and local regulations. Written policies and procedures must address at a minimum the following:

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- a. Handling and storage of administrative documentation;
 - b. Client registration requirements;
 - c. Client reporting requirements;
 - d. Client donations;
 - e. Instructions on how to obtain meal credits;
 - f. The C-1 meal schedule;
 - g. Project menus;
 - h. Project evaluation;
 - i. Program restrictions, i.e., maximum number of meals available to a participant per month, gratuities, and taking meals out for consumption elsewhere;
 - j. Provision of nutrition education;
 - k. Nutrition Program's monitoring of the site using the Nutrition Program Compliance Review form;
 - l. Nutrition Program review of public health department review of restaurant;
 - m. Monthly billing; and
- 5. Develop a survey for determining participant satisfaction concerning:
 - a. If the meal option is meeting the recipient's needs;
 - b. The quality of the meals; and
 - c. The service provided by C-1 site volunteers/staff.
- 6. Evaluate potential site for appropriateness. Evaluation must include, but is not limited to the following:
 - a. Location in an underserved area;
 - b. Accessibility to elders in the community;
 - c. Diversity of service area;
 - d. If using a restaurant, Assurance that is a fixed facility and meets the standards in Florida Administrative Code 64E-11;
 - e. Compliance with all Americans with Disabilities Act (ADA) accessibility requirements;
 - f. If using a restaurant, review of the three most recent health inspections.
 - g. Capability of meeting the administrative and operational demands of the program as outlined below.

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F. Restaurant Provider's Responsibilities:

1. To become a C-1 meal site, a potential sites, including restaurants, must have the appropriate capabilities to administer components of the program to include but not limited to:
 - a. Serving elders in a dignified and culturally sensitive manner;
 - b. Permitting unannounced access to the food preparation area to the local nutrition provider, AAA or State Agency staff;
 - c. Providing adequate space, permitting elders the opportunity to dine in a comfortable setting;
 - d. Meeting or exceeding the local food service licensing, health regulations, and fire regulations;
 - e. Following the Program and Services handbook regulations for OAA Title III C meals;
 - f. Providing a pre-defined meal or meal options to authorized individuals; and
 - g. Developing menus by collaborating with the nutrition provider staff and qualified dietitian. If using a restaurant, the menu used should be the current restaurant menu to the greatest extent possible. The pre-defined menu or menu options must comply with the Program and Services handbook and
approved by nutrition program's RD prior to use.
2. All C-1 sites, including restaurants, must be willing to perform at a minimum the following tasks:
 - a. Provide participants with a written menu(s);
 - b. Follow the procedures established by the nutrition provider to validate that participants are registered and authorized for consumption of C-1 meals served;
 - c. Use the system established by the nutrition provider to document the total number of meals served to participants monthly;
 - d. Use the system established by the nutrition provider to document the total number of unduplicated participants;
 - e. Facilitate or permit facilitation of a nutrition education program;
 - f. Notify the Nutrition Provider immediately of any closures (temporary or permanent) or Administrative Complaints against the restaurant;
 - g. Notify the Nutrition Provider within 24 hours of any sanitation inspections and provide a copy of the report;

PLANNING FOR NUTRITION SERVICES:

Nutrition Planning Requirements:

- A. Objectives:** Nutrition service providers must establish measurable objectives related to the needs of eligible individuals in the approved service area and objectives must address the following requirements:
1. Targeted individuals to be served;
 2. Services to be provided, including the number and frequency of meals to be served in congregate and in home-delivered settings; and
 3. Plans for monitoring progress towards achieving objectives.
- B. Priority for Services:** Nutrition services under the OAA should be reserved for those individuals age 60 years and older who have been identified as being in greatest economic or social need, and especially low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural area. Additional factors which should be considered in establishing priority include those older persons who:
1. Cannot afford to eat adequately;
 2. Lack the skills or knowledge to select and prepare nourishing and well- balanced meals;
 3. Have limited mobility which may impair their capacity to shop and cook for themselves; or
 4. Have a disabling illness or physical condition requiring nutritional support or have been screened at a high nutritional risk.

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C. Nutrition Provider Staff, Consultants, and Volunteer Required

Training/Credentials: Nutrition service providers shall cooperate with the AAA to ensure that training will be provided for both paid and volunteer staff.

1. Job specific training shall be available for each staff member.

Each nutrition service provider shall set aside sufficient budgetary funds for training, including in-service training. This may include the payment of a tuition fee, travel, and per diem to local, statewide, or out-of-state training programs designed to expand staff capacity to effectively carry out nutrition services.

2. **Food Protection Manager Training:** Nutrition Programs that operate a kitchen and have three or more employees at one time engaged in the storage, preparation, display, or service of food must identify an individual as the manager and that manager must be a Certified Food Protection Manager, unless the manager is a qualified dietitian (refer to Nutrition Planning, Section E).

The manager must be present during the food service operation. Programs that do not prepare their own food must have a Certified Food Protection Manager responsible for the storage, display, and serving of food for meal sites, but the Certified Food Protection Manager does not have to be present always. (Refer FAC 64E-11). New managers must be certified as a Food Protection Manager within 90 days of employment. The AAA may grant an extension up to 180 days.

3. **Employee Food Safety Training Requirements:** All food service staff and volunteers must receive annual training by a RD, or competent Certified Food Protection Manager under the direction of the RD, on the prevention of foodborne illness. Staff and volunteers must be trained prior to assuming food service assignments.
4. On-going training plans should be based upon information obtained through the evaluation of training sessions and needs identified at that time, as well as staff requests.

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Approved Certified Food Protection Manager Training Programs:

A. Nutrition Consultant:

1. Each nutrition service provider shall obtain the advice of a qualified dietitian in planning and providing nutrition services. The number of consultation hours should be based on the size and complexity of the nutrition service provider and may be established by the AAA.
2. The qualified dietitian shall be either a provider employee or an independent consultant, hired by the project (paid or in-kind.) **The dietitian paid by the project's food service vendor is not acceptable in this position.**

Qualified Dietitian Definition: For the Florida, elderly nutrition program, a "qualified dietitian" is a licensed or licensed registered dietitian. The following define criteria for a registered dietitian and a licensed dietitian.

Registered Dietitians (RD) are credentialed through the Commission on Dietetic Registration (CDR.) RD's must provide a copy of their current CDR card upon hire. RD's must remain credentialed through CDR throughout the duration of their employment

Licensed Dietitian/Nutritionist (LD or LD/N) are credentialed through the Florida Department of Health (DOH.) LD or LD/N's must provide a copy of their current State of Florida Dietitian/Nutritionist license upon hire. LD or LD/N's must remain licensed throughout the duration of their employment.

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NOTE: A change in qualified dietitian requires a funding application packet to be submitted to the AAA, containing the following information:

For a Licensed and Registered Dietitian:

- a. A resume for the provider's qualified dietitian,
- b. A copy of the individual's current registration with the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics; and
- c. A copy of the individual's current Florida license with the Department of Health(Refer to F.A.C. Chapter 64B8.)

For a Licensed Dietitian:

- a. A resume for the provider's qualified dietitian,
- b. A copy of the individual's current Florida license with the Department of Health (Refer to F.A.C. Chapter 64B8.)

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3. Responsibilities and functions of the qualified dietitian shall include, but not be limited to, the following:
 - a. Participation in developing menus with input from the advisory council (Reference: Section 1);
 - b. Ensuring all menus as written meet nutritional criteria as required by DOEA (refer to Menu Planning, Development, Review, and Approval Requirements section);
 - c. Approval of all menus (as indicated by an authorizing signature and date on each weekly or monthly approved and posted menu) 4 weeks prior to implementation;
 - d. Monitoring, at least annually, every meal site using the current Nutrition Program Compliance Review form;
 - e. Monitoring, at least annually, every food service vendor's sanitation inspection reports;
 - f. Reviewing corrective action plans of food service vendors for all significant or high priority findings on sanitation inspection reports;
 - g. Participation in development and review of food service contract annually for adherence to current nutritional requirements and delivery components of the food service vendor contract (See Food Service Contract Requirements);
 - h. Participation in developing and approval (as indicated by an authorizing signature and date) of the annual and monthly nutrition education plan and coordinate the provision of nutrition education so it is effective and appropriate;
 - i. Providing staff and volunteer training in areas of nutrition, food service management, and food safety;
 - j. Participation in the development of client satisfaction preference assessment tools, and review assessment of results;

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- k. Providing nutrition counseling for clients, if nutrition service provider authorizes it for clients that have high-risk nutritional scores (any score higher than 5.5 on the assessment tool). This service must be provided by a Florida Licensed Dietitian (FAC Chapter 64B8- 43). Any dietitian providing nutrition counseling should be covered by malpractice insurance.

B. Technical Assistance: Each nutrition service provider should:

- 1. Inform the AAA of technical assistance needs for quality improvement and corrective action measures.
- 2. Provide technical assistance to its contract agencies, other related clients, and its advisory council.

C. Records and Reports: Nutrition providers are required to:

- 1. Develop and maintain a record on each client which documents the following:
 - a. Eligibility for services;
 - b. Information related to emergency care;
 - c. The need for, and referral to, other appropriate services.
- 2. Obtain information related to congregate clients within three days of determination of status as a client rather than a guest.
- 3. Obtain information related to homebound clients prior to receipt of a home-delivered meal. In the event of an emergency, a home-delivered meal may be provided prior to assessment.
- 4. Establish recording procedures, in accordance with AAA policy, which ensure the accuracy of the number of eligible client meals served each day.
- 5. Submit all required reports promptly.
- 6. Provide access to all records and reports on demand for audit, assessment or evaluation by authorized representatives of the AAA, state or federal agencies.

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- D. Monitoring, Assessment and Evaluation:** Each provider will be subject to the monitoring policies and procedures of the Department.
- E. Advisory Council:** All nutrition providers must establish and maintain either a project advisory council made up of representatives from each congregate nutrition site, or a site council at each congregate nutrition site. The nutrition advisory council shall advise the nutrition program director on all matters relating to the delivery of nutrition services within the program area. All recommendations of the council shall be taken into consideration. Clients may establish site councils in addition to advisory councils with concurrence of the provider director.
1. These councils must be comprised of at least 51% clients of the nutrition program, and must meet a minimum of two times per year (as evidenced by dated sign in sheet).
 2. Advisory councils must meet the following additional requirements:
 - a. The council shall not function in a policymaking or decision-making capacity. An advisory council should not be confused with the provider or contractor board of directors, which is a legal entity with policy-making authority. No member of the board of directors or employee of the provider or contractor may serve on the advisory council except as an ex-officio member. No immediate family member of a part-time or full-time employee of the grantee or contractor may serve on the advisory council.

No DOEA staff member may serve on the advisory council.
 - b. Advisory Council Roles and Responsibilities:
 - i. Serve in an advocacy role to ensure that the program serves the elderly;
 - ii. Provide means for participating clients to express their views on the services provided;
 - iii. Assist with client satisfaction surveys;

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- iv. Make recommendations to the nutrition program director regarding food preferences of clients, days and hours of dining center, operations and locations and dining center furnishings regarding disabled clients.
 - v. Advise and make recommendations to the nutrition director regarding supportive social services to be conducted at dining centers; and
 - vi. As an organized group, provide support and assistance to the ongoing development of the nutrition program.
- F. **Public Information and Dissemination:** Each nutrition service provider, in cooperation with the AAA, is responsible for the development and dissemination of information regarding services throughout its service area. Providers will be expected to utilize all appropriate media sources to keep the public informed about the nutrition program for the elderly. (All providers should coordinate with the AAA in conducting special informational events, such as Older Americans Month, public hearings, conferences, etc.).
 - 1. Area Agencies on Aging must ensure that relevant informational material received, such as policy clearances, technical assistance, pertinent grant or other funding opportunities, meetings and information issuances is documented in a timely fashion.
 - 2. Public information activities must conform to policies concerning confidentiality and public notice.
- G. **Coordination of Services:** A nutrition service provider must utilize existing social service resources in provision of necessary services. Such efforts shall include joint planning, sharing of information, and negotiation of joint funding agreements in operation of programs for the elderly.

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FOOD SERVICE:

Meals served by nutrition providers can either be prepared directly by the provider (i.e., self-preparation kitchen that serves one meal site or central kitchen which serves multiple meal sites) or through a written contractual agreement with a vendor (i.e., nearby schools, restaurants, or hospitals) or a food service management company. Meal production must comply with local, state (FAC 64E-11) and, if applicable, federal regulations (United States Department of Agriculture and Food and Drug Administration).

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CONTRACTS WITH PROFIT-MAKING ORGANIZATIONS:

Contract Requirements:

- A. Contracts/Subcontracts:** Nutrition service providers may enter contracts or subcontracts with profit-making organizations for nutrition services only with prior written approval of the AAA. Contracts for the provision of food may be executed only with those vendors who supply meals from premises that have a valid permit, license, or certificate issued by the appropriate regulatory authority. The service provider shall comply with all federal, state, and local laws, ordinances, and codes for establishments that are preparing, handling, and serving food to clients.

The vendor must submit its three most recent sanitation inspection reports to the Nutrition Provider. If a vendor has one temporary closure and/or twelve (12) high priority violations in the preceding twelve month period, the inspection reports shall be sent to the AAA for further review. The AAA will then decide if the vendor has taken appropriate action to ensure food safety compliance in order to prevent repeat violations. The vendor must agree to notify the Nutrition Provider immediately for any closure or Administrative Complaint related to food safety. The vendor must agree to notify the Nutrition Provider within twenty-four (24) hours of any sanitation inspection and provide a copy of the report to the Nutrition Provider. It is not recommended that the AAA contracts, or subcontracts, with any vendor who has more than one temporary closure and/or more than twelve (12) high priority violations in the twelve-month period prior to entering into a contract or during a twelve-month contract period

- B. Subcontracts:** If the Title III service provider subcontracts for meals, it is the responsibility of the AAA to ensure that the provider monitors the subcontractor. The AAA must also monitor the subcontractor's performance either directly or via communication with the Nutrition Provider. The Title III service provider must monitor the subcontractor on-site at least once per year during the contract period, with follow-up visits for corrective action or quality improvements made as needed.

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1. **Cooperative Monitoring:** Whenever multiple service providers utilize the services of a single food service vendor's production kitchen; the service providers may elect to monitor the subcontractor on a cooperative basis. One nutrition service provider may monitor on behalf of other providers. Cooperative monitoring must be arranged for in advance and approved by the appropriate AAA(s). For the AAA to approve cooperative monitoring, the following conditions shall be met:
 - a. The individual conducting the food service vendor monitoring shall have demonstrated knowledge of sanitation, food handling, food preparation, and food storage principles, and preferably be a Certified Food Protection Manager or a qualified dietitian;
 - b. The subcontractor's monitoring was completed in accordance with Chapter 1, Section 3 of this handbook;
 - c. Monitoring may include review of all aspects of kitchen management including, but not limited to:
 - i. All local and state level health department inspections,

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- ii. Meal/menu-related invoices;
 - iii. Food staff certifications;
 - iv. Staff in-service documentation;
 - v. Standardized recipes; and
 - vi. Standardized recipes to monitor for nutrient compliance.
- 2. **Written Monitoring Report:** All written reports documenting the monitoring visit and any other reports required by the project will be reviewed by the AAA for validation of the documented services. The AAA must notify the Department's RD in writing within 48 hours of any changes in food service vendors.
- 3. **Corrective Action Plans:** All subcontracted food service vendors must provide a written corrective action plan to the Nutrition provider for any high priority or significant findings on sanitation inspections. These corrective action plans must be approved by the provider's RD. Additionally, the AAA monitor should ensure the accuracy of all reports and require corrective action plans, if appropriate, to ensure that deficiencies are remedied.

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MENU REVIEW AND APPROVAL:

- A. Menu Planning:** The menus shall be planned and provided to the qualified dietitian for review no less than **six calendar weeks** in advance of implementation.
- B. Menu Approval:** All menus must be approved at least **four calendar weeks** prior to implementation. All menus must be approved in writing by a qualified dietitian. The approving qualified dietitian's signature and date must be documented on each page of the approved and posted menu. The approving signature verifies that all menus comply with DOEA menu standards and applicable supporting nutrient analysis documentation is maintained. The AAA qualified dietitian or the nutrition program Qualified Dietitian may approve the menus. A qualified dietitian employed by the food vendor may not approve the menus, because this is a conflict of interest.
- C. Menu Cycle:** Nutrition Programs may choose to offer two types of menu cycles:
- 1. Preselect Menu:** daily menu offers only one entrée; or
 - 2. Selective Daily Menu:** offers two to three entrée choices.

The preselect menu cycle shall be no less than 4 weeks in rotation of different food combinations to assure variety of colors, flavors, and textures. Preselect cycle menus shall run for a maximum of six months before changing, and food items should not be repeated on consecutive days or consecutive days of the week.

Meal sites offering a selective menu (i.e., buffet style meal service or kiosk) may decrease the menu rotation and the same menu item may be repeated on consecutive days or consecutive days of the week. However, the program must monitor acceptance and ensure menu fatigue is avoided. Selective menus shall run for a maximum of six months before changing.

- D. Menu Revisions:** The AAA or nutrition program qualified dietitian may require menu revisions based upon a review or the results of client satisfaction surveys. Requested menu revisions will be given to the service provider at least two weeks prior to scheduled menu implementation.
- E. Menu Corrections:** Copies of corrected menus must be resubmitted to the AAA or nutrition program qualified dietitian within one week of receipt of comments or as otherwise directed.

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- F. Menu Posting:** Approved preselect menus shall be dated and posted in a conspicuous location at each congregate nutrition site in a font size large enough for easy review by the participants. Nutrition programs that prepare their meals must also post a copy of their menus in the food preparation area.

Select Menu (i.e., buffet style or kiosk) approved menu shall be dated and posted on/near the buffet style serving line and should be printed in font size large enough for easy review.

- G. Menu Retention:** Dated and approved menu with supporting menu related documents must be kept on file, as served for a period of two years for audit purposes.
- H. Menu Adherence:** Approved menus shall be followed as written.
- I. Menu Substitutions:** A comprehensive menu substitution policy and procedure must be developed and approved by the nutrition program's qualified dietitian. The menu substitution policy must be available for the site manager's use. Each meal site shall maintain an on-site record of all substitutions that occur during the calendar year. Menu substitutions shall be minimal, but are allowed under the following conditions:
1. Menu substitutions must be from the same food group and provide equivalent nutritional value. For example, a fruit high in Vitamin C must be substituted with another fruit high in Vitamin C.
 2. Prior to use the nutrition program's qualified dietitian must approve the menu substitution policy and procedures and the menu substitution list. It is encouraged that the menu substitution list be inclusive and thorough.
 3. Documentation of all menu substitutions must be kept on file for at least two years for monitoring purposes. The documentation must include the date of substitution, the original menu item, the substitution made, the reason for the substitution and the signature of the employee authorizing the substitution. Finally, the volume and frequency of substitutions must be justified by the reasons provided. For example, a seasonal fruit may be substituted for a canned fruit.

J. Menu Development:

1. Menus should be developed with consideration for the:
 - a. Special needs of the elderly;
 - b. Religious, ethnic, cultural, and regional dietary practices or preferences of clients, if reasonable and feasible;
 - c. Variety of food and preparation methods including color, combinations, texture, size, shape, taste, and appearance;
 - d. Seasonal availability of foods;
 - e. Availability of equipment for food preparation or meal delivery service; and
 - f. Budget.
2. **Menu Development Methods:** Menus may be developed using two different methods, computer assisted nutrient analysis or component meal pattern.
 - a. The computer assisted nutrient analysis method.
 - b. The component meal pattern menu development method..

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3. **Nutrient Requirements:** All meals, regardless of development method, will provide each participating older individual with a minimum of 33 1/3 percent of the current Dietary Reference Intake (<http://fnic.nal.usda.gov/dietary-guidance/dietary-reference-intakes>) and comply with the current Dietary Guidelines for Americans. The values required meet the nutritional needs of a moderately active 70+ female, reflecting the predominant state wide demographic. The AAA may authorize a Nutrition Program to alter the nutrient requirements of their menus if most the senior population served by the Nutrition Program differs from the statewide demographic. DOEA must be provided advance notification, in writing of the demographic differences of the site(s) and the exact menu changes.
4. **Computer Assisted Nutrient Analysis Menu Development:** This method of menu development must comply with the following:
 - a. DOEA menu development standards ensuring compliance with the most recent edition of the Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture (<http://www.health.gov/dietaryguidelines/>);
 - b. Providing a minimum of 33 1/3 percent of the Dietary Reference Intake/Adequate Intake (DRI/AI) for moderately active 70+ females as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if one meal is provided per day;
 - c. Providing a minimum of 66 2/3 percent of the DRI/AI, for a moderately active 70+ female, if two meals are provided per day;
 - d. Providing 100 percent of the DRI/AI, for a moderately active 70+ female, if three meals are provided per day;
 - e. Any special dietary needs of program clients to the maximum extent practicable; and
 - f. Applicable provisions of state or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual. Ref. Chapter 64-E-11-Food Hygiene, F.A.C. (<http://fac.dos.state.fl.us>).

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Computer-Assisted Menu Development Requirements:

Targeted Nutrients: Table One represents the most current Dietary Reference Intakes and daily compliance range for target nutrients. The following nutrients are required to be analyzed for each component of each menu item: calories, protein, fat, fiber, calcium, zinc, sodium, potassium, vitamin B6, vitamin B12, vitamin C, and vitamin A (vegetable-derived/carotenoid sources). Calories, protein, fat, fiber, calcium, vitamin B6, and vitamin C must be provided in adequate amounts daily. Vitamin A, vitamin B12, zinc, magnesium, sodium, and potassium may be averaged over one week. Sodium may be averaged over one week; however, no one-meal amount may exceed 1000 milligrams. It is recommended that fortified foods should be used to meet vitamin B12 needs. Holidays and birthday celebration meals (two or fewer meal types per calendar month) may be excluded from the nutrient analysis.

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	1 meal/day 33 1/3 % DRI/AI	2 meals/day 67% DRI/AI	3 meals/day 100% DRI/AI
Macronutrients			
Kilocalories (1)	600	1200	1800
Protein grams (1) ~20% of total Kcal >14 grams from entrée per meal	30	60	90
Carbohydrate grams (1) ~50% of total Kcal	75	150	225
Fat grams (1) 20-35% of total Kcal	20	40	60
Saturated fat (1) <10% total Kcal	Limit intake		
Added sugars (1) <10% of total Kcal or 45 grams/day	Limit intake		
Dietary Fiber grams (2)	7	14	21
Vitamins			
A *(ug/d)(2)	233	46	700
C (mg/d) (2)	25	50	75
D (mcg/d) (2)	*6.7	*13.3	*20
E (mg/d) (2)	5	10	15
Thiamine (mg/d) (2)	0.37	0.73	1.1
Riboflavin (mg/d) (2)	0.37	0.73	1.1
B6 (mg/d) (2)	0.5	1.0	1.5
Folate (ug/d) (2)	133	267	400
B12 (mcg/d) (2)	0.8	1.6	2.4
Minerals			
Calcium (mg/d) (2)	400	800	1200
Copper (ug/d) (2)	300	600	900
Iron (mg/d) (2)	2.7	45.3	8
Magnesium (mg/d) (2)	106.7	213.3	320
Zinc (mg/d) (2)	2.7	5.3	8
Potassium (mg/d) (1))	1567	3134	4700
Sodium (mg/d) (1)	<767	<1533	<2300

RDA's are in bold type and AI's are in ordinary type followed by an asterisk ().

- (1) Value for 70 +, moderately active female, USDA interpretation of the Dietary Guidelines for Americans 2015 U.S. Department of Agriculture. U.S. Department of Health and Human Services. <http://www.health.gov/dietaryguidelines/2015/guidelines/appendix7/>
- (2) Used highest DRI value for ages > 70-year-old female by Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, includes the 2015 updated recommendations for calcium and vitamin D.

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Component Meal Pattern Requirements for Menu Development: This method of menu development must comply with the following:

- A. DOEA menu development standards ensuring the most recent edition of the Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture (<http://fnic.nal.usda.gov/dietary-guidance/dietary-reference-intakes/dri-tables>).
- B. Provide the minimum meal servings of the 1800-calorie component meal pattern to reflect the current Dietary Guidelines for Americans and USDA Food Intake Pattern calorie levels for a moderately active 70+-year-old female;
- C. Provide a minimum of two times the minimum meal servings of the 1800-calorie component meal pattern, if two meals are provided per day;
- D. Provide a minimum of three times the minimum meal servings of the 1800-calorie component meal pattern, if three meals are provided per day;
- E. Any special dietary needs of program clients to the maximum extent practicable; and
- F. Applicable provisions of state or local laws regarding the safe and sanitary handling of food, equipment and supplies used in the storage, preparation, service, and delivery of meals to an older individual. Ref. Chapter 64-E-11- Food Hygiene, F.A.C. (<http://fac.dos.state.fl.us>).

The 1800-calorie component meal pattern has been developed to reflect the current Dietary Guidelines for Americans and USDA Food Intake Pattern calorie levels for a moderately active 70+-year-old female (requirements for those programs that are not using computerized nutrient analysis). Holidays and birthday celebration meals (two or fewer meal types per calendar month) may be excluded from the component meal pattern requirement. The component meal pattern may be deficient in vitamin E, vitamin B12, and Zinc, therefore additional nutrition education for participants on the selection of foods that are good sources of these nutrients shall be provided.

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Items that provide the following target nutrients should be identified on the menu.

Vitamin C – must provide at least 25 mg per meal.

Vitamin A – must provide at least 233 ug at least three times per week,

Menu Focus: Whole grains and high fiber foods should be included as much as possible. It is recommended that fortified foods should be used to meet vitamin B12 needs. The use of nutrient dense foods, as well as fortified and enriched products, should be a priority.

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DIETARY GUIDELINE MEAL PATTERN REQUIREMENT FOR ONE MEAL PER DAY

Food Group	Servings/Meal	Daily Dietary Guideline Recommendations
Grains	2 servings: (1/2 cup (cooked) pasta or rice, 1 cups cereal, 1 slice of bread (1 ounce each)	6-ounce equivalent servings daily. Include 3-ounce equivalent of whole grain high fiber foods
Vegetable	1.7 servings: 3/4 cup cooked or 1-1/2 cups raw equivalent measure (may serve an additional fruit instead of a vegetable)	2 1/2 cups (5 servings daily). Serve a variety of vegetables, including those that are dark green, red, and orange.
Fruit	1 serving: 1/2 cup (4 ounces) or equivalent measure	1.5 cups (4 servings daily) Focus on whole fruits and include those that are deeply colored fruits such as oranges.
Dairy	1 serving: 1 cup (8 ounces) or equivalent measure	3, 1-cup equivalent servings daily. Select low-fat products
Protein Foods	1.7 serving: 2-ounce edible portion or equivalent measure	5 ounce-equivalent servings daily
Fat	1 serving: 1 teaspoon or equivalent measure is optional	Select foods lower in fat and saturated fat. Limit total fat to 30%, saturated 10% (20%)
Dessert	Optional	Select foods high in whole grains, low in fat and sugar
Optional Beverages: Water, coffee, tea, decaffeinated beverages, fruit juices.	8 ounces, minimum, per seasonal preferences	

*Limit saturated fat, sodium, and added sugar

The Dietary Guideline Meal Pattern is based on the DRI for energy. It provides approximately 600 calories per meal. The number of servings for each food group is based on the USDA's ChooseMyPlate.gov for food groups and. These profiles represent the quantities of nutrients and other components that one can expect to obtain on average from one serving of food in each group. Serving sizes are based on the MyPlate (<http://www.choosemyplate.gov>). Although this meal pattern is based on food servings recommended in the Dietary Guidelines and Choose My Plate, it does not ensure that meals meet 1/3 of the DRI/AI and Dietary Guidelines.

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Food Group Components and Serving Sizes: Serving size shall meet or exceed the guidelines listed in this section. Some foods are classified in more than one food group. However, a serving of a food can only be counted in one food group within the same meal. For example, dried beans may be counted as either a meat alternate serving or as a vegetable serving, but not both in the same meal. Likewise, cottage cheese may be counted as either meat alternate serving or milk alternate serving, but not both.

- A. Grains:** A serving of bread is generally 1 slice (1ounce); ½ cup pasta or grain product, or 1 ounce of ready-to-eat cereal. A variety of enriched and/or whole grain bread products, particularly those high in fiber are recommended. Serving sizes are:

Grains		Amount that counts as 1-ounce equivalent of grains	Common Portions and ounce equivalents
Bagels	WG*: whole wheat RG*: plain, egg	1 “mini” bagel	1 large bagel = 4-ounce equivalents
Biscuits	(baking powder/buttermilk–RG*)	1 small (2” diameter)	1 large (3” diameter) = 2-ounce equivalents
Breads	WG*: 100% whole wheat RG*: white, wheat, French	1 regular slice 1 small slice French 4 snack-size slices rye bread	2 regular slices = 2-ounce equivalents
Bulgur	Cracked wheat (WG*)	1/2 cup cooked	
Cornbread	(RG*)	1 small piece (2 ½” X 1 ¼” X 1 ¼”)	1 medium piece (2 ½” X 2 ½” X 1 ¼”) = 2-ounce equivalents
Crackers	WG*: whole wheat, rye, RG*: saltines, snack crackers	5 whole wheat crackers 2 rye crisp breads 7 square or round crackers	
English muffin	WG*: whole wheat RG*: plain, raisin	1/2 muffin	1 muffin = 2-ounce equivalents

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Grains		Amount that counts as 1 ounce equivalent of grains	Common Portions and ounce equivalents
Muffins	WG* whole wheat RG* bran, corn, plain	1 small (2 ½ "diameter)	1 large (3 ½" diameter = 3-ounce equivalents
Oatmeal	(WG)	½ cup cooked 1 packet instant 1 ounce (1/3 cup) dry (regular or Quick)	
Pancakes	WG*: whole wheat, buckwheat RG*: buttermilk, plain	1 pancake (4 ½ "diameter) 2 small pancakes (3" diameter)	3 pancakes (4 ½ "diameter) = 3-ounce equivalents
Ready-to-eat breakfast cereal	WG* toasted oat, whole wheat flakes RG* corn flakes, puffed rice	1 cup flakes or rounds 1 ¼ cup puffed	
Rice	WG*: brown, wild RG*: enriched, white, polished	½ cup cooked 1 ounce dry	1 cup cooked = 2 ounce equivalents
Pasta- spaghetti, macaroni noodles	WG*: whole wheat RG*: enriched, durum	½ cup cooked 1 ounce dry	1 cup cooked = 2-ounce equivalents
Tortillas	WG*: whole wheat, whole grain corn RG*: flour, corn	1 small flour tortilla (6" diameter) 1 corn tortilla (6" diameter)	1 large tortilla (12" diameter) = 4-ounce equivalents

*WG = whole grains, RG = refined grains. This is shown when products are available both in whole grain and refined grain forms. Source: ChooseMyPlate.gov.

1. Increase servings of whole grain, wheat, bran, rye bread, and cereal products, to provide adequate complex carbohydrates and fiber.
2. Limit high-fat bread and bread-alternate selections such as biscuits, quick bread, muffins, cornbread, dressings, croissants, fried hard tortillas and other high fat crackers to limit total fat as well as saturated fat.
3. Bread alternates do not include starchy vegetables such as potatoes, sweet potatoes, corn, yams, or plantains. These foods are included in the vegetable food group.

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- B. Vegetables:** A serving of vegetable, including dried beans, peas, lentils, lima beans, potato, plantains, sweet potato, and corn is generally the following:

	Amount that counts as 1 cup of vegetables	Amount that counts as ½ cup of vegetables
Dark Green Vegetables		
Broccoli	1 cup chopped or florets 3 spears 5" long raw or cooked 1 cup cooked	
Spinach	1 cup cooked 2 cups raw is equivalent to 1 cup of vegetables	1 cup raw is equivalent to ½ cup of vegetables
Raw leafy greens: spinach, romaine, watercress, dark green leafy lettuce, endive, escarole	2 cups raw is equivalent to 1 cup of vegetables	1 cup raw is equivalent to ½ cup of vegetables
Red and Orange Vegetables		
Carrots	1 cup, strips, slices, chopped, raw, or cooked 2 medium 1 cup baby carrots (about 12)	1 medium carrots About 6 baby carrots
Tomatoes	1 large raw whole (3") 1 cup chopped, sliced, raw, canned, or cooked	1 small raw whole (2 ¼" diameter) 1 medium canned
Tomato juice	1 cup	½ cup
Sweet potato	1 large baked (2 ¼" or more diameter) 1 cup sliced or mashed, cooked	
Winter squash (acorn, butternut, hubbard)	1 cup cubed, cooked	½ acorn squash, baked = ¾ cup
Beans and Peas		
Dry beans and peas (such as black, garbanzo, kidney, pinto, soy bean beans, black eyed peas, or split peas	1 cup whole or mashed, cooked	

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	Amount that counts as 1 cup of vegetables	Amount that counts as ½ cup of vegetables
Starchy Vegetables		
Corn, yellow, or white	1 cup 1 large ear (8" to 9" long)	1 small ear (about 6" long)
Green peas	1 cup	
White potatoes	1 cup diced, mashed 1 medium boiled or baked potato (2 ½" to 3" diameter) French fried: 20 medium to long strips (2 ½" to 4" long) (Contains added calories from solid fats.)	
Other Vegetables		
Cabbage, green	1 cup, chopped or shredded Raw or cooked	
Cauliflower	1 cup pieces or florets raw or cooked	
Celery	1 cup, diced or sliced, raw or cooked 2 large stalks (11" to 12" long)	1 large stalk (11" to 12" long)
Cucumbers	1 cup raw, sliced, or chopped	
Green or wax beans	1 cup cooked	
Green peppers	1 cup chopped, raw, or cooked 1 large pepper (3" diameter, 3 ¾" long)	1 small pepper
Lettuce, iceberg or head	2 cups raw, shredded, or chopped = equivalent to 1 cup of vegetables	1 cup raw, shredded, or chopped Equivalent to ½ cup of vegetables
Onions	1 cup chopped, raw, or cooked	
Summer squash or zucchini	1 cup cooked, sliced, or diced	

Source: <http://www.ChooseMyPlate.gov>

1. Fresh or frozen vegetables are preferred.
2. Vegetables as a primary ingredient in soups, stews, casseroles, or other combinations dishes should total ½ cup per serving.

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C. **Fruits:** A serving of fruit is generally the following:

	Amount that counts as 1 cup of fruit	Other amounts (count as ½ cup of fruit unless noted)
Apple	½ large (3.25" diameter) 1small (2.5" diameter) 1 cup sliced or chopped, raw or cooked	½ cup sliced or chopped, raw or cooked
Applesauce	1 cup	1 snack container (4 oz.)
Banana	1 cup sliced 1 large (8" to 9" long)	1 small (less than 6" long)
Cantaloupe	1 cup diced or melon balls	1 medium wedge (1/8 of a medium melon)
Grapes	1 cup whole or cut-up 32 seedless grapes	16 seedless grapes
Grapefruit	1 medium (4" diameter) 1 cup sections	½ medium (4" diameter)
Mixed fruit (fruit cocktail)	1 cup diced or sliced, raw or canned, drained	1 snack container (4 oz.) drained = 3/8 cup
Orange	1 large (3-1/16" diameter) 1 cup sections	1 small (2-3/8" diameter)
Orange, mandarin	1 cup canned, drained	
Peach	1 large (2 ¾" diameter) 1 cup sliced, diced, raw, cooked, or canned, drained 2 halves, canned	1 small (2" diameter) 1 snack container (4 oz.) drained = 3/8 cup
Pear	1 medium pear (2.5 per lb.) 1 cup sliced, diced, raw, cooked, or canned, drained	1 snack container (4 oz.) drained = 3/8 cup
	Amount that counts as 1 cup of fruit	Other amounts (count as ½ cup of fruit unless noted)
Pineapple	1 cup chunks, sliced or crushed, raw, cooked, or canned, drained	1 snack container (4 oz.) drained = 3/8 cup
Strawberries	About 8 large berries 1 cup whole, halved, or sliced, fresh or frozen	½ cup whole, halved, or sliced
Watermelon	1 small wedge (1" thick) 1 cup diced or balls	6 melon balls
Dried fruit (raisins, prunes, apricots, etc.)	1/cup dried fruit is equivalent to 1 cup fruit. ½ cup raisins; ½ cup prunes; 1/cup dried apricots	¼ cup dried fruit is equivalent to ½ cup fruit 1 small box raisins (1.5 oz.)
100% fruit juice (orange, apple, grape, grapefruit, etc.)	1 cup	½ cup

Source: <http://www.ChooseMyPlate.gov>

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1. Frozen or canned fruit must be packed in juice or water.
2. Title III funds may only pay for full strength fruit juices. The only exception to this requirement is cranberry juice.

D. Dairy:

1. One cup low-fat, fat-free, buttermilk, low-fat chocolate milk, soy milk, or lactose- free milk fortified with Vitamins A and D should be used. Milk should be served from its original container, usually 8 ounces in size. Any deviations from this policy should be submitted in writing to the AAA's qualified dietitian for approval.
2. Low-fat or fat-free milk is recommended for the general population.
3. Powdered dry milk or evaporated milk may be served at congregate meal sites, but not for the main meal except for cultural or religious reasons. Each powdered milk or evaporated milk serving size must be equivalent to one cup of milk. Powdered milk may be used with frozen home-delivered meals and emergency meals.
4. Dairy alternates, listed in the chart below, may be provided in place of milk (for the equivalent of one cup of milk).
5. All milk containers must have a clearly labeled expiration date.
6. Policies and procedures shall be developed, and implemented, to address instances when milk is received, e.g., without an expiration date, past the expiration date, past the sell-by date, past the best-by date, or past the use by date.

Dairy Alternates
1 cup yogurt
1 ½ ounce hard cheese (Cheddar, Monterey, Provolone, Colby, American Mozzarella, Swiss, Parmesan) or 2 ounces processed cheese (American)
8 ounces tofu (processed with calcium salt)
1 ½ cup ice milk/ice-cream
1 ½ cup cottage cheese 1% fat
1 ½ cup custard

Source: <http://www.ChooseMyPlate.gov>

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- E. Protein Foods:** Two to three ounces edible portion of meat, poultry, fish, or meat alternate (or a combination of) should be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating. A one-ounce equivalent of a meat alternate includes:

	Amount that counts as 1 ounce equivalent in the Protein Foods Group	Common portions and ounce equivalents
Meats	1 ounce cooked lean beef 1 ounce cooked lean pork or ham	1 small steak (eye, round, or filet) = 3 ½ to 4-ounce equivalents 1 small lean hamburger = 2 to 3-ounce equivalents
Poultry	1-ounce cooked chicken or turkey, without skin 1 sandwich slice of turkey (4 ½" x 2 ½ x" 1/8")	1 small chicken breast half = 3-ounce equivalents ½ cornish game hen = 4-ounce equivalents
Seafood	1-ounce cooked fish or shell fish	1 can tuna, drained = 3 to 4-ounce equivalents 1 salmon steak = 4 to 6-ounce equivalents
Eggs	1 egg	3 egg whites = 2-ounce equivalents 3 egg yolks = 1-ounce equivalents
Nuts and seeds	½ ounce of nuts (12 almonds, 24 pistachios, 7 walnut halves) ½ ounce of seeds (pumpkin, sunflower, or squash seeds, hulled, roasted) 1 Tablespoon of peanut butter or almond butter	1 ounce of nuts or seeds = 2-ounce equivalents
Beans and peas	¼ cup of cooked beans (black, kidney, pinto, or white beans) ¼ cup of cooked peas (chickpeas, cowpeas, lentils, or split peas) ¼ cup of baked beans, refried beans ¼ cup (about 2 ounces) of tofu 1 oz. tempeh, cooked ¼ cup roasted soybeans 2 Tablespoons of hummus	1 cup split pea soup = 2-ounce equivalents 1 cup lentil soup = 2-ounce equivalents 1 cup bean soup = 2-ounce equivalents 1 soy or bean burger patty = 2 ounce equivalents

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1. A one ounce serving or equivalent portion of meat, poultry, or fish may be served in combination with other high protein foods.
2. Except to meet cultural and religious preferences and for emergency meals, avoid serving dried beans, peas or lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days.
3. Cooked dried beans, peas, or legumes intended as the meat alternative for any meal may not also count toward the fruit/vegetable requirement for the same meal.
4. Nuts and seeds may be used to meet no more than one-half of the meat alternative meal requirements, and must be appropriately combined with other meats/meat alternates to fulfill the requirement.
5. Cured meat products, such as ham, smoked or polish sausage, corned beef, dried beef, luncheon meats, and hot dogs are very high in sodium and the use of these type products must be limited to no more than once a week. Bacon is not considered a meat alternate, since it provides primarily fat, sodium, and few other nutrients.
6. Vegetable protein products or textured vegetable protein (VPP or TVP) are low cost alternatives and are effective in increasing the protein intake of program clients. The recommended ratio of protein product to meat is 20:80.
7. Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non- imitation product) cannot be served as meat alternates.

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Portion Control Guide—Protein Foods	
Food Item	Required Portion Size = 3 ounces
Cottage cheese—2 ounces by weight = $\frac{1}{4}$ cup	6 ounces by weight = $\frac{3}{4}$ cup
Chicken	1 drumstick and 1 thigh or $\frac{1}{2}$ breast = 3 ounces
Chili, soups	Must serve at least 1 $\frac{1}{2}$ cup containing 3 ounces of meat or meat alternate to provide one meal
Cooked dried beans and peas	1 $\frac{1}{2}$ cup
One egg = 1 ounce	3 eggs
Lasagna, Macaroni and Cheese, Beef or other Meat Stew, Meat Casseroles	1 $\frac{1}{2}$ cup
Meat Loaf 1 slice 2" x 4" x 2" = 4 ounces	4 ounces (yield from a 20" x 12" x 2" pan = 33 servings)
Pizza 3 $\frac{1}{4}$ "x 7" = 3 ounces M/MA	10 servings per 18" x 26" pan or 5 + servings from 12" x 20" pan
Roast Meats	3 ounces
Sandwiches, sliced meats/cheese Salad type fillings	3 ounces 3 ounces = $\frac{3}{4}$ cup filling
Spaghetti sauces with ground beef	1 cup
Tofu	4 ounces

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F. Prepared Fish Products:

Fish Product	Serving or Portion Size
Fish sticks, Frozen Fried Breaded, 60 percent fish	Six 1-ounce sticks = 3 ounces cooked fish
Fish sticks, Frozen Raw Breaded, 72 percent fish	Six 1-ounce sticks = 3 ounces cooked fish
Fish portions, Frozen, Fried Battered. There is no standard portion for this product. Specify 45 percent fish and require a certificate of inspection	9-ounce portion = 3 ounces cooked fish
Fish portions, Frozen, Fried Breaded	6-ounce portion = 3 ounces cooked fish
Fish portions, Frozen, Raw Breaded 75 percent fish	6-ounce portion = 3 ounces cooked fish
Fish portions, Frozen, Unbreaded	4-ounce portion = 3 ounces cooked fish

G. Additional Menu Development Considerations:

- Canned Soups:** Most canned soups do not contain enough meat to make a substantial contribution to the meat requirement. For example: Bean soup or Pea Soup: A 1-cup serving of soup contains $\frac{1}{2}$ cup beans or peas. This is equivalent to one ounce of Meat/Meat Alternative. It would take 3 cups to provide the required 3 ounces of Meat/Meat Alternative.
- Hot Dogs/Frankfurters:** Red meat (beef, pork, etc.) and poultry (turkey, chicken) hot dogs that do not contain meat by products, cereals, binders, or extenders:
 - 1 ounce of product provides 1 ounce of cooked lean meat. Look for products labeled "All Meat", "All Beef", "All Pork", etc. If a single hotdog equals 2 ounces, it will take one and a half hot dogs to equal a 3-ounce portion.
 - Hot dogs containing meat by-products, cereals, binders, or extenders are not acceptable on an ounce-for-ounce basis. Product labeling will indicate the presence of any such ingredients.

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- c. If using hotdogs containing extenders or binders, only the cooked or lean meat portion of the product can be used toward the Meat/Meat Alternatives requirement. Obtain product information from the manufacturer if necessary.

H. Accompaniments, Condiments, and Product Substitutes:

1. Include traditional meal accompaniments as appropriate, e.g., condiments, spreads, and garnishes. Examples include: mustard and/or mayonnaise with a meat sandwich, tartar sauce with fish, salad dressing with tossed salad, and margarine with bread or rolls. Whenever feasible, provide reduced fat alternatives.
2. Salt substitutes shall **not** be provided. Sugar substitutes, pepper, herbal seasonings, lemon, vinegar, non-dairy coffee creamer, salt, and sugar may be provided, but shall not be counted as fulfilling any part of the nutritive requirements.
3. Sugar, condiments, seasonings or dressings intended for self-service use shall be provided only in individual packages or from dispensers that protect their contents.

I. Fat:

1. Minimize use of saturated fat in food preparation. Fats should be primarily monounsaturated and polyunsaturated vegetable oils, such as olive, peanut, corn, safflower, canola, cottonseed, and soybean oils.
2. The use of butter or fortified margarine as a spread for the bread is optional because of the emphasis on reducing fat content of the meals.

J. Desserts:

1. Dessert may be provided as an option to satisfy the caloric requirements or for additional nutrients. However, effort must be made to limit the amount of added sugar in the food preparation.
2. Preferred desserts include fresh, frozen, or canned fruit packed in their own juice, and low-fat products made with whole grains and/or low-fat milk.

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3. Pudding made with low-fat milk, low-fat ice cream, ice milk, or frozen yogurt may be served where feasible due to the increased calcium needed by the elderly.
 4. High-fat baked goods such as brownies, cakes, cobblers, cookies, and pies should be limited to once a week.
- K. Beverages:** In addition to beverages listed on the posted menu, drinking water should be available at all times. .
- L. Functional Foods:** Functional foods are foods in which the concentrations of one or more ingredients have been manipulated or modified to enhance their contribution to a healthy diet. Examples include everything from fruits, vegetables, grains and legumes, to fortified or enhanced foods. Nutrition programs are encouraged to use functional foods in menus whenever possible. Additional information regarding functional foods can be found at <http://www.eatright.org>.
- M. Dietary Supplements:** Dietary supplements encompass a wide range of products, including but not limited to vitamins, minerals, amino acids, and herbs. Although some older adults may need dietary supplements for health enhancement and/or to assist in meeting daily nutrient needs, they cannot be included in nutrition program meals.
- N. Modified Diets:** Modified or therapeutic medical diets may be provided as required by the client's special needs and medical condition.
1. **Documentation:** A written or documented verbal order must be on file for everyone receiving a modified diet, and the order should be reviewed annually with the client's healthcare provider.

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2. **Therapeutic Diet:** A therapeutic diet is an individualized diet prescription written by a medical professional that defines the client's daily intake for specific nutrients, i.e., an insulin-controlled diabetic diet would specify grams of carbohydrates, protein, fat and calories. For each client requiring a therapeutic diet, it is the responsibility of the qualified dietitian to develop an individual diet plan that provides the exact prescription of the prescribing medical professional and is adapted to the individual's food preferences as much as possible. Therapeutic diets require in-depth planning, counseling, and on-going supervision by a qualified dietitian.
3. **Modified/Therapeutic Menu:** Modified or therapeutic menus must be planned and prepared under the supervision of a Qualified Dietitian.
4. **Malpractice Insurance:** It is recommended that any dietitian providing therapeutic diet instruction be covered by malpractice insurance.
5. **Manual of Medical Nutritional Therapy:** A current Florida Manual of Medical Nutritional Therapy must be used as the basis for therapeutic or modified menu planning.
6. **Feasibility/Appropriateness of Modified/Therapeutic Diet:** In determining feasibility and appropriateness, the provider must determine whether:
 - a. There are sufficient numbers of persons needing special menus to make their provision practical.
 - b. The food and skills necessary to prepare the special menus are available in the AAA.
7. **Texture Modified Meals:** Modifying food texture and consistency may help older adults with chewing and swallowing problems. Chopping, grinding, pureeing, or blending foods are common ways to modify food textures. Texture modified food has the same nutritive value of solid foods and can be just as tasty and appealing. Serving sizes should account for any dilution to the food item during the preparation process. Thickened liquids are often required for individuals with dysphagia. The provision of such foods should be planned and prepared under the advice of a qualified dietitian.
8. **Adaptive Equipment:** When feasible and appropriate, reasonable attempts will be made to provide appropriate food containers and utensils for clients with disabilities.

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- O. Emergency Meals:** Nutrition programs are required to develop and have available written plans for continuing services for congregate and home delivered meals during weather-related or other emergencies including food procurement. Programs may offer shelf- stable meals to clients for later use. In accordance with NOI 020520-1-I-SWCBS, Emergency Home Delivered Meals (EHDM) must be reported in CIRTS with the aggregate number of meals received by the Nutrition Provider (after receipt).

Client specific information shall be maintained by the Nutrition Provider for audit purposes. This information must include the following:

- Client Name
- Client Signature
- Client ID Number
- Date of meal received by client

In the event there are no emergencies requiring the distribution of EHDM, Nutrition Providers are responsible for having a distribution plan for these meals.

The guidelines for shelf stable meals are:

9. Nutrient content of the meal must meet all requirements of the program and be approved by the AAA or nutrition program qualified dietitian.
10. Only top-grade, non-perishable foods in intact packages shall be included.
11. Cans are to be easy open, with pull tabs whenever possible.
12. All individual foods packages are to be labeled with expiration dates. All foods must be shelf stable. (Note: Meals with a multiple year shelf life, if stored properly, can be retained from one year to another and may help contain costs.)
13. Fruit and vegetable juices are to be 100 percent pure juices.
14. Dried fruit must be packed in an airtight container.
15. When applicable, easy-to-read preparation instructions should be included.

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- O. Holiday Meals:** Nutrition programs are required to develop and have available written procedures that address congregate meal site holiday closures including, but not limited to, the following items:
- 1.** Holiday closing schedule - The State of Florida recognizes the following holidays for employees: New Year's Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Veterans Day, Thanksgiving Day, Friday after Thanksgiving Day, and Christmas Day. Providers must receive prior written authorization from the AAA for any additional planned closing dates. Also, providers must ensure that planned holiday closings do not result in the closure of a congregate meal site for more than four (4) consecutive day meal service days, which may or may not include weekend days.,
 - 2.** Requirements for provision of meals - The provision of congregate services during site closures must be addressed in the AAA/provider contract. Providers must meet all requirements of the program and be approved by the AAA or nutrition program qualified dietitian.
 - 3.** Reporting of meals - Nutrition programs must meet all requirements for reporting of service units

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FOOD PURCHASING/PREPARATION STANDARDS:

Food Purchasing and Preparation Standards:

- A. Food Purchasing:** All food purchasing shall be transacted in accordance with DOEA policies and procedures, F.A.C. 64E-11 (Food Hygiene code), state, and federal regulations and food service contract provisions.
- B. Quality, Sanitation, and Safety:** Nutrition programs shall purchase food from sources that comply with all federal, state, and local laws relating to food quality, labeling, sanitation, and safety. Food shall be safe for human consumption, sound and free of spoilage, filth or contamination. Food from unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents, or swells shall not be used.

 - 1. Food in hermetically sealed containers shall be processed in an establishment operating under appropriate regulatory authority.
 - 2. All milk products used and served must be pasteurized. Fluid milk shall meet Grade A quality standards, as established by law.
 - 3. All meats, poultry, and shellfish shall be obtained from a source that is licensed under a state or federal regulatory program.
 - 4. Only clean eggs with shells intact and without cracks or checks, pasteurized liquid, frozen, or dry eggs or pasteurized dry egg products shall be used except for commercially prepared and packaged peeled hard-boiled eggs. Pasteurized liquid, frozen, or dry eggs or egg products shall be substituted for shell eggs in the preparation of recipes calling for uncooked eggs, such as Caesar salad, hollandaise or béarnaise sauce, noncommercial mayonnaise, eggnog, ice cream, and egg fortified beverages.
 - 5. All ready-to-eat, or drink, foods shall have an expiration date, use-by date, sell-by date, or best-by date. All food and drinks must be received prior to the expiration date, use-by date, sell-by date, and/or best-by date.
- C. Commercial Processors of Food:** All foods the provider purchases and uses in a nutrition program for the elderly must meet standards of quality for sanitation and safety applying to commercially processed foods.

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- D. Use of Donated Food:** Nutrition programs may use contributed and discounted foods only if they meet the same standards of quality, sanitation, and safety as apply to foods purchased from commercial sources. Acceptable items include:
1. Fresh fruits and vegetables received clean and in good condition; and
 2. Food collected from a food bank, which can be prepared and served before the expiration date, use-by date, sell-by date, or best-by date.
- E. Unacceptable Food Items:** In accordance with the Florida Food Code, unacceptable items include:
1. Food that has passed its expiration date, use-by date, sell-by date, or best-by date;
 2. Home canned or preserved foods;
 3. Food cooked or prepared in an individual home;
 4. Prepackaged unpasteurized juice (including unpasteurized apple cider);
 5. Any road-kill;
 6. Wild game donated by hunters; and
 7. Fresh or frozen fish donated by sportsmen.
- F. Frozen Foods:** Foods, which are frozen for later consumption by clients, must meet applicable local, state, and federal standards. Equipment and methods for freezing must also meet these standards.
- G. Group Food Purchasing:** Providers are encouraged to participate in group food purchasing or regional or local power buying coalitions provided this method can efficiently and responsibly meet the cultural and/or ethnic culinary needs of congregate and home-delivered meal participants.

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Meal Cost Analysis: Calculation of the full cost of a meal is an essential food service management practice. This information is important for determining a suggested donation per meal and for informing clients of the full cost of the meal.

Meal Cost Calculation: Each program that prepares its own meals shall calculate the component cost of meals provided per the following categories:

- A. **Raw food:** All costs of acquiring foodstuffs to be used in the program.
- B. **Labor:**
 - 1. **Food service operation:** All expenditures for salaries and wages, including valuation of volunteer hours for personnel involved in food preparation, cooking, delivery, serving, and cleaning of dining centers, equipment, and kitchens.
 - 2. **Project management:** All expenditures for salaries and wages, including valuation of volunteer hours for non-food service operations of the program.
- C. **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 \$1,000.
- D. **Supplies:** All expenditures for items with a useful life or less than one year and an acquisition cost of less than \$1,000.
- E. **Utilities:** All expenditures for gas, electricity, water, sewer, waste disposal, etc.
- F. **Other:** Expenditures for all other items that do not belong in any of the above categories (e.g., rent, insurance, fuel for vehicles) to be identified and itemized.

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FOOD PREPARATION AND SAFETY STANDARDS:

- A. **Regulations:** In all phases of the food service operation (storage, preparation, service, and delivery of meals), nutrition programs shall adhere to the state and local fire, health, sanitation, and safety regulations applicable to the types of food preparation and meal-delivery systems used by the program. State regulations to the hygienic preparation and serving of food are stated in the Chapter 64E-11, Food Hygiene, F.A.C. (<http://fac.dos.state.fl.us/>). F.A.C. 64E-11 is referenced as the guidelines for all food handling referenced in the “Food Preparation and Safety Standards” section.

If applicable, the current food permits and/or inspection report, issued by the Department of Health or the Department of Business and Professional Regulation shall be posted or on file.

- B. **Sanitation Program:** All Title III central kitchens and vendors must maintain a written, formal sanitation program that meets or exceeds the minimum requirements of state, federal, municipal, or other agencies authorized to inspect or accredit the food service operation.
- C. **Food Handling, Preparation and Service:** All staff working in the preparation of food must be under the supervision of a Certified Food Protection Manager (see Planning for Nutrition Services, Part C.) Food shall be prepared, plated, and transported with the least possible manual contact, with suitable utensils, and on surfaces that, prior to use, have been cleaned, rinsed, and sanitized to prevent cross contamination.

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- D. **Cleaning and Sanitizing:** Effective procedures for cleaning and sanitizing dishes, equipment, food contact surfaces, work areas, serving and dining areas shall be written, posted or readily available, and followed (refer to 64E-11, FAC.)
- E. **Safety:** Material Safety Data Sheets (MSDS) must be readily available on all chemicals used by the nutrition program. Employees must be informed about potentially dangerous chemicals used in the workplace and how to safely use them (<http://www.msdssearch.com>). Toxic materials, such as cleaners and sanitizers, shall be maintained in the original container or transferred to a clearly labeled appropriate container. Toxic materials must be stored separate from food, food equipment or single-service articles. Sanitizers, detergents, or other cleaning compounds shall be stored separately from insecticides, rodenticides, and other poisonous or toxic materials using methods such as different storage cabinets or separate areas of a room. Ref. Occupation Safety & Health Administration (OSHA) 1910.1200(g).
- F. **Quality and Quantity of Meals:** Tested standardized quantity recipes, adjusted to yield the number of servings needed, must be used to achieve the consistent and desirable quality and quantity of all meals.
- G. **Food Palatability:** All foods must be prepared and served in a manner to preserve optimum flavor and appearance, while retaining nutrients and food value.
- H. **Portion Control:** Nutrition programs must use standardized portion control procedures and equipment to ensure that each served meal is uniform and to reduce plate waste.
- I. **Potentially Hazardous Foods:** Potentially hazardous food is any food or food ingredient, natural or synthetic, which requires temperature control because it is in a form capable of supporting the rapid and progressive growth of infectious toxigenic microorganisms. Potentially hazardous foods that may cause foodborne illness include, but are not limited to:
 - 1. Any food that consists in whole or in part of milk or milk products, shell eggs, beef, poultry, pork, lamb, fish, shellfish, tofu, soy protein foods, cooked rice, beans, potatoes, or other heat-treated plant foods;

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2. Chicken salad,, pasta salad,, , tuna salad, potato salad, and other mixed foods containing potentially hazardous ingredients or dressings;
3. Raw seed sprouts;
4. Cut fruit; and
5. Garlic-in-oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth as specified in the definition.

J. Temperature and Time Control Requirements:

1. Cooling temperature requirements:

- a. Potentially hazardous foods requiring refrigeration after preparation, such as, chicken salad, , tuna salad, potato salad, or other mixed foods containing potentially hazardous ingredients or dressings shall be prepared from chilled products with a minimum of manual contact and shall be rapidly cooled to an internal temperature of 41° F. or below within four hours.
- b. Shell eggs do not apply if placed in a refrigerated unit immediately upon delivery.

2. Internal cooking temperature requirements:

- a. Eggs, fish, meat, and pork must meet an internal temperature of 145° F.
- b. Comminuted food (chopped, flaked, ground, or minced such as; ground beef, sausage, and gyros) must meet an internal temperature of 155° F.
- c. Stuffing, stuffed meat, or poultry must meet an internal temperature of 165° F.
- d. Fresh, frozen, or canned fruits and vegetables that are cooked for hot- holding must meet an internal temperature of 140° F for 15 seconds.

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- e. Microwave cooking temperatures for raw animal foods must be to a temperature of 165° F. in all parts of the food, allowed to stand for 2 minutes after cooking, covered to retain heat and stirred or rotated during cooking for even distribution of heat.
- f. Potentially hazardous foods that have been cooked and then refrigerated, or frozen, shall be reheated rapidly to a minimum of 165° F. for 15 seconds throughout all parts of the food before being served or placed in hot food storage equipment.

K. Holding temperature requirements:

- 1. Hot-holding temperatures for all hot foods are 140° F. or above.
- 2. Cold-holding temperatures for all cold foods are 41° F. or below.
- 3. Frozen foods shall be maintained frozen solid.

M. Meal Temperature Documentation Requirements: Temperature checks shall be taken, and documented, daily. Documentation shall be maintained for at least two years. Documentation must include at a minimum:

- 1. Time menu items delivered;
- 2. Each menu item and serving size;
- 3. Temperature(s) of each potentially hazardous menu items must be taken:
 - a. When the food is received by the nutrition site;
 - b. If there is more than 30 minutes between when the food is received at the meal site and when it is served, then a time and a temperature of each food item must be documented again at the time the meal is served; and
 - c. If a nutrition provider prepares the meal on site, then temperature must be taken and recorded when the food is leaving the production area.

Food grade probe-type thermometers must be used; other thermometers such as infrared thermometers, which do not insert into food cannot be used to take food temperatures. Thermometers must be correctly calibrated at least weekly, to ensure accuracy. Thermometers must be clean and sanitized between uses.

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N. Hazard Analysis Critical Control Point:

1. Hazard Analysis Critical Control Point (HACCP) is a proactive, comprehensive, science-based food safety system that allows operators to continuously monitor their establishments and reduce the risk of foodborne illness. The Florida Administrative Code does not currently require HACCP plans; however, nutrition programs that prepare their meals are encouraged to incorporate them into their operations to improve food safety at all levels of food service.
2. A HACCP Plan involves seven principles:
 - a. **Analyze hazards:** Potential hazards associated with a food, and measures to control those hazards, are identified. The hazard could be biological (i.e. microbe,) chemical (i.e. toxin,) or physical (i.e. ground glass or metal fragments).
 - b. **Identify critical control points:** These are points in a food's production at which the potential hazard can be controlled or eliminated from its raw state, through processing and shipping, to consumption by the client. Examples include cooking, cooling, packaging, and metal detection.
 - c. **Establish preventive measures with critical limits, for each control point:** For example, for a cooked food, this might include setting the minimum cooking temperature and time required to ensure the elimination of any harmful microbes.
 - d. **Establish procedures to monitor the critical control points:** Such procedures might include determining how and by whom cooking time and temperature should be monitored.
 - e. **Establish corrective actions** to be taken when monitoring shows that a critical limit has not been met. For example, reprocessing or disposing of food if the minimum cooking temperature is not met.
 - f. **Establish procedures to verify that the system is working properly:** For example, testing time and temperature recording devices to verify that a cooking unit is working properly.

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- g. Establish effective record keeping documenting the HACCP system:** This would include records of hazards and their control methods, the monitoring of safety requirements, and action taken to correct potential problems. Each of these principles must be backed by sound scientific knowledge. For example, published microbiological studies on time and temperature factors for controlling foodborne pathogens.

NOTE: A HACCP principles guide for operators of food service is available at <http://www.fda.gov/Food/GuidanceRegulation/HACCP/ucm2006801.htm>

- O. Food Service Employees/Volunteers:** All food preparation staff must work under the supervision of a Certified Food Protection Manager who ensures the application of hygienic techniques and practices in food preparation and service. A Certified Food Protection Manager is an individual who has successfully completed a Department of Health approved food safety and sanitation course and maintains a current certificate of completion.

- 1. Employee Orientation:** Any new staff or volunteer having contact with food service must have a general orientation to safe food handling and sanitation practices.
 - 2. Employee Health and Hygiene:** Employees can transmit foodborne illnesses through cross contamination of food, improper food temperature control, and food handlers' personal hygiene and medical condition.

All food handlers must adhere to 64E-11 FAC along with the standards set forth in the Nutrition Program Compliance Review form.

P. Suspected Foodborne Illness Outbreak Procedure:

- 1.** Nutrition programs should have a plan in place to respond to a suspected foodborne illness outbreak.

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2. Employees or volunteers shall direct all calls from clients claiming they became sick from a congregate or home delivered meal they consumed to the manager or person in charge immediately. An incident report collecting the following information shall be completed:
 - a. What is the name, address, and telephone number of person calling, including date and time of call?
 - b. Who became ill and what were the symptoms?
 - c. Was the illness diagnosed by a healthcare provider? Obtain healthcare provider's name if diagnosed.
 - d. What food and/or drinks were consumed?
 - e. What was the location, date, and time the food was consumed?
 - f. What is the name of person who served the food?
3. Evaluate the information promptly. Consider that a foodborne disease outbreak may have occurred when two or more persons experience a similar illness, usually gastrointestinal, after eating a common food.
4. If a foodborne outbreak is suspected, the following contacts shall be notified immediately:
 - a. Area Agency on Aging;
 - b. Local health department;
 - c. Department of Elder Affairs;
 - d. Food vendor (if applicable); and
 - e. Attorney and insurance agent.

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NUTRITION SERVICES INCENTIVE PROGRAM (NSIP):

The Nutrition Services Incentive Program (NSIP) is a cash allotment or commodity program that supplements funding of food used in meals served under the OAA. It is intended to provide incentives for the effective delivery of nutritious meals to older individuals. NSIP allows programs to increase the number and/or the quality of meals served. Florida has opted for cash payments in lieu of donated foods. This decision was based upon the preferences of the nutrition program directors. Nutrition programs are not qualified for USDA commodities from any source.

A. OAA Law and Federal Regulation Requirements for NSIP funds:

1. Only Title III nutrition program providers receive funds.
2. Nutrition programs shall use the funds to purchase U.S. grown foods.
3. Nutrition programs use funds to provide meals to eligible clients.
4. Nutrition program shall report meal counts of eligible meals to the AAA as required for the purposes of NSIP.
5. Each program shall develop and utilize a system for documenting meals included in the NSIP meal count. Acceptable methods for documenting meals served include:
 - a. Obtaining a signature from each client on a daily or weekly congregate meal service log or on a daily or weekly home delivered meal route sheet; or
 - b. Obtaining a signature from the congregate meal site manager/coordinator or the home delivered meal deliverer on a daily or weekly congregate meal service log or on a daily or weekly home delivered meal route sheet. The meal route sheet must include the client's name, address, and number of meals served.

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B. NSIP Meal Count-Eligible Meals: Area Agencies on Aging shall submit a meal count to the DOEA each year that includes all eligible meals served during the previous federal fiscal year (FFY), October 1 through September 30. DOEA will submit this information to the Administration for Community Living (ACL) in November of each year. This meal count will be used by the ACL to calculate NSIP grants for the next FFY. Ref: Section 311(42 U.S.C. 3030a). For a meal to be included in the NSIP meal count, the following conditions must be met:

1. DOEA menu development standards.
2. The meal shall be served to an eligible client.
3. The meal shall be served by an agency that has received a grant under the OAA Title III. Ref. OAA Section 311(42 U.S.C. 3030a).
4. The meal is served by a nutrition service provider who is under the jurisdiction, control, management, and audit authority of the AAA and the DOEA.

NOTE: OAA-funded congregate meals served to a long-term care enrollee can be included in the NSIP reporting; however, HDM funded in whole or in part under Statewide Medicaid Managed Care Long-Term Care, Home Care for the Elderly, Community Care for the Elderly (except clients who are not assessed a co-payment for the meal), or other means-tested programs cannot be included in the NSIP count.

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NUTRITION ASSISTANCE PROGRAM:

The Nutrition Assistance Program, aka Supplemental Nutrition Assistance Program (SNAP) formerly known as Food Stamps, helps individuals who meet eligibility requirements to buy food.

Providers shall offer referrals to clients who desire food assistance or who have a need identified on DOEA Forms 701S, 701A, 701B, or 701C.

An online application is available at the Automated Community Connection to Economic Self-Sufficiency (ACCESS) website (<http://www.myflorida.com/accessflorida>).

The provider may refer clients to a case manager for assistance in completing the application process.

If available, the provider may refer clients to the Aging and Disability Resource Center for online Food Assistance Program application assistance, using a voice recognition signature.

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FOOD SERVICE CONTRACT PROVISIONS:

Food Service Contract Requirements:

- A. **Food Service Contracts:** Food service contracts are defined as contracts for the purchase of meals or portions of meals or for food preparation.
- B. **Adherence to Standards:** All service providers must adhere to all standards set forth herein and incorporate the “Menu Planning, Development Review, and Approval Requirements” section of this handbook.
- C. **Competitive Bidding Time Frame:** Competitive bidding for food service vendor contracts must be conducted a minimum of every six years.
- D. Nutrition Programs are encouraged to ensure that their food service vendors use production kitchens located within the state of Florida. Any nutrition provider wanting to do business with a vendor that maintains meal preparation kitchens outside the state of Florida must seek prior approval from DOEA and ensure the production kitchen follows the Food and Drug Administration and the United States Department of Agriculture and any other applicable federal or state regulation.
- E. Preference may be given to vendors requiring the least amount of delivery time needed to facilitate meal quality. Multiple vendors’ contracts may be required to ensure meal sites offer culturally appropriate meals with limited meal delivery transit time.
- F. **Bid Specifications and Terms:** Food service vendor contracts should include, but not be limited to, the following specifications:
 - 1. **Delivery:**
 - a. **Transportation:** Trucks and vans capable of holding food at the required temperature and are clean and well maintained;
 - b. **Delivery sites:** Addresses and location of dining centers to be served;

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c. Delivery Schedule:

- i.** Number of days per week and specific days of required service;
- ii.** Number of holidays and days when meals are not to be served;
- iii.** Number of meals served with a time schedule for ordering additional or cancellation of daily meal counts; and
- iv.** Delivery schedules with a description of the time span between food packaging and delivery (to the extent possible not to exceed 4 hours). Preference should be given to the vendor that provides the best quality and the shortest time span between packaging and delivery of hot food.

d. Containers:

- i.** Food packaging style for transport;
- ii.** Food transport equipment specifications; and
- iii.** Responsibility for purchase and maintenance of the food transport equipment.

2. Menus: Menus shall be written per DOEA standards specified in this handbook and include the following:

- a.** Name and title of person who completed the menus;
- b.** Name and title of person who approved the menu;
- c.** Statement indicating which menu development methodology the vendor is utilizing:
 - i.** Menus must indicate serving sizes of all components; and

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- d. Requirement that menus must be submitted to the project director at least six calendar weeks in advance of implementation. Nutrition Program's qualified dietitian must approve menus.
 - e. Provision for evaluation of menu acceptability and menu revisions; and
 - f. Requirement to obtain prior approval by the nutrition service provider's qualified dietitian for all menu substitutions outside of a pre-approved menu substitution list.
- 3. **Food Safety and Sanitation:** The following food safety and sanitation requirements must be addressed in the vendor contract:
 - a. Requirement for documentation of a food safety management program within the facility that meets or exceeds the minimum requirements of federal, state, municipal, or other agencies authorized to inspect or accredit the food service operation;
 - b. Requirement to provide documentation of the three most recent food preparation inspections conducted by the state regulatory authority;
 - c. Requirement to provide a written plan of correction for any high priority or significant findings on sanitation inspections;

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- d. Requirement to notify the Nutrition Provider immediately for any closures or Administrative Complaints regarding food safety; and notify the Nutrition Provider within 24 hours of any sanitation inspections;
 - e. Description of vendors' delivery standards and sanitation that includes holding temperatures for transporting and serving food; and
 - f. Right of the nutrition program, AAA, or Department staff to inspect the food preparation and storage areas.
- 4. **Food Service:** The following food service topics must be included:
 - a. Number of meals and unit price for meals and other food served;
 - b. Breakdown of bid price for the raw food cost, labor, transportation, equipment, paper and plastic supplies, profit and other costs;
 - c. Food provided, including:
 - i. Entrée;
 - ii. Grain;
 - iii. Vegetable;
 - iv. Fruit;
 - v. Milk;
 - vi. Juice;
 - vii. Salad;
 - viii. Beverage;
 - ix. Cream/substitution;
 - x. Condiments; and
 - xi. Butter/margarine.
 - d. A provision stating that the nutrition program is not required to pay for food not meeting the proper specifications.

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- e. A provision stating that the nutrition program will procure food from other sources at the vendor's additional expense, if the vendor: fails to deliver a meal or any portion of a meal, delivers food that was spoiled, out of date, or otherwise inedible.
- f. A provision addressing supply of substitution food items to be kept at the meal site in case a substitution is necessary. If a supply of substitution items is kept on site, then a system must be in place to ensure all food items are used prior to the product's expiration date, use-by date, sell-by date, or best-by date.
- g. Provision for napkins, table covering, home-delivered meal containers, paper towels, and table service, including plates, cups, glasses, and silverware. The vendor shall provide specifications of the disposable supplies (each vendor shall be requested to provide samples of proposed packaging with the bid).
- h. Administration:
 - Schedule and method of payment to the food vendor;
 - Sales tax exemption;
 - Responsibility for product liability insurance and property damage;
 - Bonding;
 - Requirement that the vendor's financial records are open for audit purposes;
 - AAA approval; and
 - Binding time of the contract, as well as the termination process agreed upon by both parties.

NOTE: All food service contracts with profit-making organizations shall have prior approval from the AAA.

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CONTRIBUTIONS FOR NUTRITION SERVICES:

Procedures for Client Contributions:

- A. Contributions:** Clients will be given an opportunity to voluntarily and confidentially contribute to the cost of the service.
- B. No eligible individual shall be denied a meal because of failure to contribute.**
- C. Privacy and Confidentiality:** Nutrition providers shall establish procedures to protect the privacy and confidentiality of each client relative to his/her contribution.
- D. Use of Contributions:** All nutrition contributions shall be used to increase the number of meals, expand the meal service, facilitate access to nutrition services, and/or to provide nutrition counseling and nutrition education.
- E. Nutrition Assistance Program aka SNAP, (formerly Food Stamps):** Nutrition service providers may apply for authorization to accept Nutrition Assistance Program as contributions. Authorization may be obtained from USDA Food and Nutrition Services.

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Procedures for Handling Contributions: Procedures must be established by each provider in accordance with DOEA guidelines for handling funds collected to insure against loss, mishandling, or theft.

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LEFTOVER FOOD:

Procedures for Handling Leftover Food:

- A. Leftover food from a congregate meal site or from a home delivered meal route may not be transported back to the preparation site.
- B. Leftover food shall be stored properly or discarded at the congregate nutrition meal site.
- C. Leftover food may not be frozen to be served as client meals later.
- D. Leftover food may be served as seconds at a congregate meal site or on a home delivered meal route. **NOTE:** If a congregate meal client requests a second meal, then the meal must be opened and presented to the individual for consumption at the congregate meal site.
- E. The second meal may be counted only if served in its entirety as written on the posted menu.
- F. The nutrition provider should observe trends of foods typically left over and if due to client refusal, then consider revising the menu to accommodate most of the client's meal preferences.

DISPOSAL OF UNEATEN FOOD:

Foods, which have been served and not eaten, shall be discarded unless they are in their original containers and unopened (e.g., carton of fruit juice, packaged crackers.) Employees or volunteers shall not take food from kitchens or sites, except when packaged, taken and counted as a home-delivered meal to an eligible client.

SAFETY OF FOOD AFTER IT HAS BEEN SERVED:

The client is responsible for food safety after the food has been served to the client and if it is removed from the congregate nutrition meal site. Providers may post a sign stating: "For health reasons, taking out potentially-hazardous foods from the meal site is not recommended. Doing so is at your own risk." The risk of foodborne illness should be stressed and should be addressed through nutrition education.

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OUTREACH:

All nutrition service providers must ensure that outreach services are available to ensure participation of the maximum number of eligible older persons. Outreach services must be provided in accordance with this Handbook. See Appendix A – Service Descriptions and Standards.

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NUTRITION EDUCATION:

Congregate nutrition education is regularly scheduled culturally sensitive nutrition, physical fitness, or health information presentations and instruction to clients and caregivers in a group setting. Nutrition education is the process by which individuals gain the understanding, skills, and motivation necessary to make informed food, activity, and behavioral choices that can improve their health and prevent chronic disease. Home-delivered nutrition education is a formal program of regularly scheduled individual distribution of culturally sensitive nutrition, health, physical activity, and disease prevention information.

Providers shall conduct nutrition education as follows:

- A.** Nutrition education activities shall be planned, directed, and provided by a qualified dietitian, cooperative extension agents, or trained meal site or wellness coordinators, under the direction of the qualified dietitian.
- B.** Nutrition education is provided at each site and distributed to each home delivered meal client a minimum of once a month. If a congregate meal site is in a restaurant setting, then nutrition education may follow the home delivered meal requirements.
- C.** The provider's qualified dietitian or the AAA's designated qualified dietitian, shall develop a written annual nutrition education plan that documents subject matter, presenters and materials to be used.
- D.** Congregate sessions shall be a minimum of 15 minutes in length.
- E.** Each nutrition service provider shall maintain written documentation, for monitoring purposes that include the date of the presentation, name and title of presenter, lesson plan or curriculum, and number of persons in attendance. The documentation requirement for materials delivered to homebound clients, or restaurant-based congregate meal site clients, shall include the date of distribution, copy of distributed material, and number of clients receiving the information.

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NUTRITION COUNSELING:

Nutrition counseling provides one-on-one individualized advice and guidance to persons, who are at nutritional risk because of their poor health, nutritional history, current dietary intake, medications use, or chronic illness. Nutrition counseling includes options and methods for improving an individual's nutritional status. A qualified dietitian or a registered dietetic technician, under the supervision of a qualified dietitian evaluates the client's nutritional needs, conducts a comprehensive nutrition assessment, and develops a nutrition care plan in accordance with Chapter 64-B8-43, Florida Administrative Code. Based on the individual's needs and with appropriate contact with the individual's healthcare provider and caregiver, the qualified person referred to above develops and implements, or supervises the development and implementation, of the nutrition care plan. The initial counseling session, to the extent possible, must be face-to-face.

- A. Provider Qualifications:** A qualified dietitian who is covered by liability insurance shall provide nutrition counseling. A licensed dietitian employed by a county health department is covered by the state's sovereign immunity protection (section 768.28(9), F.S. A registered dietetic technician may assist the licensed dietitian in the screening and assessment process.
- B. Documentation:** A qualified dietitian shall keep applicable written client records that include the nutrition assessment, the nutrition care plan, dietary orders, nutrition advice, progress notes, and recommendations related to the client's health or the client's food or supplement intake, or any client examination or test results, in accordance with Chapter 64B8-44, Florida Administrative Code.
- C. Client Contributions:** Clients shall be given the opportunity to contribute to the cost of the nutrition counseling service.

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CONGREGATE MEALS

Program Requirements:

- A. Eligibility:** Congregate Nutrition Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with preference to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. In addition to meeting established eligibility, individuals must be mobile, not homebound, and physically, mentally, and medically able to attend a congregate nutrition program in accordance with written AAA guidelines.

Other individuals eligible to receive a congregate meal include:

1. The recipient's spouse, regardless of age or disability;
2. Individuals with disabilities, regardless of age, who reside at home with, and accompany older eligible individuals to, the congregate site;
3. Individuals with disabilities regardless of age who reside in a housing facility occupied primarily by older individuals where congregate nutrition services are provided; and
4. Individuals, regardless of age, providing volunteer services during the meal hours.

Meals served to the above eligible clients shall be included in the NSIP meal count.

B. Site Accessibility and Suitability:

1. **Basic Conditions:** Providers must ensure that congregate nutrition sites are established as follows:
 - a. Within proximity to most eligible individuals' residences as feasible, preferably within walking distance;
 - b. With attention to locations in multipurpose centers, schools, churches, or other appropriate community facilities; and

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- c. Located in a facility where individuals will feel free to visit. The selection shall also ensure the type and location of the facility so as not to offend the cultural and ethnic preferences of the individuals in the service area.

Whenever feasible, the nutrition provider may request assistance from the local transportation providers to transport clients to and from the dining site.

2. **Responsible Individual:** There must be an individual, either volunteer or paid staff, who is responsible for all activities at the site.
3. **Physical Plant Standards:** Sites should be clean and neat, have adequate lighting and ventilation, and meet all applicable health, fire, safety, and sanitation regulations.
4. **Dining Equipment and Arrangement:** There should be equipment, including tables and chairs, which are sturdy and appropriate for older persons. Tables should be arranged to ensure an appropriate, pleasant atmosphere and to encourage maximum socialization among the clients. There should be adequate aisle space between tables to allow for persons with canes, walkers, crutches, or wheelchairs to maneuver easily.
5. **Table Settings:** Appropriate settings, acceptable to the nutrition advisory council, should be provided. If disposable dinnerware is used, it must be of a quality that is sturdy to prevent buckling, spillage, melting, bending, and splintering. It must also be non-porous to prevent leakage and must be sanitary and attractive.
6. **Separation of Dining and Food Preparation Areas:** Provision should be made for separation between the dining area and the food preparation area, if food is prepared and served in the same facility.
7. **Adequate Time of Operation:** The site should be open each day meals are served, for a period adequate for all clients to leisurely eat a meal. Lunch meals should be served between 10:30 a.m. and 2:30 p.m., unless there is prior approval from DOEA.
8. **Supportive Services:** To the maximum extent feasible, the site should have available sufficient space and time for the provision of needed supportive services.

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9. **Celebrations:** Provisions should be made for the celebration of special occasions.
10. **Fire, Safety & Sanitation Inspections:** Nutrition providers must have documentation on file that all congregate meal sites are inspected for fire, safety, and sanitation in accord with local requirements at least annually.
11. **Food Temperature Documentation:** Nutrition providers must have documentation on file that temperatures of all potentially hazardous foods are taken and recorded daily at the time of delivery to the meal site and immediately before serving, if there is more than 30 minutes between delivery and serving time of meal. If meals are prepared on site, then the temperature of potentially hazardous foods must be taken immediately before serving.
12. **Taking Food Home:** The safety of food after it has been served to a client and when it has been removed from the dining center is the responsibility of the client. This policy must be available and posted at each meal site.
13. **Carry-Out Meals:** Carry-Out Meals are not allowed.
14. **Local Services Program (LSP) Congregate Meal Service:** As the Legislature appropriates Local Services Program (LSP) funds to be used for meals to high risk clients in some areas of the state, congregate meal clients may be provided a meal to consume in the home. The provider must ensure “proper storage and heating facilities are available in the home (as evidenced by a completed DOEA Form 217) and the participant is able to consume the second meal independently or with available assistance and within the expiration date indicated on the meal.” Providers that serve congregate clients a meal to consume at home are required to establish a food safety system that has been tested to maintain safe food temperatures per the Florida Administrative Code, 64E-11. Food safety education must be administered and documented for each client that is provided with a meal to consume at home. The AAA must approve the provider’s food safety system and food safety education materials prior to implementation. Meals must meet the OAA nutritional requirements to be claimed for Nutrition Services Incentive Program (NSIP) reimbursement. Also, the meal will be counted as a home-delivered meal.

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Statewide Medicaid Managed Care Long-Term Care OAA Congregate Meal Service:

Nutrition providers cannot bill for OAA Title III C1 if meals are being paid for by another funding source such as SMMC or Adult Care Food Program, or if included in private pay rate.

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HOME-DELIVERED MEALS

Program Requirements:

- A. Eligibility:** Home-Delivered Meal Nutrition Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with preference given to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. In addition to meeting established eligibility, individuals must be homebound, or physically, mentally, or medically unable to attend a congregate nutrition program in accordance with written AAA guidelines.

Other individuals eligible to receive home-delivered meals include:

1. The spouse of a homebound eligible individual, regardless of age, if the provision of the collateral meal supports maintaining the person at home;
2. Individuals with disabilities, regardless of age, who reside at home with eligible individuals and are dependent on them for care; and
3. Individuals at nutritional risk who have physical, emotional, or behavioral conditions that would make their service at a congregate nutrition site inappropriate; and persons at nutritional risk who are socially or otherwise isolated and unable to attend a congregate nutrition site.

B. Requirements for Home-Delivered Meal Providers:

1. **Frequency:** At a minimum, each provider shall be able to deliver meals to homebound participants and serve home-delivered meals at least once a day, five or more days a week. Providers are encouraged to provide meals seven days a week.
2. **Meal Service:** Home-delivered meals may be hot, cold, frozen, dried, or canned with a satisfactory storage life, and must conform to all standards contained in this handbook.
3. **A Client/Home Evaluation Form** for frozen meals should be on file for each client receiving a home-delivered frozen meal.

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4. **Multiple Meals:** More than one meal may be delivered for consumption each day, provided proper storage and heating facilities are available in the home, and the client can consume the second meal either alone or with available assistance.
5. **Menu development and Nutrient Requirement:** Menus must be written in accordance with DOEA standards (See section: "Menu Development Review and Approval Requirements").

Note: Community Care for the Elderly Lead Agencies must comply with the requirements for home delivered meal providers.

C. Basic Conditions for Food Packaging and Transportation: All nutrition programs shall have equipment that maintains the safe and sanitary handling of all menu items during the time between the completion of the cooking process through the end of the serving or delivery period.

1. The time between the completion of food preparation and the delivery to the homebound client, to the extent possible, should not exceed four (4) hours.
2. All hot home-delivered meals for the lunch meal shall be delivered to the client no earlier than 10:30 a.m. and no later than 2:30 p.m.
3. All food shall be individually packaged.
4. Cold and hot food shall be packaged and packed separately.
5. Food utensils shall be completely wrapped or packaged to protect them from contamination.
6. Food containers should be sectioned so that food doesn't mix, leak, or spill.
7. All food shall be packed in secondary insulated food carriers that can maintain food temperatures at 140° F. or higher or at 41° F. or lower.
8. Food carriers must be constructed as to prevent food contamination by dust, insects, animals, vermin, or infection.
9. Food carriers should be enclosed to protect food from contamination, crushing, or spillage and be equipped with insulation and/or supplemental sources of heat and/or cooling as necessary to maintain safe temperatures.
10. Food carriers must be clean and sanitized, or use containers with inner liners that can be sanitized.

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11. Each provider shall monitor their HDM meal routes. Providers shall monitor the meal temperatures of all hot and cold potentially hazardous food items. Routes shall be monitored on a random and rotating basis; however, each route must be monitored at least annually. When temperature noncompliance is reported or identified, on a route, the provider must monitor that route on a weekly basis until adequate corrective action has been achieved.

- D. **Frozen Meals:** When frozen meals are delivered to clients, the temperature shall be a maximum of 20° F, or the food shall be frozen solid.

Cold Meals (meals not requiring heating before consumption: i.e. sandwich): When cold meals are delivered to clients, the temperature shall be a maximum of 41° F.

Home-Delivered Frozen and Cold Meals: Elderly clients who receive frozen or cold meals must be evaluated using DOEA Form 217 before choosing, is option and at least annually thereafter. The nutrition provider shall ensure that:

1. **Home Equipment:** The client or caregiver has the needed equipment in the home (electricity, a stove with an oven that works, a working microwave oven, or a working toaster oven, and a freezer in which to store the meals).
2. **Ability to Follow Directions:** The client or caregiver has both the physical and mental capability to follow cooking directions and use the equipment.
3. **Dated and Labeled:** The frozen meals shall be dated and clearly labeled. Instructions for storage and cooking shall be provided in large print. If milk is received frozen, the container must have an expiration date; and the milk must be received and scheduled to be consumed prior to the expiration date.
4. **Emphasis on Following Directions:** The importance of following directions is emphasized with clients on a regular on-going basis.
5. **Inability to Follow Instructions:** Clients who may be unable to follow the instructions should not receive frozen meals in the home.
6. **Multiple Meals:** More than one meal may be delivered each day, provided proper storage and heating facilities are available in the home and the client can consume the second meal independently or with available assistance.

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- E. High-Risk Individuals Needing Additional Meals:** When feasible, programs should have a policy and procedure in place to offer additional meals to clients who are at high nutritional risk. Guidelines for programs to determine who is eligible for additional meals are as follows:
1. The individual is at high nutritional risk, as indicated on the assessment tool.
 2. The individual must not have other resources to provide additional meals.
 3. The individual must have facilities to store meals that may be delivered.
 4. The individual must be able, or have a friend or family member available, to operate kitchen equipment, which is required to later reheat prepared, delivered meals for consumption.
- F. Referral to Other Services:**
1. **Screening:** Home-delivered meals clients shall be screened for need for other services and referred as appropriate.
 2. **Referral:** Persons who can function sufficiently well should be referred to congregate nutrition programs, when such programs are available.

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DOEA Form 2017

Nutrition Program Policies

**Attachment 1:
Client Evaluation Form for Cold or Frozen, Home-Delivered Meals**

NAME: _____

ADDRESS: _____

PHONE: _____

IN EMERGENCY CONTACT: _____

EMERGENCY CONTACT PHONE: _____

Rating: Place an "X" in the appropriate space.

PHYSICAL EVALUATION:

_____ GOOD _____ FAIR _____ POOR

If poor, please explain: _____

EYESIGHT: GOOD _____ FAIR _____ POOR _____

If poor, please explain: _____

ABILITY TO MOVE AROUND IN KITCHEN: (GENERAL MOBILITY; WALKER, CANE, ETC:)

GOOD _____ FAIR _____ POOR _____

If poor, please explain: _____

DOEA FORM 217, January 2020

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ABILITY TO PERFORM SMALL MOTOR TASKS (ARTHRITIS?)

GOOD _____ FAIR _____ POOR _____

If poor, please explain: _____

MENTAL EVALUATION: (ALZHEIMER'S, CONFUSION, ETC.)

GOOD _____ FAIR _____ POOR _____

If poor, please explain: _____

COOKING FACILITIES:

YES

NO

Working Refrigerator

Working Freezer

Working Oven

Working Toaster Oven

Working Microwave

ADDITIONAL COMMENTS: DO YOU FEEL THIS CLIENT HAS THE NECESSARY EQUIPMENT AND IS PHYSICALLY AND MENTALLY CAPABLE FOR HANDLING FROZEN OR COLD HOME-DELIVERED MEALS?

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Evidence-Based Disease Prevention
and Health Promotion Services

PURPOSE AND LEGAL AUTHORITY:

The primary purpose of the Title IIID Evidence-based Disease Prevention and Health Promotion program is to provide services and activities that have been demonstrated through rigorous evaluation to be effective evidence-based programs to assist older adults in maintaining a healthy lifestyle. As set forth by the Older Americans Act, the Department shall give priority to areas of the State that are medically underserved, and areas where there are large numbers of older individuals who have the greatest economic need for Title IIID services. Additionally, the OAA requires targeting services to older individuals with the greatest economic need and individuals with greatest social need, with particular attention to low-income individuals, including low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. Title IIID services may be provided through the following venues:

- A. Senior centers;
- B. Congregate meal sites; and
- C. Other appropriate senior locations.

Legal Basis: The legal basis for Title IIID services is found in the Older Americans Act of 1965 as amended.

Specific Legal Authority:

Older Americans Act, Title III, Part D, Sections 361-42

U.S.C. 3030m, n

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Evidence-Based Disease Prevention
and Health Promotion Services

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SERVICES OFFERED:

- A.** A Matter of Balance (MOB)
- B.** Active Living Every Day
- C.** Arthritis Foundation Exercise Program
- D.** Arthritis Self-Management Program
- E.** Applied Suicide Intervention Skills Training (ASIST)
- E.** Brief Intervention and Treatment for Elders (BRITE)
- F.** Chronic Disease Self-Management Program
- G.** Chronic Pain Self-Management Program
- H.** Counseling (Gerontological)
- I.** Counseling (Mental Health/Screening)
- J.** Diabetes Empowerment Education Program (DEEP)
- K.** Diabetes Self-Management Program
- L.** Enhance Fitness
- M.** Enhance Wellness
- N.** Fit & Strong!
- O.** Health Eating Every Day
- V.** Healthy Ideas

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Evidence-Based Disease Prevention and Health Promotion Services

- W.** Healthy Moves for Aging Well
- X.** HomeMeds
- Y.** Nutrition Counseling
- AA.** Medication Management
- BB.** Physical Fitness
- CC.** Powerful Tools for Caregivers
- DD.** Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)
- EE.** Programa de Manejo Personal de la Arthritis
- FF.** Programa de Manejo Personal de la Diabetes
- GG.** Stepping On
- HH.** Stay Active and Independent for Life (SAIL)
- II.** Stress-Busting Program for Family Caregivers
- JJ.** Tai Chi for Arthritis
- KK.** Tai Chi/Tai Ji Quan: Moving for Better Balance
- LL.** Tomando Control de su Salud
- MM.** Un Asunto de Equilibrio
- NN.** Walk with Ease

Descriptions of these services are included in Appendix A, Service Descriptions and Standards, of this Handbook.

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Evidence-Based Disease Prevention
and Health Promotion Services

ELIGIBILITY:

Program Eligibility Requirements:

- A. Persons Eligible:** Persons 60 years of age or older.
- B. Targeted Services:** Services should be targeted to persons:
 - 1.** Residing in medically underserved areas; and
 - 2.** Residing in areas where many older individuals have the greatest economic need for services.
 - 3.** Low-income older individuals, including low-income minority elders, older individuals with limited English proficiency, and older individuals residing in rural areas.
- C. Restriction:** Evidence-based disease prevention and health promotion services shall not include services for which payment may be made under Title VIII and Title XIX of the Social Security Act (42 U.S.C. 1395 et seq.).

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PURPOSE AND LEGAL AUTHORITY:

Purpose of Section 8: This section describes the procedures for obtaining OAA, Title IIIB funding for the acquisition, renovation and construction of Multipurpose Senior Centers (MPSCs), when funding is available.

Specific Legal Authority:

Older Americans Act, Title III, Part B, Sections 321(b)(2) 42
U.S.C. 3030d

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MULTIPURPOSE SENIOR CENTER CONTRACTS:

Multipurpose Senior Center Requirements and Definitions:

- A. Acquisition/Renovation/Construction of Multipurpose Senior Centers:** The AAA in the area plan may allocate OAA, Title IIIB funding for the acquisition, renovation or construction (A/R/C) of multipurpose senior centers (MPSC) in the PSA.
- B. Definitions:** For purposes of this Section, the following additional definitions apply:
 - 1. Acquisition:** Obtaining ownership of an existing building (including a mobile facility) in fee simple or by lease arrangement for 10 years or more for use as a MPSC.
 - 2. Renovation:** Making modifications or alterations to an existing facility that are necessary for its effective use as a MPSC. Renovation may include restoration, repair, expansion and all related improvements.
 - 3. Construction:** Building a new facility, including the costs of land acquisition, architectural and engineering fees and construction costs. Refer to the noted section in 2 above regarding an exception.
 - 4. Cost of Personnel:** The costs of professional and technical personnel to operate or staff the MPSC will not be included in the A/R/C proposal or funding award.
- C. Special Conditions:** Acquisition or construction will not be approved until it has been determined that leasing or renovating a suitable facility is not practical.
- D. Cost of Fixtures:** The cost of fixtures may be included in the project if essential for operation as a MPSC.

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LOCATION OF MULTIPURPOSE SENIOR CENTERS:

Location Considerations and Requirements:

- A. Location:** Each AAA will carefully consider the placement of MPSCs, giving preference to location in areas with the greatest incidence of older persons with social or economic need, with attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
- B. Special Considerations:** Specific consideration is to be given to:
1. Transportation accessibility;
 2. Neighborhood security;
 3. Convenience for collocation of services; and
 4. Availability of supportive and nutrition services to be provided at the MPSC.

NOTE: A minimum of at least 3 services must be provided.

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MULTIPURPOSE SENIOR CENTER PROPOSALS AND PROJECTS:

Inclusion in Area Plan:

- A. Funding:** Each AAA intending to identify a specific project for an A/R/C contract will designate OAA, Title III funding for this purpose in the area plan.
- B. Application:** Such projects identified in the area plan will then be formalized by a specific application from a local applicant agency for the necessary A/R/C funding.

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PLANNING ACQUISITION, RENOVATION, OR CONSTRUCTION (A/R/C) PROJECTS:

A/R/C Planning Phase:

- A. Planning Activities:** Each AAA will perform and document the planning activities preceding an A/R/C application. The following criteria should be considered:
1. Analyzing the need for a MPSC in a county/city/community;
 2. Determining the essential services and activities which will take place in the MPSC; and
 3. Evaluating the potential buildings and sites suitable for a MPSC.
- B. Ad Hoc Committee:** During this planning phase, the AAA is encouraged to designate an ad hoc committee of local officials, older persons and community representatives to thoroughly consider the community needs, preferences and priorities for MPSC development, and examine potential facilities or locations.
1. **Emphasis on Community Resources:** The emphasis should be on using community persons and resources to develop the MPSC project while the AAA provides technical assistance and documents the planning process.
 2. **Use of Existing Buildings:** In the planning stage, the suitability of existing buildings will be determined and the decision to lease/purchase/construct must be made Existing buildings must also be considered from the standpoint of renovation requirements and costs.
- C. Professional Services:** The services of an architect or engineer may be appropriate in the planning phase, whether the decision is made to use an existing facility or, if this is not feasible, to construct a new facility.
- D. Resolution of Issues:** The planning phase must realistically resolve the following issues:
1. **Location** of the MPSC;
 2. **Services** to be offered for older persons;
 3. **Land/facility** acquisition to be by lease or purchase;
 4. **Renovations** necessary for effective use of an existing building;

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5. **Feasibility** of a construction project if no existing building is suitable;
 6. **Funding source** to be used for the A/R/C project;
 7. **Local matching funds** are sufficient;
 8. **Resources** are available to operate and maintain the facility after the A/R/C phase;
 9. **Funding source** for on-going activities and staff after the A/R/C phase;
 10. **Assurances** that older persons have equitable access and usage of the MPSC and costs are pro-rated if there are multiple funding sources involved;
 11. **Resolution** of technical questions about the architectural and/or engineering requirements; and
 12. **Application selection** for the public or private non-profit agency responsible for the MPSC project.
- E. **Planning Phase:** The planning phase is to clearly develop and document the following descriptions:
1. **Number** of older persons and their needs to be met by the MPSC project;
 2. **Services, benefits and activities** to be provided by the center;
 3. **Location** and neighborhood of the center;
 4. **Transportation accessibility** to the MPSC;
 5. **Estimated costs and funding** resources available for the MPSC;
 6. **Resources** available to operate and maintain the MPSC;
 7. **Potential for collocation and coordination** of CCE services using the MPSC as a focal point; and
 8. **Potential** for use of the MPSC for the following groups of recipients:
 - a. Title III, Older Americans Act;
 - b. Alzheimer's Disease Initiative;

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- c.** DOEA or Department of Children and Families residents of Adult Living Facilities or Adult Family Care Homes; and
- d.** Home Care for the Elderly or Community Care for the Elderly programs for provision of adult day care if recipients are physically and mentally capable of participation.

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A/R/C PROJECT APPLICATIONS:

A/R/C Application Process and Requirements:

- A. Applicant:** The applicant agency or the sponsoring organization must develop an application for funding and ensure the required local matching resources are available.
- B. DOEA Approval:** Approval for A/R/C projects to proceed must be obtained from DOEA. The application must clearly detail the specifics of the MPSC project. The project proposed must be responsive to the requirements outlined below:
 - 1. Acquisition:** The application must include:
 - a. Long-Term Lease:** Specify whether the facility acquisition is by long term lease (10 years or more), payable in advance (lump sum); or, in fee simple purchase.
 - b. Descriptive Specifications:** Incorporate complete, current descriptive specifications of the physical facility and must include current design and construction documents on the building.

The inclusion of photographs and sketches are encouraged for supplemental information.
 - c. Architectural Requirements:** Meet the architectural requirements specified in paragraph 8-7 a (7) below.
 - d. Existing Facility Requirement:** Specify that renovations are being made by the current owner/seller to meet MPSC standards prior to acquisition.
 - e. Down Payment:** Specify if acquisition is proposed utilizing a down payment from OAA. Title III funds and a realistic program for paying the balance is included.
 - f. Interest Payments:** Direct payment of interest from OAA, Title III funds is a non-allowable cost.

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2. **Renovation:** The application must include the following:
 - a. A complete description and drawings of the facility prior to the renovation;
 - b. A description of the proposed renovation actions and associated architectural drawings; and
 - c. Complete details regarding the current ownership and tenancy of the land and building(s) involved in the renovation.
3. **Construction:** The application must include the following:
 - a. Current ownership and tenancy of the land on which construction is proposed;
 - b. Complete description of the construction proposal; and
 - c. Complete architectural specifications and drawings.

C. **Application Submittal--Applicant:** All MPSC project applications must be submitted to the AAA as follows:

1. Utilizing the formats and instructions prescribed by DOEA;
2. Ensuring all information is complete, accurate and responsive to the requirements; and
3. Within the time frame determined by the AAA.

Application Submittal—AAA: The AAA is to review and critique the application, notifying the applicant of required revisions, additions, or corrections required. The initial application is considered a **draft** until it is accepted and approved by the AAA.

D. **Approved Application:** The application as approved by the AAA must include:

1. The critique of the application by the AAA;
2. A specific statement of support and approval of the A/R/C project by the AAA board of directors;

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3. A specific assurance that Title III, OAA funding is available to the AAA; or, if not, identify the resources proposed; and
 4. A specific assurance that the A/R/C project is included in the area plan; or, if not, an area plan revision must be attached.
- E. **Advertising for Bid Proposal:** The AAA will formally notify the applicant that advertising for bids may proceed only after notification is received from DOEA that the project application follows MPSC requirements.
- F. **Pre-application Steps:** The AAA may devise and utilize a more extensive system of pre-application steps to be used in the planning and application development stages to guide the ad hoc committee in the project planning.

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A/R/C ASSURANCES:

Regulatory and Other Compliance Requirements:

- A. Regulatory Compliance:** Each applicant for OAA, Title III funding for A/R/C of a multipurpose senior center must ensure compliance with the following health, safety and application requirements:
1. Section 504 of the Rehabilitation Act of 1973;
 2. National Historical Preservation Act;
 3. Flood Protection Act. (If a facility is to be in a flood prone area, there must be evidence that flood insurance will be provided.);
 4. Davis-Bacon Act and other mandatory federal labor standards;
 5. Architectural Barriers Act of 1968;
 6. "Life Safety Code", NFPA No. 101;
 7. All applicable state or local building codes. (In the absence of these codes, compliance with Chapter 12 of the Standard Building Code must be ensured.);
 8. All applicable state and local health, sanitation and zoning codes or ordinances; and
 9. Americans with Disabilities Act.
- B. Other Requirements:** Other assurances required of MPSC projects are that:
1. The facility will be used for the purposes for which it was acquired:
 - a. For 10 years or more, if acquisition or renovation is funded by OAA, Title IIIB; or
 - b. For 20 years, if construction is funded by OAA, Title IIIB.
 2. Sufficient funds will be available to meet the non-federal share of the A/R/C costs.

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3. Sufficient funds will be available for effective use of the facility for the purposes for which the A/R/C project was approved.
4. The facility will not be used and is not intended to be used for sectarian instruction or as a place for religious worship.
5. In the case of construction or purchase, an assurance that no existing facilities in the community were available or suitable for leasing as a MPSC.
6. The facility will be adequately insured.

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APPROVAL OF A/R/C PROJECTS:

DOEA Approval Process:

- A. Completed Applications:** The AAA shall provide DOEA with two copies of the application after it has received AAA approval.
- B. DOEA Review:** DOEA will review the application and obtain architectural/engineering review of the drawings and specifications from a consulting architect.
- C. DOEA Notification:** DOEA may notify the AAA of any deficiencies that must be corrected prior to approval.
- D. DOEA Approval:** When deficiencies have been corrected, DOEA will provide an approval notification to the AAA that OAA, Title III funding for this project may be contracted to the applicant agency.

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SPECIAL CONSIDERATION FOR RENOVATION OR CONSTRUCTION PROJECTS:

Special Competitive Bid Procedure:

A. Building Construction: The applicant undertaking renovation or construction projects must utilize a competitive bid procedure to obtain building construction services. All applicants must ensure that:

1. **Form HHS 514:** Form HHS 514 "Requirements for Federally Assisted Construction Regarding Labor Standards and Equal Employment Opportunity" is incorporated in the bid specifications and contracts.
2. **Federal Wage Determination:** Federal wage determination information in accordance with the Davis-Bacon Act must be obtained prior to developing bid specifications and contracts. A wage determination is a listing of the rates of pay for laborers and mechanics prevailing in the locality as determined by the U.S. Secretary of Labor.
3. **Request for Wage Determination:** Six weeks prior to the anticipated date of need, the applicant agency or its consulting architect must request the wage determination information through DOEA.
4. **Labor for Federally Assisted Projects:** Laborers or mechanics on federally assisted construction projects shall not be paid less than these prevailing wages regardless of any contracting relationship that may exist between a general contractor or sub-contractor and such laborers and mechanics.
5. **Labor Prohibition:** The use of piecework or contracts for personal services to circumvent the federal labor provisions is prohibited.
6. **Contracts Over \$2,000.00:** A wage determination must be requested for all prime contracts more than \$2,000.00 and all sub-contracts regardless of the amount. The request must include the following information as outlined in Technical Handbook for Facilities Engineering and Construction Section 1.5.3, Information on Federal Wage Rate and Labor Standards:
 - a. Estimated advertising date;
 - b. Estimated bid opening date;
 - c. Estimated value of the contract;

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- d. Type of work (construction or renovation);
- e. Project location (city, county, state);
- f. Project name and concise description of project work to be performed; and
- g. Crafts needed.

B. Architect or Engineer Services: The services of an architect or engineer (A/E) are required on all renovation or construction projects costing \$5,000.00 or more. In addition, the A/E must be registered in Florida; and, if possible, be selected for professional knowledge and experience relating to the design for and special needs of older persons.

A/E Service Agreement: The services of the A/E are to be formalized by a written service agreement. The A/E agreement shall provide for all services necessary to the successful implementation of the MPSC Project including:

1. **Completion Schedule:** Preparation of a schedule for completion of each phase of the work, (i.e., schematic design, design development and construction documents);
2. **Pre-construction Conference:** Provision for attendance at a pre-construction conference;
3. **Monthly Site Visits:** Site visits at least monthly after the start of the renovation or construction project;
4. **Final Inspection:** A final inspection of the renovation or construction project in conjunction with the project applicant, contractors, AAA staff, DOEA representative and DOEA consulting architect;
5. **Compliance Assurance:** Assurance that the A/E is aware of and will comply with all requirements of the Davis-Bacon Act, Federal Labor Standards, the Architectural Barriers Act and NFPA No. 101 "Life Safety Code;"
6. **Smoke Detectors:** Assurance that an adequate number of approved smoke detectors will be included in the MPSC project;
7. **Women and Minorities:** Assurance that Form HHS 514, and, where applicable, the goals and timetables for women and minorities in the construction industry are included in the bid specifications and construction contracts;

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8. **EEO:** Assurance that all bid specifications or construction contracts over \$10,000 shall include the Equal Employment Opportunity (EEO) clause and the standard EEO contract specifications;
9. **Prioritization of Activities:** A prioritization of renovation or construction activities, to be utilized in case of bid costs exceeding estimates;
10. **Design Documents for Construction:** For construction projects the A/E must provide the following design documents prepared to professional standards for review by the DOEA consulting architect.
 - a. **Schematic design** documents.
 - b. **Construction documents** (including construction drawings and specifications suitable for bid specifications).
 - c. **Design development** documents (upon completion of project).
11. **Design Documents for Renovation:** The AAA may also require the design documents described above be prepared for renovation projects. In this event, DOEA will likewise review design documentation prior to contracting for renovation;
12. **Compensation:** Compensation for basic A/E services shall be determined by a fixed fee. The allowable fixed fee shall not exceed that which prevails for comparable services in the project area, for an equivalent renovation or any construction project. Reasonable A/E fee may be comparable to six to ten percent of the project cost;
13. **Disallowed Costs:** Costs incurred by the A/E for additional consultant services for work expected to be included in the basic fee for A/E services shall not be allowed as an additional cost to the project; and
14. **Waiver:** If the requirement for A/E services creates a major difficulty for an applicant, the applicant may request a waiver from DOEA through the AAA specifying the facts and circumstances which make obtaining A/E services a hardship and proposing a reasonable alternative procedure for ensuring that the renovation or construction proposed can meet all requirements for MPSC funding under OAA, Title III.

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- C.** Each AAA, which has an approved application for renovation or construction projects pending, must provide technical assistance to the applicant to assure contracting procedures are observed and that received bids are responsive to the bid specifications.
- D.** After renovation or construction has begun, the AAA must remain current on project progress, render technical assistance as needed, and make sure reports are submitted to the DOEA, as may be required.

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EMPLOYMENT UTILIZATION REPORT:

Monthly Employment Utilization Report Requirements:

- A. DOL CC 257:** All building contractors performing work on projects more than \$10,000 are required to submit a Monthly Employment Utilization Report, DOL CC 257, to the area Office of Federal Contract Compliance Programs (OFCCP) by the fifth day of the month following the month being reported.
- B. Work Hour Utilization:** This report requires the work hours' utilization information covering the contractors' and/or subcontractors' aggregate work force performing work on both federal and non-federal funded construction projects within the geographic area.
- C. Failure to Report:** Failure to report may result in contracts being cancelled, terminated or suspended in whole or in part; and, the contractor may be declared ineligible for further federally-assisted construction contracts.

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OBLIGATION OF OAA, TITLE III FUNDS FOR A/R/C PROJECTS:

Specific Requirements:

- A. Project Approval Obligation:** The approval of an A/R/C project obligates the OAA, Title III funding for this purpose.
- B. Obligated Funds Time Schedule:** Because A/R/C projects may be built or acquired over a period, it may be necessary to provide a time-scheduled release of the obligated funds particularly for renovation or construction projects.
- C. Expenditures:** Expenditures may occur over several fiscal, area plan years or contract periods.
- D. Caution:** Care must be taken to re-contract with the A/R/C applicant agency if there is an unexpended balance of the funds obligated for this approved project.

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MONITORING OF A/R/C PROJECTS:

Specific Requirements:

- A.** The AAA must conduct monitoring of the progress on A/R/C projects including construction progress in accordance with Chapter 1, Section III of this handbook.
- B.** The AAA must ensure that funds are expended for the purposes expressed in the application and that progress is being made in accordance with the approved construction schedule.
- C.** The applicant must conduct on-site labor standards compliance interviews for renovation and construction projects in accordance with Chapter 1, Section III of this handbook.

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COMPLETION OF A/R/C PROJECTS:

Specific Requirements:

- A. DOEA On-Site Inspection:** When the applicant determines that the MPSC is ready for acceptance, the applicant will notify the AAA. The AAA will subsequently notify DOEA. A time and date will be established for on-site inspection by the DOEA consulting architect.

- B. On-Site Inspection Results:** After acceptance by the DOEA consulting architect, DOEA will verify to the AAA that the facility has been accepted as meeting MPSC requirements.

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ANNUAL VERIFICATION:

Specific Requirements:

- A. Annual Evaluation:** The AAA will annually verify that the facility continues to be used for the purposes for which it was acquired, renovated or constructed and that the assurances given in the A/R/C Assurances on pages 196-197 are still valid for the following period:

 - 1. Ten years after acquisition or renovation; or
 - 2. Twenty years after construction.
- B.** This verification is done using DOEA Form 207 or equivalent (Attachment 1).
- C.** For purposes of efficiency or economy, any AAA may arrange with any other AAA to perform this annual verification.
- D.** If the AAA determines that the use of the facility has changed and/or that the assurances required are invalid, action will be taken in accordance with the recoupment procedures as outlined in the Recapture of Payments (see page 208_, by prompt notification to DOEA of the verification results.

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RECAPTURE OF PAYMENTS:

Recoupment Procedures:

- A. Recoupment:** If it is determined that the MPSC is not being used for the purposes for which the OAA, Title III funds were approved, the Administration for Community Living (ACL) may require the applicant to repay the funds or a portion thereof.

Waiver: This requirement may be waived by the Assistant Secretary for Aging under unusual circumstances.

- B. Acquisition or Construction:** The federal government is entitled to recapture a portion of federal funds from the owner of a senior facility, if within 10 years of acquisition or 20 years after completion of construction:

1. The owner ceases to be public or non-profit agency; or
2. The facility is no longer used for multi-purpose senior center activities.

- C. Recoupment Formula:** The amount recovered is that portion of the current fair market value of the facility equal to the percentage of federal funds contributed to the original cost.

- D. Federal Share:** When the state has determined that funds will be returned by a senior center provider, a check for the federal share must be made out to DOEA and submitted through the AAA to the DOEA Division of Financial Administration.

- E. Disposition:** DOEA will notify the Administration for Community Living Regional Office in Atlanta of the receipt of recaptured federal funds and request disposition instruction.

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REQUESTING A WAIVER OF FEDERAL PAYBACK:

Federal Payback and Waiver Procedures:

- A. **Federal Waiver Authority:** The Assistant Secretary for Aging in Washington, D.C., has the authority to grant a waiver of the payback of federal funds owed for construction or acquisition of a senior center.
- B. **DOEA Waiver Authority:** DOEA has the authority to grant a waiver of the payback of federal funds owed for the renovation of a senior center.
- C. **Grantee Responsibility:** The grantee agency will inform the contractor (usually the AAA) of plans to vacate the existing facility.
- D. **Contractor Responsibility:** The contractor will inform the grantee that the original contract commitment period (for 10 or 20 years) has not been fulfilled and pursuant to their agreement a percentage of federal funds must be repaid.
- E. **Amount of Payback:** The amount of payback owed for construction or acquisition is based upon the following criteria:
 - 1. The fair market value of the senior center.
 - 2. Percentage of the fair market value equal to the percentage of the original federal share of the grant.

Example: If fair market value is \$100,000, and the federal government's original share of the facility costs was 75%, then the government is owed \$75,000, or a request for waiver of the federal payback amount must be approved.
- F. **Waiver Request:** The grantee agency then requests from the contractor a waiver for the amount owed and justifies its request.
- G. **Contractor Approval of Waiver Request:** The contractor (usually the AAA) approves or disapproves this request and forwards the request along with its reasons for approval or disapproval to the DOEA.

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- H. **DOEA Approval of Waiver Request:** If this waiver is for a facility that was funded for renovations, the Secretary of DOEA will approve or disapprove the request. A written notice of the waiver action regarding federal payback will be sent to the regional office of the ACL.

Note: If the waiver request is for renovations, the process ends here at the State level: **STOP!** If the waiver request involves funding for acquisition or construction, then the process continues as indicated below: ↓

- I. **Federal Regional Office Approval of Waiver Request:** If the waiver is for a facility funded for acquisition or construction, the DOEA forwards the waiver request along with a memo concurring or not concurring with the contractor's letter of approval or disapproval to the regional office of the ACLA.
- J. **Federal Assistant Secretary for Aging Approval of Waiver Request:** The regional office of the ACL forwards the request to the Assistant Secretary for Aging in Washington, D.C. who will then approve or deny the waiver request.
- K. **Federal Response Time:** Once the waiver request leaves DOEA, the usual response time from Washington, D.C. is six to eight weeks.
- L. **DOEA Notification:** DOEA will notify the AAA of the waiver action decided by the assistant secretary. The AAA will notify the contracting agency that will take appropriate action with respect to the sponsoring agency that requested the waiver.

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SELECTION OF FOCAL POINTS:

Collocation of Services: Each MPSC funded under Title III, OAA must be given special consideration for designation as a focal point for collocation of services.

STAFFING AND OPERATION OF THE MPSC:

A/R/C Funding Prohibition: The funding designated for A/R/C cannot be used to provide staffing for senior center operation or for costs of operating or maintenance. Each applicant for A/R/C funding must realistically plan to obtain resources for this purpose to meet the requirements of the annual MPSC verification.

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COMPLETION OF 10 OR 20 YEAR COMMITMENT:

Procedures for Completion of Commitment:

- A. Facility File Closure:** When a MPSC has completed its 10-year (acquisition or renovation) or 20-year (construction) commitment and has achieved its final anniversary date, the file on this facility can be closed.
- B. Retention Guidelines:** State title retention guidelines stipulate that the contract should be retained for 5 years thereafter.
- C. Final Anniversary Date:** The AAA will inform the Department that the facility is approaching the final anniversary date. The AAA and the Department should maintain the original (or a copy) of the contract and the final DOEA-AA Form 207, Annual Verification.
- D. AAA Notification of File Closure:** The AAA is to inform the Department in writing upon closing out a MPSC file.

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SENIOR CENTER ANNUAL VERIFICATION FORM ACQUISITION/RENOVATION/CONSTRUCTION

Facility Name: _____		
Address: _____ (Street) (City) (Zip)		
Telephone: () _____ Contact Person: _____		
Project Type (Check one): ___ Acquisition ___ Renovation ___ Construction		
Date Verification Period Begins: _____ Ends: _____ <u>Anniversary Date</u>		
The owner has assured that the facility will be used as a multipurpose senior center for not less than ten years after acquisition or renovation or not less than 20 years after construction (Check appropriate choice.)		
The following information has been verified within three months of the anniversary date of the project. The items listed below follow Federal and State requirements. ___ 1) The owner of the facility is a public or nonprofit private agency or organization. ___yes ___no ___ 2) The facility continues to be used for the purposes for which it was acquired/renovated/constructed. ___yes ___no.		
If "no" was checked for 1 or 2 above, note the changes in ownership or status changes/actions that affect Federal reversionary interests.		

Area Agency on Aging

Date

DOEA Form 207, July 2008

February 2020

3-195

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National Family Caregiver Support Program

PURPOSE AND SPECIFIC LEGAL AUTHORITY:

Purpose of : The purpose of Title III, Part E, of the OAA, as amended, is to enable AAAs and entities that AAAs contract with, to provide multifaceted systems of support services to the following individuals:

- A.** Family caregivers; and
- B.** Grandparents or older individuals, 55 years of age or older, who are relative caregivers of children not more than 18 years old or individuals with disabilities.

Specific Legal Authority:

Older Americans Act, Title III, Part E, Sections 371-376 42
U.S.C. 3030s

Developmental Disabilities Assistance and Bill of Rights Act, Section 102 42
U.S.C. 6001

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DEFINITIONS

Term:

Child: Individual not more than 18 years old or an individual with a disability.

Family Caregiver: Adult family member, or another individual, who is an informal provider of in-home and community care to an older individual.

Frailty: The older individual is determined to be functionally impaired because the individual:

- A.** Is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or
- B.** Due to cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

Grandparent or older individual who is a relative caregiver: Grandparent or step grandparent of a child, or a relative of a child by blood, marriage or adoption who is 55 years old or older, and who meets the following conditions:

- A.** Lives with the child;
- B.** Is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver for the child; and
- C.** Has a legal relationship to the child, legal custody or guardianship, or is raising the child informally

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National Family Caregiver Support Program

CAREGIVER SUPPORT PROGRAMS/SERVICES:

Caregiver support programs/services shall include the services listed below. Refer to the Appendix A, Services Descriptions and Standards, for a description of each service. The Caregiver Support Services Program components are designated in the Client Information and Registration Tracking System (CIRTS) as follows:

- A. Caregiver Support Services (OA3E):** The following services are intended to provide direct help to caregivers who provide care for elder recipients (60 and older). These services assist in the areas of health, nutrition and financial literacy and help caregivers in making decisions and problem solving related to their caregiving roles and responsibilities.

Elder recipients (60 and older) must meet the frailty requirement to be eligible to receive OA3E caregiver respite services as follows:

1. Adult Day Care/Adult Day Health Care
2. Respite Services (Direct Pay, Facility-Based and In-Home)

A caregiver of an elder recipient (individual 60 or older who meets the frailty requirement) may receive supplemental services, without receiving respite services.

The frailty requirement for elder recipients (60 and older) does not apply to the following OA3E caregiver services:

3. Caregiver Training/Support
4. Counseling (Gerontological and Mental Health)
5. Education/Training
6. Financial Risk Reduction (Assessment and Maintenance)
7. Information
8. Intake
9. Outreach

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10. Referral/Assistance
11. Screening/Assessment
12. Transportation

- B. Caregiver Supplemental Services (OA3ES):** At least ten percent (10%), but no more than twenty 20 percent (20%), of the total Title III E funds shall be used to provide supplemental support services. OA3ES supplemental services are available to elders age 60 and older, or grandparents and non-parent relative caregivers, age 55 and older, enrolled in OA3EG (grandparent) caregiver programs. The elder must meet the frailty requirement to be eligible to receive supplemental services under OA3ES.

The frailty requirement does not apply to the OA3EG program recipients. The following services are provided to complement the care provided by caregivers.

1. Chore Services
2. Housing Improvement
3. Legal Assistance
4. Material Aid
5. Specialized Medical Equipment, Services and Supplies

- C. Grandparent or Non-Parent Relative Support Services (OA3EG):** At least five percent (5%), but no more than ten percent (10 %), of the total Title III E funds shall be used to provide support services to grandparents and older individuals who are relative caregivers. Services for non-parent relative caregivers (55 and older) caring for children under the age of 18 and children aged 18 and older with disabilities designed to help meet their caregiving obligations include:

1. Caregiver Training/Support
2. Child Day Care
3. Counseling (Gerontological and Mental Health)
4. Education/Training
5. Legal Assistance

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6. Outreach
7. Referral/Assistance
8. Screening/Assessment
9. Sitter
10. Transportation

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POPULATION SERVED AND PRIORITY:

Population Served: Services under a State program shall be provided to:

- A. Family caregivers; and
- B. Grandparents and older individuals who are relative caregivers of children not more than 18 years old or individuals with a disability.

Prioritization within Population Served: Services under a State program shall give priority to older individuals under the following conditions:

- A. Those with greatest social and economic need, paying attention to low- income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
- B. Those providing care and support to persons, including children, with severe disabilities.

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OAA Registered Services

OLDER AMERICANS ACT (OAA) REGISTERED SERVICES:

Registered Services are the cluster of services for which the ACL requires the collection of client-specific data as a component of NAPIS (National Aging Program Information System) reporting.

OAA registered services:

- A.** Adult Day Care
- B.** Adult Day Health Care
- C.** Chore
- D.** Congregate Meals
- E.** Escort
- F.** Home-Delivered Meals
- G.** Home Health Aide
- H.** Homemaker
- I.** Nutrition Counseling
- J.** Personal Care
- K.** Respite
- L.** Screening and Assessment

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Vulnerable Elder Rights Protection Activities

PURPOSE AND LEGAL AUTHORITY:

Purpose of Title VII: Allotments are made to states under Title VII of the OAA to pay for the cost of carrying out vulnerable elder rights protection activities. This section focuses on vulnerable elder rights protection activities which include establishment of an Office of Long-Term Care Ombudsman; programs to address the prevention of elder abuse, neglect and exploitation; and, legal assistance development.

Legal Basis: The legal basis is found in the Older Americans Act of 1965 as amended.

- A. General State Provisions
- B. Ombudsman Programs
- C. Prevention of Elder Abuse, Neglect and Exploitation
- D. State Legal Assistance Development Program

Specific Legal Authority:

Older Americans Act, Title VII, Subtitle A, Chapter 1 (Sections 701-705); Chapter 2 (Section 711-713); Chapter 3 (Section 721); Chapter 4 (Section 731) Subtitle C (Section 761-765)

42 U.S.C. §§ 3058, 3058a-d, 3058f-j, 3058bb-ee

Sections 400.0060-0091, F.S.—Ombudsman Program

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DESCRIPTION OF TITLE VII VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES:

Title VII, Prevention of Elder Abuse, Neglect and Exploitation Program Services Include:

- A. Information:** The program is intended to provide information to the public on ways to conduct outreach, identify and prevent elder abuse, neglect and exploitation. Activities may include provision of:

1. Published literature such as brochures, pamphlets and posters;
2. Videos;
3. Training materials;
4. Public service announcements; and
5. Radio broadcasts.

The above list of activities is not all-inclusive.

- B. Education/Training:** The program should include education/training for individuals, professionals, and paraprofessionals in relevant fields on the identification, prevention and treatment of elder abuse, neglect and exploitation (including financial exploitation) with focus on prevention and enhancement of self-determination and autonomy.

- C. Coordination Efforts:** Area Agencies on Aging and providers shall be knowledgeable of and coordinate activities with Department of Children and Families, Adult Protective Services staff, as well as with other programs that have as their focus vulnerable older individuals, including:

1. Long-Term Care Ombudsman Program;
2. Protection and advocacy programs;
3. Facility and long-term care provider licensure and certification programs;
4. Medicaid field office staff;
5. Victim assistance programs;

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6. State and local systems; and
 7. Agencies and courts of competent jurisdiction.
- D. Technical Assistance:** Area Agencies on Aging shall provide technical assistance to providers on any of the above program functions as they relate to elder abuse, neglect and exploitation (including financial exploitation). Education and training may be conducted in a variety of settings such as:
1. Forums
 2. Workshops
 3. Seminars
 4. Conferences
 5. One-on-one, etc.

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USE OF ALLOTMENTS:

The State Unit on Aging (Department of Elder Affairs) is required to work to enhance and improve the state's overall system for the prevention and treatment of elder abuse, neglect and exploitation (including financial exploitation), and protection of older individuals' dignity and rights in the delivery of protective services. In this way, the Department is an ally of the state protective services agency in working for more effective services for vulnerable older people.

The Department and/or AAAs may design services to develop, strengthen, and carry out programs for the prevention and treatment of elder abuse, neglect, and exploitation, including:

Service Design:

- A.** Providing public education and outreach to identify and prevent elder abuse, neglect and exploitation (including financial exploitation).
- B.** Conducting training for individuals, professionals and paraprofessionals, in relevant fields on the identification, prevention and treatment of elder abuse, neglect and exploitation (including financial exploitation), with focus on prevention and enhancement of self-determination and autonomy.
- C.** Providing technical assistance to programs that provide or have the potential to provide services for victims of elder abuse, neglect and exploitation (including financial exploitation) and for family members of the victims.
- D.** Conducting special and on-going training sessions for individuals involved in serving victims of elder abuse, neglect and exploitation (including financial exploitation) on the following topics:
 - 1.** Self-determination;
 - 2.** Individual rights;
 - 3.** State and federal confidentiality requirements; and
 - 4.** Other topics determined by the state agency to be appropriate

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COORDINATION:

In developing and enhancing local programs and services for the prevention of elder abuse, neglect and exploitation (including financial exploitation) of older individuals, the state agency shall coordinate the programs with other state and local programs and services for the protection of these vulnerable adults. These services and programs may include:

Coordination with Other State and Local Programs such as:

- A. AAA:** Area Agency on Aging programs;
- B. Department of Children and Families:** Aging and Adult Protective Services;
- C. Agency for Health Care Administration:** Facility and long-term care provider licensure and certification programs under the Agency for Health Care Administration;
 - 1.** Licensure and certification programs for facility and long-term care providers; and
 - 2.** Medicaid fraud and abuse services, including those provided by the Medicaid Fraud Control Unit.
- D. Victim Assistance Programs** located in the following areas:
 - 1. Crime Victim Compensation:** Florida Office of the Attorney General, Bureau of Victim Compensation, The Capitol, PL-01, Tallahassee, FL 32399. This office aids victims of crimes.
 - a.** Victim assistance is provided in each of the twenty judicial circuits. Access to this assistance is through the toll-free Victim Services Information and Referral Line: 1-800-226-6667.
 - b.** Types of assistance include the following:
 - i.** Wage loss;
 - ii.** Loss of support;
 - iii.** Disability allowance;
 - iv.** Funeral/burial related expenses;

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- v. Treatment expenses;
 - vi. Prescriptions;
 - vii. Eyeglasses;
 - viii. Dentures;
 - ix. Prosthetic devices;
 - x. Mental health counseling;
 - xi. Property loss reimbursement for the elderly (60 years of age and older); and
 - xii. Domestic violence relocation.
- 2. **Sheriff's Office:** Crime Prevention, Community Services Bureau, in local Sheriff's Office. Educational programs may be available in your area. Contact your local Sheriff's office for information.
- 3. **Law Enforcement:** Victim Witness Program. This service provides counseling support for victims of violent crime. Contact your local law enforcement office for information.

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FLORIDA LONG-TERM CARE OMBUDSMAN PROGRAM:

Statutory Requirements: Per Title VII, Section 712, a state agency shall establish and operate an Office of the State Long-Term Care Ombudsman. The program shall, without interference by any executive agency, undertake to discover, investigate, and determine the presence of conditions or individuals that constitute a threat to the rights, health, safety, or welfare of the residents of long-term care facilities. The office shall be headed by an individual who shall be as follows:

- A. Known as the State Long-Term Care Ombudsman; and
- B. Selected from among individuals with expertise and experiences in the following fields:
 - 1. Long-term care, and
 - 2. Advocacy.

State Requirements:

Florida Statutes: In Florida, Chapter 400, Part I, F.S. establishes the Long-Term Care Ombudsman Program and lists the program's requirements related to the OAA, and how the state of Florida complies with these requirements. These requirements are:

- A. Establish an Office of State Long-Term Care Ombudsman headed by the state ombudsman;
- B. Establish a State Long-Term Care Ombudsman Council to serve as an advisory body to the state ombudsman;
- C. Establish a process for designing local districts covering the state in which individuals certified as ombudsmen carry out the duties of the state ombudsman program; and
- D. Establish a process for appointment as a certified ombudsman including application, level 2 background screening, 20 hours of initial training, and 10 hours of continuing education.

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Purpose: The Program's primary purpose is to provide ombudsman services to residents residing in long-term care facilities such as:

- A. Nursing homes;
- B. Assisted living facilities; and
- C. Adult family-care homes.

Responsibilities: Responsibilities of the Long-Term Care Ombudsman Program include the following areas:

- A. **Complaints:** Identify, investigate and resolve complaints made by or on behalf of residents of long-term care facilities relating to actions or omissions by providers of long-term care services, other public agencies, guardians, or representative payees that may adversely affect the health, safety, welfare, or rights of residents.
- B. **Administrative Assessments:** Conduct an annual review of conditions in each long-term care facility noting needed improvements and making recommendations to enhance the quality of life for residents.
- C. **State and Federal Compliance:** Analyze, comment on, and monitor the development and implementation of federal, state and local laws, regulations and policies with respect to long-term care and to the health, safety, welfare and rights of the residents of long-term care facilities in the state and recommend changes in such laws, regulations and policies as appropriate.
- D. **Information:** Provide information to public agencies, legislators and others regarding the services provided by the program and problems and concerns of residents of long-term care facilities.
- E. **Statewide Reporting System:** Establish a statewide reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities.
- F. **Support for Family and Resident Councils:** Provide technical support for the development of resident and family councils in long-term care facilities.

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G. Annual Report: Prepare an annual report describing the activities carried out by the office, the state council, the districts, and the local councils in the year for which the report is prepared. The state ombudsman shall submit the report to the secretary, the United States Assistant Secretary for Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of Children and Families, and the Secretary of the Agency for Health Care Administration at least 30 days before the convening of the regular session of the Legislature.

The report shall, at a minimum:

1. Contain and analyze the data collected concerning complaints about and conditions in long-term care facilities and the disposition of such complaints.
2. Evaluate the problems experienced by residents.
3. Analyze the successes of the ombudsman program during the preceding year, including an assessment of how successfully the program has carried out its responsibilities under the Older Americans Act.
4. Provide recommendations for policy, regulatory, and statutory changes designed to solve identified problems; resolve residents' complaints, improve residents' lives and quality of care; protect residents' rights, health, safety, and welfare; and remove any barriers to the optimal operation of the State Long-Term Care Ombudsman Program.
5. Contain recommendations from the State Long-Term Care Ombudsman Council regarding program functions and activities and recommendations for policy, regulatory, and statutory changes designed to protect residents' rights, health, safety, and welfare.
6. Contain any relevant recommendations from the representatives of the State Long-Term Care Ombudsman Program regarding program functions and activities.

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Grievance Procedures

Please refer to Appendix D, “Minimum Guidelines for Recipient Grievance Procedures,” located in this Handbook

Chapter 4

Administration of the Community Care for the Elderly (CCE) Program

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Section I: Purpose of the CCE Program

PURPOSE OF THE CCE PROGRAM:

- A. Chapter Contents:** This chapter provides program policies, standards and procedures for use by the Department and all contractors and subcontractors in administering the Community Care for the Elderly (CCE) program.
- B. Purpose:** The primary purpose of the CCE program is to prevent, reduce or delay premature or inappropriate placement of older persons in nursing homes and other institutions.

Additional purposes of the CCE program are to provide the following:

- 1. A continuum of service alternatives to meet the diverse needs of older people;
- 2. Access to services for elders most in need; and
- 3. A local resource that will coordinate delivery of services for the frail elder/caregiver.

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Section I: Legal Basis and Authority

LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

- A. CCE Act:** The Florida Legislature demonstrated its commitment to meeting the special needs of Florida's aging citizens by passing the CCE Act in 1973. This Act was amended in 1976, authorizing the funding and implementation of demonstration projects to determine acceptable and cost-effective ways of keeping elderly persons in their own homes to prevent, postpone or reduce inappropriate or unnecessary institutional placements. The seven demonstration projects established as a result of the Act served seniors with the greatest need who were frail or functionally impaired and required ongoing help. FS 430.205, The Department, through the area agency on aging shall fund in each planning and service area, at least one community care service system that provides case management and other in-home and community services as needed to help the older person maintain independence and prevent or delay more costly institutional care. Today, CCE funding is available in all 67 counties.
- B. Specific Authority:**
1. Chapter 430.201-207, F.S.
 2. Chapter 58C-1, F.A.C.

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Section II: Services Provided Under the CCE Program

SERVICES PROVIDED UNDER THE CCE PROGRAM:

State funds appropriated for CCE services must be used to fund an array of services that meet the diverse needs of functionally impaired elders. These categories of services are most needed to prevent unnecessary institutionalization. The Area Agencies on Aging (AAA) shall be the only organization conducting CCE intake services, unless a waiver is approved by DOEA. The AAA shall not provide any other CCE funded services. not provide CCE funded services. Refer to Appendix A, "Service Descriptions and Standards," for a description of each service. The services include the following categories:

- A. Core Services:** Core Services include a variety of in-home services, day care services, and other basic services that are most needed to prevent or delay institutionalization.
1. Adult Day Care;
 2. Chore Services;
 3. Companionship;
 4. Escort;
 5. Financial Risk Reduction;
 6. Home Delivered Meals;
 7. Homemaker;
 8. Housing Improvement;
 9. Legal Assistance;
 10. Pest Control Services;
 11. Respite Services;
 12. Shopping Assistance; and
 13. Transportation.

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Section III: Services Provided under the CCE Program

B. Health Maintenance Services: Health Maintenance Services are routine health services that are necessary to help maintain the health of functionally impaired elders. The services are limited to medical therapeutic services, non-medical prevention services, personal care services, home health aide services, home nursing services, and emergency response systems.

1. Adult Day Health Care;
2. Emergency Alert Response;
3. Gerontological Counseling;
4. Health Support;
5. Home Health Aide;
6. Medication Management;
7. Mental Health Counseling/Screening;
8. Nutrition Counseling;
9. Occupational Therapy;
10. Personal Care;
11. Physical Therapy;
12. Skilled Nursing Services;
13. Specialized Medical Equipment, Services and Supplies; and
14. Speech Therapy.

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C. Other Support Services: Other Support Services expand the array of care options to assist functionally impaired elders and their caregivers.

1. Caregiver Training/Support;
2. Case Aid;
3. Case Management;
4. Intake;
5. Material Aid; and
6. Other.

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Section IV: Program Requirements

COMMUNITY CARE SERVICE SYSTEM:

- A. Description:** The CCE law defines the community care service system as a service network comprised of a variety of in-home and other basic services for functionally- impaired elderly persons. Services may be provided by several agencies under the direction of a single Lead Agency. The purpose of the community care service system is to provide a continuum of care encompassing a range of preventive, maintenance and restorative services.

GENERAL ELIGIBILITY CRITERIA:

Listed below are the eligibility criteria for the CCE program:

- A. Age:** Individuals 60 years of age or older.
- B. Functional Impairment:** Functional impairment is characterized by physical or mental limitations, which restrict the ability to perform the normal activities of daily living and which impede the capacity to live independently without the provision of services through the CCE program. Functional impairment shall be determined through a functional assessment as determined by the 701S screening used to prioritize applicants for the program who have not begun to receive CCE services.
- 1.** The functional assessment process determines functional impairment and risk of institutionalization, facilitating the identification of the appropriate array of services needed to maintain the independence of the client. Two forms are used for conducting screening and assessment to determine functional impairment activities. Applicants can be prioritized by greatest need and risk of institutionalization without CCE services. A priority score and rank are produced when the assessment is entered in CIRTS. The Comprehensive Assessment (701B) is used for enrollment into the program prior to the initiation of services, at reassessment and to assess and update the significant change in the client's situation. A risk score is produced from the 701B and a priority score and rank from either assessment form type.

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Only after completing the assessment is a determination of an individual's functional impairment made for eligibility determination. If the individual is determined by the case manager to be functionally impaired, he or she is eligible to receive CCE services. The case manager also determines the individual's risk of institutionalization without CCE services. Priority is given to the individual most at risk.

In summary, client eligibility is based on age, need and risk of institutionalization without CCE services.

2. A client comprehensive assessment must be completed annually for each client receiving CCE services to ensure ongoing eligibility.
- C. Clients may not be dually enrolled in the CCE program and a Medicaid capitated long-term care program.

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PRELIMINARY ELIGIBILITY DETERMINATION AT INTAKE:

- A.** Approval to begin the eligibility process for Department-funded programs is determined by the availability of funds and the priority ranking of individuals. Priority groups are described on page 11..
- B.** If the applicant appears to be eligible for CCE services based on the preliminary information received, an appointment should be made for a screening as soon as possible. The person conducting the intake process will explain that a more thorough discussion of the applicant's situation and need for services is required.
- C.** If the person clearly does not appear to meet the CCE eligibility requirements, the person conducting the intake process must explain the eligibility criteria. Referral to other agencies must be made, if appropriate. The referral (if applicable) and determination of ineligibility must be documented.

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PRIORITY GROUPS:

Clients in the following subgroups are priority recipients for CCE case management and CCE services. The subgroups are listed in order, beginning with the highest priority.

If two individuals are assessed as the same priority level and are at risk of nursing home placement, priority must be given to the individual with the lesser ability to pay for services. If the ability to pay is the same, the individual with the greatest length of time on the assessed priority consumer list must be given priority.

A. Assessment and Prioritization of Service Delivery for New Clients

. Any person who has been classified as a functionally impaired elderly person is eligible to receive community-care-for-the-elderly core services. The following are the criteria used to prioritize new clients in the sequence below for service delivery. It is not the intent of the Department to remove current clients from any services in order to serve new clients being assessed and prioritized for service delivery.

1. Department of Children and Families (DCF) Adult Protective Services (APS) High Risk individuals: The Contractor shall ensure that pursuant to Section 430.205(5)(a), Florida Statutes, those elderly persons who are determined by DCF APS protective investigations to be vulnerable adults in need of services or to be victims of abuse, neglect, or exploitation who are in need of immediate services to prevent further harm, and are referred by APS, will be given primary consideration for receiving CCE services. As used in this subsection, "primary consideration" means that an assessment and services must commence within 72 hours after referral to the Department or as established in accordance with Department contracts by local protocols developed between Department service Contractors and APS.

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Designated as a “high risk referral”, the referral will be staffed by APS and the lead agency to determine the specific services needed. Such services may be time limited and designed to resolve the emergency or crisis situation that could place the person at risk of further harm. For referrals received during business hours, the lead agency must initiate the emergency or crisis resolving service(s) within 72 hours of receipt of the phone call/fax from APS. Case management alone does not meet this requirement. For high risk referrals that are currently receiving services funded by DOEA, the 72-hour time frame includes not only existing services, but also any additional emergency or crisis resolving services

Upon receipt of the referral, the lead agency must communicate to the consumer that services put in place may be limited to 31 days. The provision services(s) may exceed 31 days if:

- a. The emergency or crisis still exists, and continuation of the services is needed for resolution, or
- b. The crisis is likely to return without the provision of services.

A 701B comprehensive assessment must be completed in person within 72 hours of receipt of the APS Referral Tracking Tool (ARTT) referral packet for high risk referrals received during business hours. For high-risk referrals received after business hours, the 72 hours begins when the phone call/fax from APS is received. A 701S, 701A, or 701B assessment must be completed within 14 calendar days for intermediate and low-risk referrals.

Before services are terminated after 31 days, the client will be seen face-to-face by a lead agency case manager. If it is determined that services can be safely terminated, APS will be contacted (using contact information in the ARTT). APS staff will participate in a discussion of the client regardless of the status of the case.

CCE co-payments for services will be waived for high-risk referrals during the first 31 days of service or until the vulnerable adult’s crisis has been resolved as determined by the lead agency and APS staff.

If both parties agree that crisis-resolving services can safely be terminated, the client may be placed on a waitlist for additional services if appropriate. The case manager will complete and enter the new 701B Form in CIRTS.

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If both parties do not agree that services can safely be terminated, the lead agency case manager will assess the client's needs, and the assessment will be entered in CIRTS. An APS investigator supervisor and a case manager supervisor at the lead agency will jointly review the case to resolve the issue(s), identified at staffing.

The Contractor shall follow guidelines for DCF APS High Risk referred individuals established in the APS Referrals Operations Manual, which is incorporated by reference.

2. **Imminent Risk Individuals:** Individuals in the community whose mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or very likely within three (3) months.

Regarding question 19 (on the 701S) or 21 (on the 701A): "The individual is transitioning out of a nursing facility (NF)," certified screeners and assessors/case managers should respond, "N" because individuals in nursing homes are not considered IR according to the definition. It is the responsibility of certified screeners and assessors/case managers to screen and assess only individuals who are residing in the community (private residence, assisted living facility, or adult family care home). Please note that if an individual is currently in an NF and interested in NF services, long-term care program education should be provided, and the individual should be referred to CARES.

Regarding question 20 (on the 701S) or 22 (on the 701A): As the current IR definition only includes those individuals in the community, only question number 20 on the 701S screening form should be used by the ADRC for IR designations. "Individual is at imminent risk of NF placement," certified screeners and assessors/case managers should only respond "Y" if during completion of the assessment, the individual or their representative provides information that indicates the individual's "mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or very likely within three (3) months."

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The certified screener or assessor/case manager will not ask the individual or their representative the question but will instead check an answer based upon the observations by the screener or assessor. The screener or assessor will document justification for the designation in the appropriate "Notes and Summary" sections of the assessment form, including supervisor approval. Additionally, the Department may request Aging and Disability Resource Centers (ADRCs) to rescreen any individual ranked imminent risk prior to Enrollment Management System (EMS) release to confirm the IR designation.

3. Aging Out Individuals: Individuals receiving Community Care for Disabled Adults (CCDA) and Home Care for Disabled Adults (HCDA) services through the Department of Children and Families' Adult Services transitioning to community-based services provided through the Department when services are not currently available.
4. Service priority for individual not included in (1), (2), or (3) above, regardless of referral source, will be determined through the Department's assessment administered to each applicant, to the extent funding is available. The Contractor shall ensure that priority is given to applicants at the higher levels of frailty and risk of nursing home placement. For individuals assessed at the same priority and risk of nursing home placement, priority will be given to applicants with the lesser ability to pay for services.

Referrals for Medicaid Services:

1. The contractor shall require subcontractors to identify potential Medicaid eligible CCE clients through the assessment instrument and refer them to apply for Statewide Medicaid Managed Care Long-Term Care (SMMC LTC) Program.
2. Individuals identified as being potentially Medicaid eligible are required to apply for waiver services to receive CCE services and can only receive CCE services while the SMMC LTC Program eligibility determination is pending. If the individual is found ineligible for Medicaid services for any reason other than failure to provide required documentation, the individual may continue to receive CCE services.

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Priority Groups

3. Medicaid probable is defined as current CCE active clients whose self-reported income and assets fall below limits of established standards per the SSI-Related Programs Financial Eligibility Standards
4. Individuals who have been identified as being potentially Medicaid eligible must be advised of their responsibility to apply for SMMC LTC services as a condition of receiving CCE services during the eligibility determination process.
5. Individuals enrolled in CCE who have been terminated from the Medicaid waiver eligibility process for not meeting the required timeframes in the currently established Enrollment Management System (EMS) may remain active in CCE for an additional 30 days following termination from the process. If the individual completes the eligibility step associated with termination of the process within the 30 days, the Medicaid eligibility process can resume. However, if the individual does not complete the step associated with termination within the 30 days, CCE enrollment will be terminated with notice in accordance with the grievance procedures outlined in Appendix D of the Programs and Services Handbook.

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SERVICE PROVISION

Services may be provided to eligible CCE clients after the completion of the client comprehensive assessment and the development of the care plan. CCE clients are assessed co-payments based upon their ability to pay. A co-payment is assessed for all clients receiving any core services and/or health maintenance services. In accordance with NOI 060619-1-I-SWCBS, no co-payments will be assessed on any client whose income is at, or below, the federal poverty level (FPL) as established each year by the U.S. Department of Health and Human Services. The co-payment fee schedule will commence at \$1 above the established FPL each year.

No client may have their services terminated for inability to pay their assessed co-payment. Area Agencies on Aging, in conjunction with provider agencies, must establish procedures to remedy financial hardships associated with co-payments and ensure there is no interruption in service(s) for inability to pay. If a client's co-payment is reduced or waived entirely, a written explanation for the change must be placed in the client file. See Appendix B for instructions for assessing co-payments.

Adult Protective Services (APS) Referrals:

- A.** The Department of Elder Affairs (DOEA) and the Department of Children and Families (DCF) signed a memorandum of agreement to ensure the delivery of timely services to vulnerable elders in need of services or victims of abuse, neglect or exploitation. The agreement called for development of joint local written procedures through a memorandum of understanding for serving Adult Protective Services referrals.
- B.** Every AAA, DCF region and Lead Agency is responsible for jointly creating and signing a memorandum of understanding that defines:
 - 1.** The APS referral process;
 - 2.** Method for tracking referrals in CIRTS and the APS Referral Tracking Tool (ARTT); and
 - 3.** Service delivery guidelines.

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SERVICES TO PERSONS IN ALTERNATE CARE:

Assisted Living Facilities (ALFs) and Adult Family Care Homes (AFCHs):

Residents of assisted living facilities and adult family care homes may receive such services as home health aide or transportation; however, provision of any service would be a low priority.

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RESPONSIBILITIES OF STAKEHOLDERS:

A. DOEA:

- 1. Purpose:** The purpose of DOEA in the community care system is to budget, coordinate and develop policy at the state level necessary to carry out the CCE program.
- 2. Responsibilities:** The responsibilities of DOEA are listed below:
 - a.** Develop an area plan format, which includes CCE information.
 - b.** Develop an allocation formula for distributing CCE funds to Planning and Service Areas (PSAs).
 - c.** Allocate CCE funds to service providers through the Area Agencies on Aging (AAAs).
 - d.** Prepare CCE service provider application guidelines.
 - e.** Serve as a statewide advocate for functionally-impaired older persons.
 - f.** Ensure provision of quality services through the monitoring process.
 - g.** Establish policies and procedures for AAA, Lead Agency and CCE subcontractors.
 - h.** Evaluate the quality and effectiveness of services and client satisfaction with the CCE program, as required.
 - i.** Develop program reports.
 - j.** Provide for staff development and training.
 - k.** Review the required area plan annual update and all revisions as necessary.
 - l.** Provide and monitor program policies and procedures for the PSAs.
 - m.** Review and make recommendations for improvement on program reports.

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Responsibilities of Stake Holders

- n. Provide technical assistance to the AAAs in program planning and development and ongoing operations, as needed.
- o. Assume AAA responsibilities, if necessary, for a period not to exceed 180 days, except as provided for in Section 306 (e)(3)(B) of the Older Americans Act.
- p. Assist the AAAs and Lead Agencies in determining CCE services to be funded within the PSAs.
- q. Co-monitor with the AAAs, if feasible.
- r. Process payments to the contract agencies. Assess the availability of a 10 percent match for the AAA's budget.
- s. Develop co-payment guidelines.

B. AREA AGENCIES ON AGING (AAA):

1. **Purpose:** The purpose of the AAA in the community care system is to monitor and fund Lead Agencies and other agencies.
2. **Responsibilities:** The AAA's responsibilities are listed below:
 - a. Develop PSA level allocation formula for distribution of CCE funds.
 - b. Plan for, advertise, and approve funding for Lead Agencies.
 - c. Prepare and revise the area plan update.
 - d. Plan with Lead Agencies to determine CCE services to be funded.
 - e. Designate Lead Agencies and establish vendor agreements at the AAA level, when applicable.
 - f. Conduct CCE intake services.
 - g. Provide technical assistance to Lead Agencies and vendors to ensure provision of quality services.

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Responsibilities of Stakeholders

- h.** Require annual submission of CCE applications or updates, for funding of current Lead Agencies using minimum guidelines provided by DOEA.
- i.** Notify applicants of acceptability of applications and any further action.
- j.** Assess the applicant's ability to be a Lead Agency or vendor, as well as its ability to establish subcontracts, if the applicant indicates plans to do so.
- k.** Assess Lead Agency fiscal management capabilities.
- l.** Monitor and evaluate Lead Agency case management capabilities.
- m.** Assess the availability of a 10 percent match for Lead Agency budget.
- n.** Establish agreements for Lead Agency and CCE services according to manuals, rules and agreement procedures of DOEA. Establish vendor agreements, when applicable.
- o.** Monitor and evaluate contracts, subcontracts and vendor agreements for programmatic and fiscal compliance.
- p.** Submit timely payments to contractors in accordance with Section 287.0585, F.S.
- q.** Arrange in-service training for lead agencies at least annually
- r.** Establish appeal procedures for handling disputes involving Lead Agency, CCE services and vendor agreements.
- s.** Establish procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services. Lead Agency case management capabilities. Ensure compliance with Client Information and Registration Tracking System (CIRTS) regulations.
- t.** Monitor performance objective achievements in accordance with targets set by the Department.
- u.** Ensure implementation of co-payment guidelines.
- v.** Conduct client satisfaction surveys to evaluate and improve service delivery.

Chapter 4: Community Care for the Elderly (CCE) Program

Section IV: Program Requirements

Responsibilities of Stakeholders

C. LEAD AGENCY:

- 1. Purpose:** The purpose of the Lead Agency in the community care service system is to provide case management to all CCE clients and to ensure service integration and coordination of service providers within the community care service system.
- 2. Responsibilities:** The Lead Agency's responsibilities are to:
 - a.** Ensure that all other funding sources available have been exhausted before targeting CCE funds.
 - b.** Ensure that coordination is established with all community-based health and social services for functionally impaired older persons funded wholly or in part by federal, state and local funds to provide a continuum of care.
 - c.** Provide directly or establish subcontracts or vendor agreements, when applicable, for CCE services. If the lead agency subcontracts with an entity to provide direct services, the entity must be selected as the result of a procurement decision using competitive or non-competitive method (i.e. sole source) to provide services pursuant to a legally executed agreement.
 - d.** Provide case management to applicants and ongoing recipients of CCE services.
 - e.** Assess and collect co-payments for core services and health maintenance services provided through the CCE program.
 - f.** Train and use volunteers as possible to provide services to clients and assist with other Lead Agency activities.
 - g.** Compile accurate reports.
 - h.** Monitor subcontracts and vendor agreements to ensure quality services and efficient use of funds. Make payments to subcontractors for CCE services.
 - i.** Initiate and maintain coordination among agencies.

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Responsibilities of Stakeholders

- j.** Arrange in-service training for staff, including volunteers and CCE service subcontractors, at least once a year. Monthly, or at least quarterly, training is recommended. An in-service training on abuse, neglect, and exploitation of vulnerable adults shall be provided to staff and volunteers annually.
- k.** Accept voluntary contributions, gifts and grants to carry out a community care service system.
- l.** Demonstrate innovative approaches to program management, staff training and service delivery that impact on cost avoidance, cost effectiveness, and program efficiency.
- m.** Establish and follow procedures for handling recipient complaints concerning such adverse actions as service termination, suspension, or reduction in services.
- n.** Conduct client satisfaction surveys to evaluate and improve service delivery.

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LINES OF COMMUNICATION:

Lead Agencies shall request and receive technical assistance from the AAA. When additional interpretation is needed, the AAA should forward the request to DOEA. DOEA will address all requests and provide a timely response.

CO-PAYMENT ASSESSMENT:

Co-payment assessment information is included in Appendix B of this handbook.

GRIEVANCE PROCEEDINGS:

Please refer to Appendix D, "Minimum Guidelines for Recipient Grievance Procedures," in this Handbook.

Chapter 5

Administration of the Alzheimer's Disease Initiative (ADI)

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Chapter 5: Alzheimer's Disease Initiative (ADI)

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section I: Purpose

PURPOSE OF ADI PROGRAM:

- A. **Chapter Contents:** This chapter provides program policies, standards and procedures for use by the state office and all providers in the conduct of the Alzheimer's Disease Initiative (ADI) program
- B. **Purpose:** The purpose of the ADI is the following:
 - 1. **Special Needs:** To address the special needs of clients with Alzheimer's disease (AD) or related memory disorders, as well as their caregivers; and
 - 2. **Cure:** To find through research the cause, treatment and ultimately a cure for AD or related memory disorders.
- C. **ADI Program Components:** The ADI is composed of the following program components:
 - 1. Memory disorder clinics;
 - 2. Specialized Alzheimer's Services Adult Day Care Centers;
 - 3. Respite care; and
 - 4. The brain bank located at the Wein Center for Alzheimer's Disease and Memory Disorders at Mt. Sinai Medical Center.

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section II: Legal Basis and Authority

LEGAL BASIS, HISTORY AND SPECIFIC LEGAL AUTHORITY:

Legal Basis and History:

- A. Florida Statutes:** The Florida Legislature enacted Sections 430.501 – 430.504, Florida Statutes. The Legislature demonstrated its recognition of the alarmingly high percentage of citizens (particularly those over age 65) affected by Alzheimer's disease and other related memory disorders by creating the following:
1. An Alzheimer's Disease Advisory Committee;
 2. The Alzheimer's Disease Research Trust Fund;
 3. Respite care programs;
 4. Specialized Alzheimer's Services Adult Day Care Centers;
 5. Four memory disorder clinics; and
 6. Through subsequent amendments:
 - a. The brain bank located at the Wein Center for Alzheimer's Disease and Memory Disorders at Mt. Sinai Medical Center; and
 - b. Additional memory disorder clinics.
- B. Specific Legal Authority:**
- Chapter 430.501-504, F.S.
- Chapter 58D-1, F.A.C.
- Chapter 429.918, F.S.
- C. ADI Program Funding:** The ADI is a general revenue-funded program. Each year the level of funding is determined by the legislature during its budget process. The statute revision of 1988 established population factors to be included in an allocation formula for the distribution of respite care dollars.

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section II: Legal Basis and Authority

D. ADI Service Eligibility:

1. **Service Eligibility Requirements:** Individuals must be 18 years of age or older and have a diagnosis of Alzheimer's disease or a related memory disorder or be suspected of having Alzheimer's disease or a related memory disorder.
2. **Specialized Alzheimer's Services Adult Day Care Eligibility Requirements:** Individuals must have a participant who has a documented diagnosis of Alzheimer's disease or a dementia-related disorder (ADRD) from a licensed physician, licensed physician assistant, or a licensed advanced registered nurse practitioner.
3. **Caregivers:** Caregivers are also eligible to receive training, respite and related support services to assist them in caring for the ADI client.
4. Clients MAY NOT be dually enrolled in the ADI program and a Medicaid capitated long-term care program.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section III: Alzheimer's Disease Characteristics

ALZHEIMER'S DISEASE CHARACTERISTICS:

- A. Definition:** Alzheimer's disease (AD) affects the cells of the brain. It affects individuals from all socioeconomic levels. It produces a diminished capacity to think or understand and perform activities of daily living.
- B. Related Disorders:** Alzheimer's disease is a type of dementia. Dementia is an umbrella term used to describe a group of diseases that may cause the brain to fail. Because Alzheimer's disease is the most common cause of dementia, the term is used to encompass the many types of dementia. Some of the more well-known types of dementia that are referenced in this document every time the term Alzheimer's disease is used include, but are not limited to, the following:
1. Multi-Infarct Dementia;
 2. Lewy Body Disease;
 3. Parkinson's disease;
 4. Huntington's disease;
 5. Creutzfeldt-Jakob disease;
 6. Pick's disease; and
 7. Normal Pressure Hydrocephalus.
- a. **Memory Loss:** Memory loss, to the extent experienced by AD clients, is not a natural part of the aging process as was popularly believed in the past.
 - b. **Treatment:** There is no treatment available to stop or reverse the mental deterioration characteristic of AD. However, gains in research are occurring every year towards finding a cure.
 - c. **Diagnosis:** A definitive diagnosis can only be made upon examination of tissue from the whole brain at autopsy.
- C. Continuum of Care:** AD clients require a wide continuum of care, from basic supervision and assistance with activities of daily living (ADLs) to possible placement for skilled nursing care.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section III: Alzheimer's Disease Characteristics

1. **Impact on Caregivers:** The nature of AD is such that the impact on the caregivers is as great as the impact on the person with the disease. The caregiver of the AD client plays a key role in the prevention of premature institutionalization of the AD client. Consequently, caregivers need services to assist them in the continuation of care.
2. **Onset of Alzheimer's Disease:** In the early stages of the disease, the AD client often experiences confusion, short-term memory impairment and difficulty in performing familiar tasks.
3. **Impact on Caregiver at the Onset of the Disease:** The caregiver assumes certain responsibilities at the onset of the disease, ensuring the AD client receives the following:
 - a. Assistance in activities of daily living;
 - b. A safe environment;
 - c. Balanced meals;
 - d. Required medications; and
 - e. Instructions on how to complete routine functions.
4. **Disease Progression:** As the disease progresses, the AD client may also experience the following more advanced conditions:
 - a. Becoming lost in familiar places;
 - b. Personality change;
 - c. Behavior change;
 - d. Impaired judgment;
 - e. Difficulty finding words or finishing thoughts; and
 - f. Difficulty following directions.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section III: Alzheimer's Disease Characteristics

5. **Impact on Caregiver as Disease Progresses:** The ADI addresses the needs of the caregiver as well as those of the client. The caregiver's job becomes even more difficult and demanding as the disease progresses. When adequate services cannot be provided in the home, it may become necessary for the caregiver to consider placement outside of the home. If assisted living facility (ALF) or nursing home placement becomes necessary, the caregiver may need assistance in the selection and placement process.

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section IV: Services Provided Under the ADI Program

ADI Services:

- A. State funds appropriated for ADI services must be used for services that support and provide temporary relief from caregiving responsibilities for the ADI client's primary caregiver. These services are listed below. Case management is a required service for in-home and facility-based respite. Co-payment can be assessed for all services below as per Department guidelines except Intake. **Refer to Appendix A, "Service Descriptions and Standards," for a description of each service once an individual has been successfully screened as eligible to receive ADI services.**

1. Caregiver Training/Support;
2. Case Aide;
3. Case Management;
4. Counseling (Gerontological);
5. Counseling (Mental Health/Screening);
6. Education/Training;
7. Intake*;
8. Specialized Alzheimer's Services Adult Day Care Center;
9. Respite (Facility-Based);
10. Respite (In-Home);
11. Specialized Medical Equipment, Services and Supplies; and
12. Transportation.

*Once Client is deemed eligible post screening

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section IV: Services Under the ADI Program

B. Other ADI program components include:

- 1. Memory Disorder Clinics (MDCs):** MDCs must provide research, training and services directed to persons with symptoms of Alzheimer's disease or a related dementia. MDCs provide the following service components:
 - a.** Memory Disorder Clinics provide comprehensive diagnostic and referral services for persons with ADRD. ;
 - i.** Provide services to persons who are suspected of being afflicted with ADRD.
 - ii.** Services include accepting referrals from all respite and service providers and conducting subsequent diagnostic evaluations for all referred consumers and the public within the Memory Disorders Clinic's designated service area.

iii. Individuals with suspected memory loss may be evaluated at any one of the funded memory disorder clinics. Florida residents may access MDC services regardless of the ability to pay. Memory Disorder Clinic locations can be found at <http://elderaffairs.state.fl.us/doea/alz/clinicmap.pdf>
 - b.** Conduct service-related applied research that may address, but is not limited to, therapeutic interventions and support services for persons living with ADRD.
 - i.** MDCs shall initiate at least one contact with respite - providers annually to review progress relative to research efforts and exchange ideas with the providers.
 - c.** Training: The Memory Disorder Clinic will develop training materials and educational opportunities for lay and professional caregivers who serve individuals with ADRD and provide specialized training for caregivers, caregiver groups, and organizations in the designated service area.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section IV: Services Provided Under the ADI Program

- i. Memory disorder clinics are required to provide a minimum of 4 hours in-service training related to Alzheimer's disease annually in their designated service area for respite, in-facility respite and adult day care providers, which will include health professionals and caregivers.
- ii. AAAs, memory disorder clinics, respite, and adult day care providers must collaborate in the development of training to meet staff needs.
- iii. A staff member of the Memory Disorder Clinic is to be designated to act as the training liaison for service providers.

Individuals with suspected memory loss may be evaluated at any one of the funded memory disorder clinics. Florida residents may access MDC services regardless of the ability to pay. Memory Disorder Clinic locations can be found at <http://elderaffairs.state.fl.us/doea/alz/clinicmap.pdf>

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section IV Services Provided Under the ADI Program

2. **Alzheimer's Disease Research Brain Bank:** To be accepted into the Florida Brain Bank program, there must be documentation of the diagnosis of dementia by the medical director of a state-funded MDC, or by another licensed neurologist, psychiatrist, or geriatric internist. Medical records must also include general and neurological examinations, appropriate analyses, psychiatric assessments, hematological and biochemical studies, and Computerized Tomography (CT) or a Magnetic Resonance Imaging (MRI) scan of the brain. There must be a completed donor registration form and a request for post-mortem examination form.

Candidates can be identified from:

- a. State-sponsored memory disorder clinics;
- b. Adult day care centers and respite care providers; and
- c. Local organizations providing services to clients with dementia and their families;
- d. Self-referral; and
- e. **Bank Information:** Information regarding the Brain Bank program and applications can be obtained from:

The Wien Center for Alzheimer's Disease and Memory Disorders
Mount Sinai Medical Center
4300 Alton Road
Miami Beach, Florida 33140
Phone: 305-674-2018
<http://elderaffairs.state.fl.us/doea/BrainBank/about.php>

3. **Brain Bank Activities:** The brain bank performs the following activities:
- a. **Autopsies** on the brain tissue of AD clients and matching clinical data (obtained before a client's death) with the pathological findings. This is the only way to determine if the pre-morbid symptoms, responses to treatment, and other factors suggesting a diagnosis of AD were in fact the responses of a client with Alzheimer's disease.
 - b. **Provision of brain tissue for approved research projects** on a national basis, with Florida projects receiving priority.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section IV Services Provided Under the ADI Program

- c. **Administration of the Brain Bank:** The brain bank is administered by the Mount Sinai Medical Center in Miami. The brain bank must meet all licensure requirements mandated by the State of Florida.
 - d. **Brain Bank Minimum Service Standards:**
 - i. Brain bank clients should be selectively screened prior to death in accordance with established protocols.
 - ii. The family should receive notification of definite diagnosis, written in clear understandable terms no later than 6 months after autopsy.
 - iii. In the case of familial Alzheimer's disease, confirmation of the diagnosis in a family member carries with it an opportunity for genetic counseling.
 - e. **Regional Brain Bank Sites:**

Mt. Sinai Medical Center contracts annually with the State of Florida to operate the primary brain bank, and coordinate with regional brain bank sites in Orlando and Miami
4. **Specialized Alzheimer's Day Care:** These are licensed specialized Alzheimer's services adult day care centers, licensed in accordance with Section 429.918 F.S... FloridaHealthFinder.gov provides an up to date listing of all Specialized Alzheimer's Services Adult Day Care Centers.
- a. **Specialized Alzheimer's Services:** Specialized Alzheimer's services include, but are not limited to, those listed below:
 - i. Providing education and training on the specialized needs of persons with Alzheimer's disease or related memory disorders and caregivers;
 - ii. Providing specialized activities that promote, maintain, or enhance the ADI client's physical, cognitive, social, spiritual, or emotional health;
 - iii. Providing therapeutic, behavioral, health, safety, and security interventions; clinical care, and support services for the ADI client and caregiver; and
 - iv. Providing relief for the ADI client's primary caregiver.

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

DOEA, AAA AND SERVICE PROVIDER RESPONSIBILITIES:

A. DOEA Purpose and Responsibilities:

1. **Purpose:** The purpose of DOEA in the ADI program is to plan, budget, coordinate and develop policy at the state level necessary to carry out the statutory requirements for the ADI. Where allowed by statute, DOEA may choose to directly administer a program component or may assign this function to an AAA.
2. **Responsibilities:**
 - a. **Allocation of Funds:** Allocate ADI funds to AAAs for funding of service providers of adult day care and respite care programs;
 - b. **Contracting:** Contract directly with the memory disorder clinics and brain bank providers;
 - c. **Policies and Procedures:** Establish policies and procedures for AAAs and ADI providers;
 - d. **Technical Assistance:** Provide technical assistance on ADI;
 - e. **Evaluation:** Evaluate the ADI program as required;
 - f. **Monitoring:** Ensure quality of services through the monitoring process;
 - g. **Program Reports:** Develop program reports as appropriate;
 - h. **Provider Applications:** Prepare suggested format for the ADI provider applications;
 - i. **Staff Development and Training:** Ensure that ADI providers are given opportunities for staff development and training;
 - j. **Develop co-payment guidelines.**

B. Area Agency on Aging (AAA) Purpose and Responsibilities:

1. **Purpose:** The purpose of the AAAs is to carry out policy, develop programs and monitor the ADI respite and day care programs.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

2. **Responsibilities:** The AAA has the following responsibilities:
- a. **Competitive Solicitation:** Establish subcontracts or vendor agreements, when applicable, for ADI services. Entities providing direct services must be selected as the result of a procurement decision using competitive or non-competitive method (i.e. sole source) to provide services pursuant to a legally executed agreement. Solicitation process must be conducted as applicable, in accordance with Chapter 287, Florida Statutes, and the AAA board approved procurement procedures;
 - b. **Provider Application:** Review and critique the ADI service provider application to ensure completeness, accuracy and that all revisions are noted;
 - c. **Administration and Monitoring:** Administer and monitor ADI program policies and procedures;
 - d. **Program Reports:** Ensure that all program reports are accurately completed and submitted in a timely manner;
 - e. **Technical Assistance:** Provide technical assistance to the ADI subcontracts in program planning and development and ongoing operations as needed;
 - f. **Staff Development and Training:** Provide for AAA staff development and training;
 - g. **Contracting Responsibilities:** Assume contracting responsibilities, including review of the applicant's subcontracts, if applicable;
 - h. **Provider Fiscal Assessment:** Assess the fiscal management capabilities of the service providers;
 - i. **Performance Review:** Review the performance of service providers in carrying out their service delivery responsibilities;
 - j. **Processing:** Process requests for payment and reports on receipts and expenditures to DOEA;
 - k. **Technical Assistance:** Provide technical assistance to providers to ensure provision of quality services;

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

- l. CIRTS:** Ensure compliance with Departmental Client Information and Registration Tracking System (CIRTS) policies;
- m. Coordination:** Initiate and maintain coordination among ADI components within the planning and service area (PSA). Memory disorder clinics must provide four (4) hours of in-service training to ADI and adult day care providers annually, where applicable. The AAA must collaborate and act as liaison in arranging this training;
- n. Co-payment:** Ensure implementation of co-payment guidelines per Department guidelines; and
- o. Client Satisfaction:** Conduct client satisfaction surveys to evaluate and improve service delivery.

C. Service Provider Purpose and Responsibilities:

- 1. Purpose:** The purpose of the service provider is to provide quality services to address the special needs of individuals suffering from Alzheimer's disease and related memory disorders and their caregivers.
- 2. Responsibilities:** To provide case management, respite and/or adult day care as specified in the approved service provider application and each client's care plan.
 - a. Co-Payment:** Assess and collect co-payments in accordance with rules adopted by the Department;
 - b. Client Satisfaction:** Conduct client satisfaction surveys to evaluate and improve service delivery.
 - c. Staff Development and Training:** Provide for staff development and training related to Alzheimer's disease or related memory disorders.
 - d. Coordination of Services:** Coordinate with Memory Disorder Clinics for the coordination of service provision, research and training. Serve as a resource for research and statistical data by the memory disorder clinics.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

COORDINATION OF SERVICES:

Coordination of services among memory disorder clinics, the AAA, and service providers is required as follows:

MEMORY DISORDER CLINICS (MDCs):

A. Coordination with Florida Silver Alert Program: Memory Disorder Clinics will collaborate with Florida Law Enforcement to facilitate a fast and safe return for persons with a permanent loss of intellectual capacity.

1. When notified that someone with possible Alzheimer's or a related dementia is missing, whether driving a vehicle or on foot, the MDC will follow the protocol established by the Silver Alert:
 - a. Call the caregiver or family to gather facts and offer services.
 - b. Send the Silver Alert Referral Form to ADRC designated contact to see if lost individual is, or has been, receiving services and if a CARES assessment is appropriate.
 - c. Offer diagnostic services of MDC and Caregiver training if appropriate.
 - d. Offer specially designed training to avoid recidivism of Silver Alert.
2. Training: MDCs will provide training in their catchment area to ADRCs, senior network personnel, formal and informal caregivers, health and social services professionals and the public.

The training will explain the Silver Alert Protocols, the part played by law enforcement, the MDCs, the senior network and the public. It will emphasize the basic goals of the plan which are:

- a. Public safety,
- b. Assistance to law enforcement in locating a missing senior,
- c. Education, and
- d. Prevention.

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Section V: Program Requirements

- B. Coordination with Respite Service Providers:** MDCs will collaborate with in-home and facility-based respite service providers at the direction of DOEA for coordination of service provision, research, and training.
- 1. In-service Training:** MDCs should contact the AAA contract managers to set up four (4) hours of annual in-service training for ADI adult day care and respite care providers in the respective PSAs.
 - a. The training should be held in a central location, accessible to the providers in the PSA.
 - b. The training should be tailored to an audience of health/social service professionals, direct service staff, and caregivers and be directly related to Alzheimer's disease.
 - 2. Research:** MDCs will contact each respite care provider in their service areas to establish research efforts involving respite clients and/or caregivers.
 - 3. Annual Contacts:** The MDCs will initiate and maintain at least one annual contact with respite care providers to review progress with research efforts and exchange ideas.
- C. Service Providers:**
1. Memory Disorder Clinic Services are available to respite clients and caregivers. If a client or potential client is in need of services through the MDC, the respite care provider will provide the client and/or caregiver with the MDC map and identify the MDC within the service area.
 2. Individuals with suspected memory loss may be evaluated at any one of the funded memory disorder clinics by contacting the individual clinic to arrange a new patient appointment.
 3. MDC shall accept referrals from all respite and adult day care service providers and conduct subsequent diagnostic evaluations for referred clients, as appropriate, and
 4. Identify and make recommendations for treatment of other health conditions which present symptoms during the medical/clinical evaluation.

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Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

5. Florida residents may access MDC services regardless of the ability to pay. Memory Disorder Clinic locations can be found at <http://elderaffairs.state.fl.us/doea/alz/clinicmap.pdf>

While not required by statute or rule, Memory Disorder Clinics and the Area Agencies on Aging can volunteer to participate in the Dementia Care and Cure Initiative (DCCI). DCCI encourages the collaboration of MDCs, AAAs, service providers, and other community entities to engage their communities to be more dementia caring, promote better care for Floridians affected by dementia, and support research efforts to find a cure. These collaborative efforts strive to provide an increase in the awareness of Alzheimer's disease and related dementias and the services available to those living with and affected by the disease through educational events and awareness campaigns.

Chapter 5: Alzheimer's Disease Initiative (ADI)

Section V: Program Requirements

ESTABLISHING PRIORITIES FOR SERVICE PROVISION:

- A. Assessment and Prioritization of Service Delivery for New Clients:** The following are the criteria to prioritize new clients in the sequence below for service delivery. It is not the Department's intent to remove current clients from any services to serve new clients being assessed and prioritized for service delivery.
- 1. Priority Criteria for Service Delivery:**
 - a.** Imminent Risk individuals: Individuals in the community whose mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or likely within three (3) months.
 - b.** Service priority for individuals not included in (a) above, regardless of referral source, will be determined through the Department's functional assessment administered to each applicant, to the extent funding is available. The Contractor shall ensure that priority is given to applicants at the higher levels of frailty and risk of nursing home placement.
 - 2. Priority Criteria for Service Delivery for Other Assessed Clients:** The assessment and provision of services should always consider the most cost-effective means of service delivery.
 - a.** Functional impairment shall be determined through the Department's assessment instrument administered to each applicant.
 - b.** The frailest clients not falling into one of the priorities cited in the above section will receive services to the extent funding is available.
- B. Additional Factors:**
- 1. MDC and Brain Bank Prioritization:** Memory disorder clinics and the brain bank must establish written criteria to be used in prioritizing requests for their services.
 - 2. Denial of Services:** No one requesting a consultation from a MDC will be denied services.

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Chapter 5: Alzheimer's Disease Initiative (ADI)

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CO-PAYMENT ASSESSMENT:

For information about co-payment assessment see Appendix B, Co-Payment for Service Guidelines of this Handbook.

GRIEVANCE PROCEDURES:

Please refer to Appendix D, "Minimum Guidelines for Recipient Grievance Procedures," of this Handbook.

Chapter 6

Administration of the Home Care for the Elderly (HCE) Program

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Chapter 6: Home Care for the Elderly (HCE)

Section I: Purpose of the HCE Program

Purpose of Chapter 6: This chapter provides program policies, standards and procedures for use by the Department of Elder Affairs (DOEA) and all contractors, subcontractors, and vendors in the provision of the Home Care for the Elderly (HCE) Program.

- A. Purpose:** The purpose of the HCE Program is to encourage the provision of care for elders in family-type living arrangements in private homes as an alternative to nursing homes or other institutional care settings.
- B. Caregivers:** The program encourages a person or group of persons, acting as caregivers, to provide the following activities to three (3) or less elderly relatives or non-relatives on a not for profit basis:
 - 1. Basic support and maintenance; and
 - 2. Assistance in arranging specialized services as needed.

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Section II: Legal Basis and Specific Legal Authority:

A. Legal Basis:

The provisions of sections 430.601 through 430.608, Florida Statutes as created by Chapter 95-418, Laws of Florida, established the HCE Program. The legislative intent is to encourage the provision of care of the frail elderly at risk of institutionalization in family-type living arrangements in private homes.

Chapter 58H-1, Florida Administrative Code (F.A.C.) Home Care for the Elderly Program, is the promulgated rule mandated by Section 430.603, F.S.

B. Specific Legal Authority:

Sections 430.601–608, F.S. as created by Chapter 95-418, Laws of Florida

Chapter 58H-1, F.A.C.

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Section III. Services Provided Under the HCE Program

Services Provided:

A. Subsidy Payments:

1. Requirements: Subsidy payments may be made to caregivers and service providers of eligible HCE clients.
 - a. Subsidy vs. Nursing Home Cost: The total of subsidy payments per client may not exceed the amount expended in general revenue annually per person for nursing home care.
2. Types of Subsidy Payments: Two types of subsidy payments are available in the HCE Program.
 - a. Basic Subsidy: The basic subsidy amount is a standard \$160.
 - i. Authorization: The basic subsidy must be authorized on the client's care plan prior to payment.
 - ii. Coverage: The basic subsidy is for support and health maintenance to assist with the cost of the following expenses:
 - (A) Housing;
 - (B) Food;
 - (C) Clothing; and
 - (D) Medical or dental services and incidentals, not covered by Medicaid, Medicare or any other insurance.

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Section III: Services Provided Under the HCE Program

- b. Special subsidy: The special subsidy combines payments for goods and services necessary for maintenance of the health and well-being of the elder client.
 - i. Flexibility: The special subsidy is intended to be flexible and few restrictions are placed on the types of services and special equipment that may be arranged to support the well-being of the client.
 - ii. Authorization: The special subsidy shall be authorized on the client's care plan prior to payment. However, information related to specific services may vary.
 - iii. Restrictions: For all HCE clients, services must not be available through Medicare, Medicaid, Veterans Administration (VA) or other insurance. Additionally, special subsidies for HCE clients (enrolled after March 1, 2019) shall not be authorized for services provided and available under other funding sources, specifically SMMC LTC.
 - iv. Applicability: The services or supplies authorized for special subsidy directly relate to the client's health conditions.
 - v. Special subsidy services are included below. The descriptions of these services can be found in Appendix A, "Service Descriptions and Standards", in this Handbook.
 - (A) Adult Day Care;
 - (B) Adult Day Health Care;
 - (C) Caregiver Training/Support;
 - (D) Chore
 - (E) Chore (Enhanced);
 - (F) Counseling (Gerontological);

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Section III: Services Provided Under the HCE Program

- (G) Counseling (Mental Health/Screening);
- (H) Home Delivered Meals;
- (I) Home Health Aide Service;
- (J) Homemaker;
- (K) Housing Improvement;
- (L) Material Aid;
- (M) Occupational Therapy;
- (N) Other;
- (O) Outreach;
- (P) Personal Care;
- (Q) Physical Therapy;
- (R) Respite (Facility Based);
- (S) Respite (In-Home);
- (T) Shopping Assistance;
- (U) Skilled Nursing Services;
- (V) Specialized Medical Equipment, Services, and Supplies;
- (W) Speech Therapy; and
- (X) Transportation.

NOTE: See 'Role of HCE Caregiver' later in this chapter for the exception involving aged, functionally-limited caregivers needing emergency help with personal care, homemaker services or home delivered meals. Refer to Appendix A, "Service Descriptions and Standards," for a description of each service

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- vi. **Specialized Service:** A case manager may choose to require a physician's prescription or verification of the need for the specialized service prior to approval for special subsidy.

B. Other Access and Coordination of Services

- 1. Case Management, Case Aide, and Intake services are provided as needed to the HCE client and caregiver.
- 2. The descriptions of these services can be found in Appendix A, "Service Descriptions and Standards."

C. Setting Subsidy Amounts:

- 1. **Client's Income:** The amount of basic subsidy is determined by the client's gross income.
- 2. **Basic Subsidy Amount:** The basic subsidy is limited to the amounts listed in the subsidy chart, Attachment 3.
 - a. **Monthly Payment:** The basic subsidy amount is paid to the caregiver when the client is in the home for any part of a month.
 - b. **Hospitalization:** If the client is hospitalized, or otherwise institutionalized, but was in the home at in point during the reporting period, the basic subsidy check will be sent to the caregiver.
 - c. **Absence from the Home:** The client may remain in the HCE Program when out of the home for up to three (3) months but no basic subsidy check will be paid to the caregiver, except as cited in 'b' above.
 - d. **Termination:** If after three (3) months the client does not return home, then the client will be terminated from the HCE Program.

Chapter 6: Home Care for the Elderly (HCE)

Section III: Services Provided Under the HCE Program

3. **Special Subsidy Reimbursement Exceptions:** Reimbursement under the special subsidy provisions may not be made for any item or service fully covered by Medicaid, Medicare, VA, or other insurance.
 - a. **Cost versus Coverage:** Costs for services or items partially covered by Medicare or other insurance are reimbursable in the amount of the difference in cost and coverage reimbursed by the insurance provider.
 - b. **List of Covered Services:** The Lead Agency should contact the Agency for Health Care Administration Medicaid Area Office to obtain a list of covered services for elderly recipients.
 - c. **Payment Exclusion:** Premium payments for health, nursing home or life insurance are not reimbursable items.

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Section IV: Program Requirements

GENERAL ELIGIBILITY CRITERIA AND ELIGIBILITY PROCESS:

A. General Eligibility Criteria: To be eligible for HCE the client must meet the following criteria:

1. **Age:** Be sixty (60) years or older.
2. Be a current resident of the State of Florida with the intent to remain in the state; and
3. Meet the criteria for functional and financial eligibility set forth below:
 - a. Be at risk of nursing home placement based on 701B assessment;
 - b. Have self-declared income and assets which do not exceed the ICP limits established by Medicaid and DCF, or
 - c. Receive Supplemental Security Income (SSI), or
 - d. Receive benefits as a Qualified Medicare Beneficiary (QMB) or as a Special Low-Income Medicare Beneficiary (SLMB); and
 - e. Have an approved caregiver who meets the caregiver requirements pursuant to Rule 58H-1.006, F.A.C., and the dwelling requirements pursuant to Rule 58H-1.007, F.A.C.
- 3.
4. **Caregiver:** Be living in the home with an adult caregiver, age 18 or older who is:
 - a. Willing and able to provide care or assist in arranging services for the client; and
 - b. Qualified as an HCE caregiver based on the client's choice and the case manager's assessment.

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5. **Additional Requirements:** Program Enrollment Criteria for HCE Caregivers are more fully explained in specific eligibility sections of this chapter and are listed in Attachment 5 of this chapter.

B. Eligibility Process

1. **Required Forms:** The case manager must complete the following forms as part of the eligibility process:
 - a. Comprehensive Assessment (DOEA 701B);
 - b. Care Plan (DOEA Form 203A);
 - c. Notice of Case Action (Attachment 4); and
 - d. Financial Worksheet (for clients not identified as automatically financially eligible—Attachment 1).

C: Home Visit

1. **Potential Eligibility:** If the elder person appears to be eligible for HCE services based on the preliminary information received, the case manager should contact the applicant and schedule a home visit appointment.
2. **Purpose of Home Visit:** The case manager will explain to the applicant that the purpose of the home visit will be to have a thorough discussion of the following topics:
 - a. The applicant's physical condition;
 - b. Income and assets;
 - c. Need for services;
 - d. Suitability of the home; and
 - e. Caregiver eligibility.
3. **Income and Asset Worksheet:** The applicant should be sent a copy of the income and asset worksheet or the information should be given in detail over the phone so that the applicant will have the facts readily available when the case manager makes the first home visit.

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4. **Ineligibility:** If the person does not meet the HCE eligibility requirements based on preliminary intake information, the intake worker or case manager must explain the reason for the determination of ineligibility for the program.
 - a. **Referral to Other Sources:** Referrals to other programs must be made, if appropriate.
 - b. **Documentation:** The referral (if applicable) and determination of ineligibility must be documented for Lead Agency records.

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SPECIFIC ELIGIBILITY CRITERIA:

A. HCE Client: The client eligibility process includes an assessment of the individual's risk of nursing home placement and financial eligibility for the HCE program.

- 1. Functional Eligibility:** The case manager must administer the comprehensive assessment (DOEA 701B) for all HCE applicants to determine the applicant's need for services, level of impairment and risk of institutional placement.

The client assessment will be completed according to guidelines in Chapter 2, "Intake, Screening, Prioritization, Assessment, and Case Management".

- a. Scoring the Assessment:** The case manager shall determine the prioritization score on the comprehensive assessment (DOEA 701B) for each HCE client.
- b. Prioritization:** The priority score and rank for the HCE applicant must consider the risk category score.
- c. Priority Criteria for Service Delivery:** The following are the criteria to prioritize new clients in the sequence below for service delivery. It is not the Department's intent to remove current clients from any services to serve new clients being assessed and prioritized for service delivery.
 - i. Imminent Risk individuals:** Individuals in the community whose mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or very likely within three (3) months.

Regarding question 19 (on the 701S) or 21 (on the 701A): "The individual is transitioning out of a nursing facility (NF)," certified screeners and assessors/case managers should respond, "N" because individuals in nursing homes are not considered IR according to the definition. It is the responsibility of certified screeners and assessors/case managers to screen and assess only individuals who are residing in the community (private residence, assisted living facility, or adult family care home).

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Please note that if an individual is currently in a NF and interested in NF services, long-term care program education should be provided, and the individual should be referred to CARES.

Regarding question 20 (on the 701S) or 22 (on the 701A): “Individual is at imminent risk of NF placement,” certified screeners and assessors/case managers should only respond “Y” if during completion of the assessment, the individual or their representative provides information that indicates the individual’s *“mental or physical health condition has deteriorated to the degree that self-care is not possible, there is no capable caregiver, and nursing home placement is likely within a month or very likely within three (3) months.”* The certified screener or assessor/case manager will not ask the individual or their representative the question but will instead check an answer based upon the observations by the screener or assessor. The screener or assessor will document justification for the designation in the appropriate “Notes and Summary” sections of the assessment form, including supervisor approval. Additionally, the Department may request Aging and Disability Resource Centers (ADRCs) to rescreen any individual ranked imminent risk prior to Enrollment Management System (EMS) release to confirm the IR designation.

- ii. Aging Out individuals: Individuals receiving Community Care for Disabled Adults (CCDA) and Home Care for Disabled Adults (HCDA) services through the Department of Children and Families’ (DCF) Adult Services transitioning to community-based services provided through the Department when services are not currently available.
- iii. Service priority for individuals not included in (i) and (ii) above, regardless of referral source, will be determined through the Department’s functional assessment administered to each applicant, to the extent funding is available. The Contractor shall ensure that priority is given to applicants at the higher levels of frailty and risk of nursing home placement.

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2. **Financial Eligibility:** Once the applicant's functional status has been assessed using the comprehensive assessment (DOEA 701B), the case manager must then determine the applicant's financial eligibility.
- a. **Persons with Automatic Eligibility:** Recipients of Supplemental Security Income (SSI), Qualified Medicare Beneficiary (QMB) and Special Low-Income Medicare Beneficiary (SLMB) automatically meet the HCE financial eligibility requirements. The case manager need not proceed further in the determination of income or assets if any of these benefits can be verified.

i. .

The case manager will enter the basic subsidy amount into the Client Information and Registration Tracking System (CIRTS).

- ii. **Methods of Benefit Verification:** The case manager will note in the case narrative what evidence was used as verification of the receipt of SSI, QMB or SLMB. Listed below are methods of verification of these benefits:

Supplemental Security Income (SSI):

- (A) A copy of the SSI award letter or form, dated within 30 days from the time of application; and
- (B) Florida Medicaid Management Information System (FMMIS).

Medicaid's Fiscal Agent, HP Enterprise Service, provides verification of recipient eligibility. For information about how to access recipient eligibility data from the fiscal agent, go to <http://ahca.myflorida.com>.

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QMB—Medicare Supplement Policy sponsored by the State Medicaid Program:

- (A) Refer to ii (B) SSI above;
- (B) Copy of award letter;
- (C) Copy of DCF Form 2014 (Authorization of Medicaid Eligibility Form sent from DCF to FMMIS); or
- (D) Documentation of client benefits from the DCF “My ACCESS Account.”

SLMB—Vendor Payment for Medicare premiums sponsored by the State Medicaid Program:

- (A) Award letter; or
- (B) Documentation of client benefits from their DCF “My ACCESS Account.”

- b. **Non-SSI or Related Program Financial Eligibility:** Non-SSI or related program eligible individuals’ financial eligibility will be determined using a procedure like the Medicaid Institutional Care Program eligibility determination method.

Self-Declaration: This procedure is less rigorous in that the applicant’s self-declaration of income and assets may be accepted.

Optional Verification: The self-declaration method does not preclude the case manager from requesting written documentation of income and assets or verifying this information through other means if it is suspected that the client is providing inaccurate or false information.

Optional Verification Time Limit: If financial verification is requested, a 30-day time limit may be placed for receiving the information.

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Financial Worksheet: The financial worksheet (Attachment 1) containing the client's signature attesting to the truthfulness of the information given, must be completed, signed and placed in the client file.

- i. **Institutional Care Program (ICP) Standard:** The monthly income eligibility threshold is a total from all sources that does not exceed the Institutional Care Program standard. DOEA shall supply this information annually. Income includes the following sources:
 - (A) Social Security benefits;
 - (B) Veterans Administration benefits;
 - (C) Retirement pensions;
 - (D) Interest and dividends;
 - (E) Rental property;
 - (F) Child support or alimony; and
 - (G) Contributions from others.
- ii. **Assets:** Assets can total no more than \$2,000 for an individual or \$3,000 for a couple, if both are applying for the program.
 - (A) **NOTE:** In the QMB and SLMB programs the asset limit is \$7,160 for an individual or \$10,750 for a couple. However, since the applicant must show proof of participation in these programs, the case manager will not need to verify the applicant's assets.
 - (B) **NOTE:** Only the income and assets of HCE applicants are counted, even if they are married. If both husband and wife are applying, their income and assets are added and compared to the standard for couples.

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- iii. **Examples of Assets:** The following are examples of assets which are counted in determining eligibility:

- (A) Bank accounts-checking/savings;
- (B) Certificates of deposit;
- (C) Money market accounts;
- (D) Individual Retirement Accounts;
- (E) Christmas clubs;
- (F) Revocable burial contracts;
- (G) Life insurance;
- (H) Mutual funds;
- (I) Stocks;
- (J) Bonds;
- (K) Second automobile; and
- (L) Real property (other than homestead).

Financial Definitions: See attachment 1 regarding included and excluded assets.

- iv. **Potential Supplemental Security Income (SSI) Eligibility:** If the client appears to be eligible for SSI, the case manager will assist them in applying for these benefits at the Social Security Administration (SSA).

- (A) **SSI Application Process:** HCE services can commence if all other eligibility criteria are met during the SSI application process.

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(B) **Follow-up:** The case manager would have to follow up to determine the actual amount approved by Social Security.

(C) **NOTE:** Each HCE client should be instructed to inform the case manager of any changes in income or assets.

v. **Applicant Determined Financially Eligible:** Once it is determined that the applicant is financially eligible, the case manager should refer to the basic subsidy chart (Attachment). The client's income is figured on the Financial Worksheet (Attachment 1) and that figure is matched to the basic subsidy amount.

vi. **Client File:** The Financial Worksheet is placed in the client file. The basic subsidy amount is entered in CIRTTS in accordance with procedures in this Handbook regarding CIRTTS data entry.

B. HCE Caregiver:

1. **Caregiver Assessment:** During the home visit, the case manager shall assess the primary caregiver to determine the individual's willingness and ability to perform two basic tasks:

a. Provide basic services of maintenance and supervision of the client; and

b. Provide or arrange for specialized services for the client.

2. **Assessment Instrument Caregiver Section:** The caregiver assessment shall minimally include the completion of Section K, Social Resources and Section L, Caregiver, of the comprehensive assessment (DOEA 701B).

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3. **Caregiver Eligibility:** The case manager shall use the comprehensive assessment and other caregiver interview information, as appropriate, to determine if the caregiver meets the following eligibility criteria:
 - a. **Age:** Be at least 18 years of age who can provide a full-time, family-type living arrangement in a private home, and is willing to accept responsibility for the social, physical and emotional needs of the home care recipient.
 - b. **Relationship to Recipient:** Be related by blood or marriage or a non-related friend or neighbor, who has been accepted by the recipient as a caregiver.
 - i. A Level II Background Screening will need to be completed for all HCE caregivers who are non-relatives of the client.
 - c. **Physical Presence:** Be living in the home with the client to provide supervision and assist in arrangements of services for the recipient or have alternative arrangements for care to be assumed temporarily by another adult.
 - d. **Safety:** Maintain the residence free of conditions that could pose an immediate threat to the life, safety, health or well-being of the home care recipient.
 - e. **Relationship with Recipient:** Demonstrate evidence that the caregiver and recipient have established a positive personal relationship.
4. **Unsuitable Caregivers:** HCE caregivers are not considered suitable under the following conditions:
 - a. They hold themselves out to the public as one of the following:
 - i. Adult family care home;
 - ii. Group home;
 - iii. Half-way house;
 - iv. Assisted living facility; or

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- v. Other similar facility offering room, board and personal services.
- b. **Conversion:** They are existing HCE caregivers who intend to convert a home-style living environment into one of the group living arrangements as mentioned in (a) above.
- c. **Abuse, Neglect or Exploitation Conviction:** The caregiver has been convicted of abuse, neglect or exploitation of an older person, or has been the perpetrator of a confirmed recorded report of alleged abuse of another person.

C. Home Environment:

- 1. **Home Visit:** During the home visit, the HCE case manager will assess the home environment and surroundings. Generally, the home shall be:
 - a. **Dwelling Type:** A family-type dwelling occupied as the residence of the HCE client or caregiver;
 - b. **Type of Ownership:** Owned, leased or rented;
 - c. **Safety:** Safety for the client as determined by the case manager's assessment using the environmental assessment section (Section H) of the comprehensive assessment (DOEA 701B).
 - d. **Essential Elements:** Attention must be paid to:
 - i. Structural damage;
 - ii. Access barriers;
 - iii. Electrical and fire hazards;
 - iv. Unsanitary or infested conditions;
 - v. Insufficient water or hot water;
 - vi. Insufficient heat or air conditioning;
 - vii. Inaccessibility of community services; and
 - viii. Client inability to exit the home in an emergency.

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Critical Elements: These items (i through viii above) are critical. The case manager's notes on section H of the comprehensive assessment (DOEA 701B) are based on personal observations and answers to questions like those found in the optional Safety and Accessibility Worksheet (Attachment 4).

Walk Through: When completing this section of the comprehensive assessment, the case manager shall walk through all rooms of the house along with making observations concerning the yard and neighborhood.

Assessment Goal: The case manager's major goal in the environmental assessment is to address any potential safety or accessibility problems for the client.

Assessment Notations: All observations must be noted on the comprehensive assessment and additional sheets attached as needed. The optional Safety and Accessibility Worksheet (Attachment 3) may be used to assist the case manager in evaluating the client's environment.

- e. **Identified Problems:** The caregiver should be strongly encouraged to take steps necessary to correct any problems identified during the safety and accessibility assessment.
- f. **Corrective Action Plan:** The case manager and caregiver shall develop a plan to address any unresolved problems. Documentation shall be noted in the client file.

D. Documentation of Assessment and Recommendations:

Case Narrative: The results of the caregiver, home and client eligibility assessments will become part of the client file. The recommendation of the case manager, whether positive or negative, must be supported with documentation that justifies the decision in the case narrative.

- 1. **Annual Eligibility Determination:** An annual eligibility re-determination shall be performed in accordance with the following instructions:
 - a. An annual eligibility re-determination shall be completed every 12 months, and no later than the month of the anniversary date of the completed client assessment.

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- b. An annual eligibility re-determination includes:
 - i. Completion of the eligibility process as outlined in this chapter;
 - ii. Providing updates to the CIRT system based on changes in client information and status; and
 - iii. Completion of a new or update to the existing client care plan. In either case the care plan form must be signed annually by the client, caregiver and case manager in confirmation of the agreed upon services.

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CLIENT ENROLLMENT IN THE HCE PROGRAM:

Enrollment of the HCE client should proceed as follows:

A: Care Plan:

1. **Care Plan Development:** The HCE client/client's representative, caregiver and case manager shall develop a care plan designed to serve as an agreement between these persons regarding HCE services (e.g., basic subsidy, special subsidies and case management) to identify the client's:
 - a. Service needs to be addressed; and
 - b. Services to be delivered by HCE and other contributing programs.
2. **Caregiver:** The needs of the caregiver may be included on the care plan as they pertain to the caregiver's role in providing care. Please refer to the Role of the Caregiver, in this chapter, for additional guidance on care planning for caregivers.

B. Care Plan Signatures: The client/client's representative, caregiver and case manager must sign the care plan. The signed care plan and the program enrollment criteria become the signed agreement that the caregiver will provide HCE services for the client and will be paid a basic subsidy.

C. Notice of Case Action: A "Notice of Case Action" form is sent to the client/caregiver stating the client's eligibility for the program. (Attachment 5a to this chapter)

D. Program Enrollment Criteria: A copy of the Program Enrollment Criteria is given to the caregiver. (Attachment 6)

E. CIRTS Registration:

1. **Case Manager Responsibility:** For subsidies and case management payments to be paid, the case manager must register the HCE client in the Client Information and Registration Tracking System (CIRTS) in accordance with CIRTS data entry procedures included in this Handbook.

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2. **Cut Off Date:** The client and caregiver registration cut-off date is the 15th of the month to receive the basic subsidy. Anyone registered after the 15th shall have the first day of the subsequent month as an eligibility date.

Examples:

<u>Client</u>	<u>CIRTS Start Date</u>	Basic Subsidy (and Special Subsidy, if authorized) <u>Received For</u>
A	08/13/18	August 2018
B	08/20/18	September 2018

- E. **Units of Case Management:** Case managers shall continue the provision of case management services in accordance with Chapter 2 of this Handbook and report units of case management into the CIRTS database by the 20th of the month.

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ROLE OF THE HCE CAREGIVER:

A. Provision of Basic Services:

1. **HCE Caregiver:** The HCE caregiver will be responsible for ensuring that basic support and maintenance services are provided for the client. These basic services include the following:
 - a. Supervision;
 - b. Housekeeping;
 - c. Meal preparation;
 - d. Basic personal care as needed such as bathing and grooming; and
 - e. Maintaining a safe and accessible home environment for the client in accordance with eligibility criteria established in this chapter.
2. **Third Party Services:** Services to be provided by the HCE caregiver shall not be supplanted by purchasing these services from third parties using DOEA program resources.
3. **Exception to Policy:** The exception to the policy stated above involves a client's aged spouse or live-in companion who is also functionally limited, unable to lift or move the client and perform household tasks.
 - a. **Availability of Funds:** If in the case manager's judgment, the caregiver is unable to perform these tasks due to frailty and if sufficient program resources exist to purchase such services, the case manager may authorize the services on the care plan to maintain the home care arrangement.
 - b. **Assistance Unavailable:** If third party assistance is unavailable to assist the frail caregiver to provide the necessary care for the client, then the HCE client is no longer eligible and must be terminated from the program. The client may qualify for other programs and may need the case manager to make referrals if the HCE services are terminated.
4. **Documentation:** These actions by the case manager for the caregiver and client referred to above must be documented in the care plan and the

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case narrative.

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B. Supervision:

1. **Amount of Supervision:** Supervision must be provided as determined by the client's functional status and level of dependency.
2. **Frequency of Observation:** The requirement for the caregiver's personal observation, and the frequency of such observation, is based on the individual client's situation and what is needed to ensure the client's well-being.
3. **Critical Factor:** The critical factor is the dependent status of the client at any time due to illness, mobility problems, assistance with assistive devices and the potential for harm that could occur should the client not be adequately supervised.

C. Continued Supervision:

1. **Caregiver Arrangements:** Supervision must be continued during periods when the caregiver is not physically in the home. The HCE case manager must approve the caregiver's arrangements for supervising the client during periods when the caregiver is not in the home.
 - a. **Absences:** During absences, the caregiver will identify a competent adult person to supervise and observe the status of the client.
 - b. **Alternate Caregiver:** When absences from the home are daily or of a routine nature, i.e., primary caregiver has part-time or full-time employment, then, arrangements for care must be made with an alternate caregiver to promote continuity of relationship and to prevent unnecessary confusion for the client.

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2. **Arrangements for Supervision:** The caregiver should plan for supervision, including the name(s) of the person(s) to be providing supervision in the absence of the caregiver.
 - a. **Supervision Schedule:** The primary caregiver must develop a schedule that meets the client's needs and clearly indicates who will be caring for the client and when.
 - b. **In-Home Care:** Plans will be based on the client being cared for within the home of residence.
 - c. **Case Manager Approval:** The HCE case manager must approve the plans.
 - d. **Case Manager Disapproval:** The case manager will not approve plans containing a pattern of numerous periods of absence during the day, regardless of whether these are temporary or prolonged.
3. **Continued Caregiver Absence:** If the case manager frequently finds that neither the caregiver nor alternate caregiver is present when making telephone calls or home visits, the following procedure shall be followed:
 - a. **Discussion with Caregiver:** The case manager shall explain to the caregiver at the earliest opportunity, (preferably during a home visit, but a phone call or a letter may be used in certain circumstances) that the client is at risk when the caregiver is not present to supervise the client and assist with the client's activities of daily living.
 - b. **Unannounced Contacts:** Through a series of unannounced visits and phone calls, the case manager will determine if the caregiver's (primary or alternate) absence is an ongoing problem. The case manager may also talk with the client to determine if the client feels safe and feels that his/her needs are being met by the caregiver.
 - c. **Supervisory Consultation:** If the problem continues, the case manager will share the information gathered with his/her supervisor and with the case management agency director.
 - d. **Termination and Referrals:** A decision may be made to terminate the client from the program. The client may qualify for other programs and may need the case manager to make referrals if the HCE services are terminated.

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D. Caregiver Responsibility for Service Arrangement and Accountability:

1. **Basic Subsidy:** Although the HCE caregiver enters into an agreement to render support and maintenance to the client, the Basic Support and Health Maintenance Subsidy only contributes to a portion of the cost of housing, food, clothing, medical expenses and incidentals.
2. **Special Subsidy:** The special subsidy for additional medical support and special services is designed to reimburse the costs of any other service or special care not covered by Medicaid, Medicare, or private insurance when these services are determined to be essential to maintain the well-being of the home care recipient.
 - a. **Arranging Special Subsidy Services:** The caregiver is involved in arranging for the delivery of medical or special support services pre-authorized by the case manager as a special subsidy on the care plan.
 - b. **Types of Arrangements:** Two arrangements are possible for special subsidy services:
 - i. **Caregiver Reimbursement:** The caregiver may first pay for pre-authorized services and later be reimbursed by the AAA.
 - (A) **Remaining Balance:** Consideration can be given to making subsequent payments on medical equipment for which there is a remaining balance.
 - (B) **Interest Exclusion:** Interest or credit costs incurred in purchase arrangements for such equipment is not reimbursable.
 - (C) **Documentation:** The caregiver must obtain documentation for expenditures made for such services:
 - (1) Dated receipts marked "Paid" must support expenditures.
 - (2) The caregiver must sign the back of each receipt.

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- (D) **Time Limits:** The caregiver must submit the receipts to the case manager within 30 days. Caregivers shall be reimbursed within 60 days of submitting the original receipts.
 - (E) **Case Manager Assistance:** The case manager should assist the caregiver in the development of an organized system to collect and account for expenditure receipts.
 - (F) **CIRTS:** The case manager forwards the payment information to the AAA via CIRTS as outlined in the CIRTS data entry requirements but retains the receipts for a paper trail in the client record.
 - ii. **Vendor Reimbursement:** Special subsidy services may be authorized through a vendor agreement between the Lead Agency and a provider of goods and services on behalf of the caregiver and client. The Lead Agency may also be a vendor of services.
 - (A) **Advantage:** In this method the client and/or caregiver's personal funds do not become involved in the purchase of the services.
 - (B) **CIRTS:** The Lead Agency transmits the payment information for the subsidy via CIRTS, as outlined in the CIRTS data entry procedures.
- c. **Recoupment:** Subsidy amounts, which are found to be in error due to false information provided to the case manager, will be considered fraudulent. The case management agency in conjunction with the AAA will establish a recoupment schedule with the caregiver for repayment of the funds.

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Section IV: Program Requirement

SERVICE COORDINATION WITH OTHER DOE A SERVICE PROGRAMS:

- A. HCE Recipient Eligibility for Services under Other Programs:** HCE clients may also be eligible for home-based services under other programs such as:

1. Community Care for the Elderly (CCE);
2. Alzheimer's Disease Initiative (ADI); and
3. The Older Americans Act (OAA).
4. Effective March 1, 2019, HCE clients may be dually enrolled in the HCE BASI program and a Statewide Medicaid Managed Care Long-term Care (SMMC LTC) program.

HCE clients who are released from the SMMC Program enrollment may keep their HCE BASI caregiver subsidy benefit if desired. The change to allow dual enrollment in HCE and SMMC is not retroactive. HCE BASI benefits may apply for such benefits but must still meet program participation requirements and may only be enrolled if available funding exists.

If an existing SMMC LTC client applies for HCE BASI, and there is insufficient budget in the HCE program to enroll the client in HCE, they will be waitlisted as is the current process when resources are not available for adding new clients.

- B. HCE as Funding Source:** Upon funding availability, the HCE program may be considered as a funding source for case management activities when:

1. The client only receives HCE services; or
2. The client receives HCE services and CCE, Local Services Program (LSP), OAA, or ADI services.

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C. HCE Case Management Coordination:

1. The HCE client's services will be managed by only one case manager. The case manager will work with the client to ensure the most appropriate mix of services and will provide coordination between all service providers and the client. The case manager must be designated in the client record.
2. If a client is enrolled in multiple programs, the service providers for the client will cooperatively decide which program/entity will provide and fund the case management.
3. Some HCE clients may receive CCE day care for needed socialization, health or therapeutic services. This is allowable if the situation is such that the client benefits from it and it is still more cost effective to do so rather than have the client institutionalized.
4. For clients enrolled in HCE BASI and SMMC LTC (no Special Subsidy), there is no need to develop a care plan for these clients as that function will be conducted by their SMMC LTC case manager. HCE case managers are responsible for completing the annual eligibility re-determination every 12 months (no later than the month of the anniversary date of the complete client assessment). Case Aids shall complete monthly HCE caregiver calls (or case managers where there are not case aids).

Clients enrolled in both HCE BASI and SMMC LTC will be allowed to choose Participant Directed Options (PDO); the client's enrollment in HCE should not be affected if they are in SMMC PDO.

Section IV: Program Requirements

AGENCY RESPONSIBILITIES:

A. Department of Elder Affairs (DOEA):

- 1. Purpose:** The purpose of DOEA in the community care system is to budget, coordinate and develop policy at the state level necessary to carry out the HCE Act.
- 2. Responsibilities:** The responsibilities of DOEA are listed below:
 - a. Require the inclusion of HCE information in the development of the area plan;
 - b. Develop an allocation formula for distributing HCE funds to the Planning and Service Areas (PSAs);
 - c. Allocate HCE funds through the AAAs for funding service providers;
 - d. Provide technical assistance on the HCE program;
 - e. Establish policies and procedures for AAAs, case management agencies and HCE subcontractors;
 - f. Evaluate the quality of services, effectiveness and client satisfaction with the HCE program;
 - g. Develop program reports;
 - h. Review the required AAA/HCE area plan annual update and all revisions as necessary;
 - i. Review program reports and make recommendations for program improvement;
 - j. Provide technical assistance to the AAAs in program planning and development and ongoing operations as needed; and
 - k. Process payments to the AAAs based on approved invoices.

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B. Area Agencies on Aging (AAAs):

1. **Purpose:** The purpose of the AAA in the community care system is to act as the agency to plan for, monitor, and fund Lead Agencies and other agencies involved in the HCE program.
2. **Responsibilities:** Responsibilities of the AAA are as follows:
 - a. Develop the PSA level allocation formula for distribution of HCE funds;
 - b. Plan for, advertise, and approve funding for local service providers;
 - c.. Prepare and revise the AAA area plan update;
 - d. Plan with local service providers to determine service needs;
 - e.. Provide technical assistance to local service providers and vendors to ensure the provision of quality HCE services;
 - f. Require an annual submission of HCE application or updates for funding of current local service providers and vendors;
 - g. Assess and monitor the local service provider's fiscal and programmatic management capabilities;
 - h. Establish agreements for services in accordance with DOEA rules and agreement procedures;
 - i. Review and evaluate contractor agreements, subcontractor agreements, and vendor agreements for programmatic and fiscal compliance;
 - j. Submit timely payments to subcontractors in accordance with Section 287.0585, F.S.;
 - k. Arrange in-service training for case management agencies and vendors annually;
 - l. Ensure that case management agencies follow established grievance procedures regarding denial, reduction or termination of HCE services to clients;

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- m. Ensure compliance with CIRTS regulations.
- n. Monitor performance objective achievements in accordance with targets set by the Department; and
- o. Conduct client satisfaction surveys to evaluate and improve service delivery.

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C. Case Management Agency:

1. **Purpose:** The purpose of the case management agency in the community care system is to provide case management to HCE clients as needed and to ensure service integration and coordination of HCE service providers within the community care system.
2. **Responsibilities:** Responsibilities of the case management agency are as follows:
 - a. Ensure that all other funding sources available are exhausted before targeting HCE funds;
 - b. Ensure coordination is established with all community-based health and social services for functionally impaired older persons funded wholly or in part by HCE to provide a continuum of care;
 - c. Use volunteers as possible to provide services to clients as well as to assist in other activities of the Lead Agency;
 - d. Compile accurate reports;
 - e. Monitor subcontractors to ensure quality services and efficient use of funds and make payments to subcontractors for core services;
 - f. Arrange in-service training, including prevention of elder abuse, neglect and exploitation, for staff, including volunteers and core service subcontractors and vendors at least annually;
 - g. Follow established grievance procedures regarding denial, reduction or termination of HCE services to clients;
 - h. Determine applicants' eligibility for program;
 - i. Enroll clients into the program;
 - j. Carefully track available funding; and
 - k. Ensure caregiver meets the criteria for the role of the HCE caregiver.

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Lines of Communication:

- A. Lead Agencies:** Case management agencies shall request and receive technical assistance from the Area Agencies on Aging. When additional interpretation is needed, the AAA staff will forward the request for technical assistance to DOEA.
- B. DOEA:** DOEA will address all requests and provide a timely response.

Grievance Proceedings :

Please refer to Appendix D, "Minimum Guidelines for Recipient Grievance Procedures," in this Handbook.

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Section V: Grievance Proceedings

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Section VI: Attachment 1

HCE Financial Worksheet

HOME CARE FOR THE ELDERLY FINANCIAL WORKSHEET:

This worksheet is for use with HCE applicants and clients who **ARE NOT** recipients of SSI, QMB, or SLMB.

Applicant/Client Name: _____

NOTE: Information refer only to the APPLICANT'S/CLIENT'S income and assets.

INCOME INFORMATION			
Ask the applicant/client: "Do you receive income from any of the following sources, and if so, in what amounts?"			
#	Income Source:	Yes (✓)	No (✓) Amount
1.	Social Security (SSA)*		\$
	1a) Supplemental Security Income (SSI)		\$
	1b) Social Security Disability Income (SSDI)		\$
2.	Veteran's Administration (VA)		\$
3.	Disability Payments including Worker's Compensation (Not , SSI, SSDI or VA)**		\$
4.	Retirement Pensions (Railroad, Union, Government)		\$
5.	Interest and Dividends		\$
6.	Annuity Income including Civil Service		\$
7.	Rental property		\$
8.	Estate/Trust Fund Income		\$
9.	Alimony/child support		\$
10.	Contributions from another person		\$
11.	Other income		\$
TOTAL APPLICANT/ CLIENT INCOME			\$

* Gross SSA income needs to be counted. The SSA check is the net amount after the Medicare premiums are deducted.

** Disability payments should only include private disability insurance payments. State and federal disability payments should not be included.

COMMENTS/NOTES/CALCULATIONS:

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HCE Financial Worksheet

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ASSET INFORMATION				
Ask the applicant/client: "Do you have any of the following assets, and if so, what are their values?"				
#	Asset:	Yes (✓)	No (✓)	Amount
1.	More than one automobile (include amount only if car is less than 7 years old or more than 25 years old)			\$
2.	Life Insurance Policies that have a total face value of over \$2,500.			\$
3.	Cash on hand			\$
4.	Checking Account(s)			\$
5.	Savings Account(s)			\$
6.	Certificate(s) of Deposit			\$
7.	Individual Retirement Account(s)			\$
8.	Revocable Burial Contract			\$
9.	Trust(s)			\$
10.	Stocks/Bonds/Mutual Funds			\$
11.	Real Property (not homestead)			\$
12.	Christmas Club savings			\$

*** If the applicant's/client's assets are valued at over \$2,000, he/she can specifically designate up to \$2,500 worth of assets as burial funds in a written statement to the case manager. The designated amount of burial funds will then be subtracted from the total asset amount to determine the total countable asset amount.**

TOTAL APPLICANT/CLIENT COUNTABLE ASSETS: \$ _____

COMMENTS/NOTES/CALCULATIONS:

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FINANCIAL ELIGIBILITY DETERMINATION		
1. Income	Yes (✓)	No (✓)
If the applicant's/client's gross income is less than the current Institutional Care Program (ICP) standard, then he/she meets the income eligibility requirement. (Please refer to the current ICP standard issued each year by the Department of Elder Affairs). Does the applicant/client meet the income eligibility requirement?		
2. Assets		
If the applicant's/client's countable assets amount is \$2,000 or less (after the \$2,500 of designated assets are subtracted), then he/she meets the asset eligibility requirement. Does the applicant/client meet the asset eligibility requirement?		
3. Financial Eligibility		
If the applicant/client meets both eligibility requirements cited in 1 and 2 above, then he/she is financially eligible for the HCE program. Does the applicant/client meet both requirements?		

The applicant/client must read, sign and date the following statement attesting to the accuracy of the financial information provided. The case manager will also sign and date the financial worksheet and include in the applicant/client file.

ATTESTATION:

I hereby attest that the income and asset information I have provided is accurate and true based on my present financial circumstances. I hereby grant the HCE case manager my permission to verify any of the information I have provided if there is any question about its validity and will sign a specific release of information for that purpose if requested.

Applicant/Client Signature: _____

Date: _____

Worksheet prepared by: _____

Date: _____

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HCE Financial Worksheet

FINANCIAL DEFINITIONS:

Assets:

Assets are the valuable possessions individuals accumulate over time. Applicants can have some of these possessions without affecting their eligibility. The remainder of these possessions is counted towards the program's asset limit. Assets fall into two types of categories: excluded and included. They are listed in the following matrices:

Excluded Assets:

#	Term	Definition
1.	Automobile	The individual's automobile, which includes any mode of transportation regardless of use or value.
2.	Burial (Funds set aside for)	Up to \$2,500.00 in otherwise included assets may be excluded if they are specifically designated by the individual as assets to be used for their burial. These assets include liquid assets such as savings, certificates of deposit, savings bonds, and stocks; or real/non-liquid assets such as automobiles, land, jewelry, farm or business equipment, or any other real property so designated
3.	Burial Spaces Inclusions:	A burial space for each individual and immediate family which includes the following individuals: A. Spouse; B. Minor or adult children; C. Stepchildren; D. Adopted children; E. Brothers and sisters; F. Parents; G. Adopted parents; and H. Spouse of any of the above.

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#	Term	Definition
3	Burial Spaces Inclusions:	Exclusions: Immediate family does not include members of the spouse's family, the individual's grandchildren or other relatives.
4.	Homestead	The individual's principal place of residence including the following: A. All land appertaining to the home; B. All buildings located on such land, and C. Any adjoining land and any land which would adjoin it if it was not for roads, streams, rivers, easements, or public rights of way. Note: Only one residence may be excluded.
5.	Household Goods and Personal Effects	Usual household goods and personal effects are presumed to be excluded. However, if the individual claims to have a collection of personal items or effects they consider to be worth a large amount of money, then the value is counted except for one wedding ring, one engagement ring, and medical equipment.
6.	Irrevocable Pre-Paid Burial Contracts	Those contracts between the individual and a funeral director or funeral home, which are considered irrevocable as stated in the contract regardless of the value.
7.	Life Estate in Non-Home Property	The type of ownership in which the individual is given legal title or deed of ownership to another but retains a lifetime interest in the property. Life estate is of no marketable value and is thus excluded.
8.	Life Insurance Policies	Total face values of all policies owned by the individual is \$2,500.00 or less. Any term insurance and burial insurance policies are excluded regardless of face value.
9.	Property Essential To-Self-Support	Income producing property. This would include stores, service stations, beauty shops, condominiums, mobile homes, and any other property, which is producing income for the client's self-support.

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HCE Financial Worksheet

#	Term	Definition
10.	Real Property Which is Up for Sale	Any real property, regardless of value, which the individual is making a bona fide effort to sell, is excluded if it is on the market. If the property is not marketable due to the condition, nature, or location of the property, then the property is excluded

Included Assets:

#	Term	Definition
1.	Additional Automobiles	One or more additional automobiles other than the one excluded
2.	Cash on Hand	Any cash in the individual's possession that is not income for the month is considered as an asset.
3.	Certificates of Deposit (CD) and Individual Retirement Accounts (IRA)	These accounts are considered assets in the amount of their cash surrender value (current cash value minus any penalties for early withdrawal). IRAs are designated for retirement, so they cannot be considered for burial funds. However, CDs can be designated for burial funds.
4.	Checking and Savings Accounts	The lowest balance of the individual's bank accounts as of any day in the month minus any deposits made to the account from income received during the month is considered an asset. A. If an HCE applicant jointly holds an account with another person (John Smith "and" Mary Wilson), then the funds and any interest received are equally divided. B. If an HCE recipient has unrestricted access to the funds (John Smith "or" Mary Wilson), then the whole balance and all interest received is considered the applicants.
5.	Life Insurance	If the total face value of life insurance policies exceeds \$2,500.00, then the cash value of those policies must be considered as an asset. These policies may be designated for burial and the cash value would be added to other burial assets. Up to \$2,500.00 of those assets would be excluded.

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HCE Financial Worksheet

#	Term	Definition						
6.	Real Property (Other than Homestead)	This is land and other associated buildings on land in which the individual has ownership interest. Ownership is either simple (individual alone) or shared. If shared, the value is divided equally among the owners. It includes mineral rights, timber rights, leasehold, or allotment to farm on a piece of land.						
7.	Revocable Burial Contracts	Revocable burial contracts/agreements do not have the word “irrevocable” on the document and therefore the individual can withdraw the money. The balance of these burial funds is added to any other burial designated funds and up to \$2,500.00 is excluded						
8.	Stocks, Bonds, Mutual Funds Shares	Stocks represent ownership in a corporation. The value would be determined by the closing price as of the date of application. Bonds are a promise to pay cash. They cannot be redeemed for their stated value until the specified date of maturity. Mutual Fund is a company that buys and sells securities and other property. Verification: Values can be verified as follows: <table><tr><th>Type:</th><th>Verification Method</th></tr><tr><td>Stocks, bonds, mutual funds</td><td>Stockbroker</td></tr><tr><td>U.S. Savings Bond</td><td>Bank</td></tr></table>	Type:	Verification Method	Stocks, bonds, mutual funds	Stockbroker	U.S. Savings Bond	Bank
Type:	Verification Method							
Stocks, bonds, mutual funds	Stockbroker							
U.S. Savings Bond	Bank							
9.	Trusts	Trusts are money or property held by a trustee for the of the individual who is the beneficiary. This type of asset is the only one that is also considered income in the same. A. The principal balance of the trust is not usually available to the beneficiary, this is not considered an asset. B. Exception: If the individual for his/her own benefit set up the trust fund or if the spouse set up a trust fund for the individual, regardless of availability, the total balance of the trust is considered an asset. This type of asset is the only one that is also considered income in the same month.						

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Section VI: Attachments 2

HCE Basic Subsidy Chart

HCE BASIC SUBSIDY CHART

Recipients Monthly Income	Basic Subsidy Amount
\$0 – Up to the Institutional Care Program (ICP) Income Ceiling	\$160

Existing clients receiving a Basic Subsidy greater than \$160.00 per month will continue to receive their current subsidy amount.

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Section VI: Attachment 3

HCE Safety and Accessibility Worksheet

OPTIONAL HCE SAFETY AND ACCESSIBILITY WORKSHEET:

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Structure of Home, Floors—Overall Risk				
Exposed wiring				
Creaking or uneven floors				
Ceilings with water marks				
Doors open with difficulty				
Windows cannot be opened				
Outside structure appears to be leaning				

Questions and Responses:

1. How old is your home?

Response:_____

2. Have you or your caregiver consulted anyone about problems with the structure of the home?

Response:_____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Access—Overall Risk				
Client lives above the 1 st floor of the building				
Client lives above the 1 st floor of the building with no elevator				
Client has limited/deteriorating mobility				
Client lives in 2-story home with bedrooms upstairs				
Client cannot climb stairs				
Client uses a wheelchair for mobility				
Entrance to the home has steps				
Doorways are too narrow, rooms too small to safely maneuver				

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Section VI: Attachments 3

HCE Safety and Accessibility Worksheet

Question and Response:

1. If the client uses a wheelchair for mobility, ask how he/she can maneuver within and in and out of the home?

Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Electrical System—Overall Risk				
Electrical cords are frayed				
Extension cords are overused				
Electric plugs are partially hanging out of the wall				
The wiring in the home is poor				

Questions and Responses:

1. Have you or your caregiver ever been shocked trying to plug or unplug anything?

Response: _____

2. Do you have to change fuses frequently?

Response: _____

3. Has your electric bill increased significantly even though you are not using more appliances?

Response _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Fire Safety—Overall Risk				
Wall-to-wall clutter				
Client and/or caregiver smoke				
No smoke alarms or alarms do not work (no batteries)				
Use of non-vented space heater				
Fireplace used without a screen guard				

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Section VI: Attachment 3

HCE Safety and Accessibility Worksheet

Questions and Responses:

1. Have you or your caregiver ever fallen asleep while smoking?

Response: _____

2. Do you or your caregiver forget food cooking on the stove or in the oven?

Response: _____

3. Do you have a fire extinguisher and do you know how to use it?

Response: _____

4. Have you checked the smoke alarm and changed batteries lately?

Response: _____

5. Do you set a timer when using the oven or toaster oven?

Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High
Sanitation—Overall Risk				
Unpleasant odor in the house				
House is unclean				
Bathrooms are unclean and odorous				
Furniture/carpet are soiled				
Evidence of pest or pest's droppings in the house				
Evidence of dead pest odor				
Evidence of pet odor				

Questions and Responses:

1. Do you have pest control service?

Response: _____

2. Do you have pests in the house such as roaches, rats or mice?

Response: _____

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HCE Safety and Accessibility Worksheet

3. Do you use sprays or tablets for control?

Response: _____

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Hot Water/Water—Overall Risk				
Evidence of excessive amounts of dirty dishes from lack of water				
Client is unkempt, unclean and has body odor				
Client's clothing is unclean				

Questions and Responses:

1. Do you have running water?

Response: _____

2. Do you have hot water?

Response: _____

Additional Comments:

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AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Heating/Air Conditioning—Overall Risk				
Temperature in the house is too warm or cold				
Room is stuffy even with air conditioner on				

Questions and Responses:

1. How do you keep warm in the winter?

Response: _____

2. Do you have a central air and heating system? Does it work adequately?

Response: _____

3. Do you have to unplug another appliance to run a space heater or air conditioner?

Response: _____

4. Do you sleep with a space heater on at night?

Response: _____

5. Does the heat bother you in the warm months?

Response: _____

6. Why don't you run your air conditioner?

Response: _____

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HCE Safety and Accessibility Worksheet

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Shopping Accessibility—Overall Risk				
Evidence of little or no food in cabinets/pantry/refrigerator				
Evidence of prescriptions not filled				

Questions and Responses:

1. How do you do your shopping/errands?

Response: _____

2. When was your last trip to the grocery store?

Response: _____

3. Can you afford to pay someone to do your shopping and pick up your prescriptions?

Response: _____

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HCE Safety and Accessibility Worksheet

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Transportation Accessibility—Overall Risk				
Client is unable to get to local transportation pickup				
Client does not drive or have anyone who can drive him/her				
Caregiver does not drive				

Questions and Responses:

1. How do you and your caregiver get to stores to shop, run errands?

Response:

2. Is transportation available from other local agencies?

Response:

3. Are you able to get on a bus?

Response:

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Telephone Accessibility—Overall Risk				
No telephone is visible				
No phone number is listed on the referral				

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HCE Safety and Accessibility Worksheet

Questions and Responses:

1. Are you able to afford a telephone?

Response: _____

2. Is the client able to use the telephone?

Response: _____

3. Are you able to use a neighbor or friend's phone?

Response: _____

4. How can I reach you or you reach me when necessary?

Response: _____

5. How do you get help in an emergency?

Response: _____

6. May I contact your family to discuss the possibility of getting you a telephone?

Response: _____

Chapter 6: Home Care for the Elderly (HCE)

HCE Safety and Accessibility Worksheet

AREA OF CONCERN	No Risk	Low Risk	Moderate Risk	High Risk
Emergency Evacuation Capability—Overall Risk				
The doors and windows are boarded up, nailed shut, covered with burglar bars or otherwise will not open				
The client is unable to walk, transfer to a wheelchair, open doors or manage stairs, making evacuation attempts impossible				
Exit access is obstructive (clutter, furniture, etc.)				
Client's bedroom does not have two means of unobstructed exit				

Questions and Responses:

- 1.** Do you feel that you could evacuate the home safely in an emergency?

Response:

2. Can you describe what you would do in case of an emergency?

Response:

3. Would the caregiver be able to get both himself/herself and the client out of the home in case of an emergency?

Response:

Additional Comments:

Additional Comments:

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Chapter 6: Home Care for the Elderly (HCE)

Section VI: Attachment 3

Notice of Case Action

STATE OF FLORIDA DEPARTMENT OF ELDER AFFAIRS HOME CARE FOR THE ELDERLY NOTICE OF CASE ACTION

SECTION 1	
Applicant's Name	
Address:	
Telephone	
Caregiver's Name:	
This form is to notify you of your eligibility determination for receiving Home Care for the Elderly (HCE) Services.	
SECTION 2a: ELIGIBILITY:	
You are eligible to receive HCE services effective: _____ The amount of your monthly basic subsidy is \$_____ You are responsible for immediately notifying your case manager of any change in your physical or financial conditions.	
SECTION 2b: ELIGIBILITY	
_____ A.	The results of the assessment instrument do not meet the eligibility standards.
_____ B.	You are financially ineligible.
_____ C.	You do not have an adult caregiver.
_____ D.	Other:
SECTION 3: CHANGE IN ELIGIBILITY	
Your services are being:	_____ Terminated _____ Suspended _____ Reduced
For the following reason (s):	
_____ A.	Your caregiver is no longer eligible.
_____ B.	You are temporarily out of the home.
_____ C.	Your medical condition has improved.
_____ D.	You are financially ineligible.
SECTION 4: GRIEVANCE RIGHTS	
If you believe this decision is incorrect, please contact me so that we may discuss the situation. You have the right to file a grievance regarding this decision. Should you desire to file a grievance, you have 30 days from the date of this notice to make your request	

Case Manager: _____ **Date:** _____

Agency Address: _____ **Phone:** _____

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Chapter 6: Home Care for the Elderly (HCE)

Section VI: Attachment 4

Notice of Case Review

STATE OF FLORIDA DEPARTMENT OF ELDER AFFAIRS HOME CARE FOR THE ELDERLY NOTICE OF CASE REVIEW

SECTION 1	
Applicant's Name	
Address:	
Telephone	
Caregiver's Name:	
This form is to notify you of the decision regarding review of your case action.	
SECTION 2: DECISION	
Based on all the information involved in this reconsideration, the Lead Agency:	
_____ A.	Confirms the decision.
_____ B.	Does not confirm the decision.
Comments: _____	

SECTION 3: GRIEVANCE RIGHTS	
If you do not agree with this decision, you have the right to file a grievance regarding this decision by requesting a review of the case action by the Area Agency on Aging no later than 15 calendar days from the date of this notice. Please send your request to the following address	

Case Manager: _____

Date: _____

Agency Address: _____

Phone: _____

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Chapter 6: Home Care for the Elderly (HCE)

Section VI: Attachment 5 Program Enrollment Criteria for HCE Caregivers

1. **Responsibility for Recipient:** Accepting responsibility for the social, physical, mental and emotional needs of the home care recipient with whom they live.
2. **Physical Presence:** Living in the home with the client to provide supervision and assist in arrangements of services for the recipient.
3. **Emergency Arrangements:** Having alternative arrangements for care planned with another adult (18 years or older) in the case of an emergency.
4. **Alternate Caregiver:** Planning for an alternate caregiver to provide caregiver services in the home when absences from the home are daily or routine. The alternate must also meet all the enrollment criteria for caregivers.
5. **Maintaining Safe Environment:** Maintaining the residential dwelling free of conditions that pose an immediate threat to the life, safety, health, or well-being of the home care recipient.
6. **Personal Relationship:** Maintaining a positive personal relationship with the recipient.
7. **Abuse, Neglect, Exploitation:** Being free of conviction of the abuse, neglect, or exploitation of another person.
8. **Maintaining Family Environment:** Maintaining a family type living environment and not pursuing, or planning to pursue, a group living arrangement.
9. **Reporting Changes:** Maintaining contact with the case manager, immediately reporting any changes in the client's medical condition, financial condition or living arrangement.
10. **Care Plan Development:** Assisting in the development of the care plan, signing the plan and assisting in carrying out the plan with the client and case manager.
11. **Case Manager Access to Client:** Providing the case manager with unlimited access to the home and client.
12. **Use of Basic Subsidy:** Using the basic subsidy payment to assist with reimbursement of costs associated with the basic needs of the client such as:
 - A. Housing;
 - B. Food;

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Program Enrollment Criteria for HCE Caregivers

- C. Clothing;
 - D. Medical services;
 - E. Dental services; and
 - F. Incidentals not covered by Medicaid, Medicare or any other insurance.
13. **Use of Special Subsidy:** Using the special subsidy payments authorized prior to purchase as reimbursement for specific services or items purchased for the client.
14. **Receipts of Purchases:** Providing the case manager with receipts for special subsidies within 30 days of the purchase.
15. **Eligibility Determination:** Providing information needed for determining eligibility available for the case manager at the time of assessment and reassessment.

Chapter 7

Administration of the Respite for Elders Living in Everyday Families (RELIEF) Program

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Chapter 7: Respite for Elders Living in Everyday Families (RELIEF) Program

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Chapter 7: Respite for Elders Living in Everyday Families (RELIEF) Program

Section I: Purpose of the RELIEF Program

Chapter Contents: This chapter provides program policies, standards and procedures for use by the Department and all contractors and subcontractors in administering the Respite for Elders Living in Everyday Families (RELIEF) program.

- A. Purpose: The RELIEF program provides volunteer-based in-home respite services, beyond the provisions of current public programs, designed to support family caregivers of frail homebound elders age 60 and older and those with Alzheimer's disease and related dementia. Additionally, the RELIEF program provides the following:
1. Opportunities for multi-generational corps of volunteers, age 18 and older, to contribute to their communities; and
 2. Up to four (4) hours of in-home respite services at a time with an emphasis on evening and weekend hours; and
 3. Stipends to those who qualify, and reimbursements to volunteers to enable them to provide services at no cost to themselves.

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Chapter 7: Respite for Elders Living in Everyday Families (RELIEF) Program

Section II: Legal Basis and Specific Legal Authority

Legal Basis: The authority for this program is provided by: Specific Authority:

- 1.** Florida Statute (F.S.), Chapter 430.071
 - 2.** Florida Statute (F.S.), Chapter 430.0402
-

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Section III: Services Provided Under the RELIEF Program

SERVICES PROVIDED UNDER THE RELIEF PROGRAM:

Respite is provided primarily during evenings and weekends, times that are not usually covered by other respite programs. Volunteers may spend up to four hours per visit providing companionship to a frail homebound elder, giving the caregiver an opportunity to take a much-needed break to allow the family unit to continue caring for a homebound elder without becoming ill themselves.

Activities may include:

- Providing companionship, conversation, playing games, or solving puzzles;
- Assist with reading, writing letters, or journaling;
- Encouraging exercise and recreation, going to the park, or taking walks;
- Preparing or serving a light meal or snack pre-approved by the caregiver.

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Chapter 7: Respite for Elders Living in Everyday Families (RELIEF) Program

Section IV: Program Requirements

GENERAL CLIENT ELIGIBILITY CRITERIA:

Listed below are the eligibility criteria for the RELIEF program:

1. Individuals are 60 years of age and older;
2. The family unit is unable to pay for evening/weekend respite without jeopardizing other basic needs;
3. The homebound elderly individual would need to be moved to an assisted living or nursing facility without the assistance of the RELIEF program;
4. The client may not be enrolled in a Medicaid capitated long-term care program.

Target Groups

In addition to serving frail homebound elders at risk of institutionalization, the program serves the special needs of clients who have Alzheimer's disease or related dementia and clients and caregivers.

Client Priority

In addition to priority list criteria, assignments should be made that accomplish the following:

1. Deter or delay institutionalization of homebound elders with mental, emotional and/or physical impairments who need outside assistance to achieve and maintain their fullest potential to manage their loved;
2. Provide respite to households in which the burden of care for aged persons rests with household members who find it difficult to provide the level of support needed to prevent institutional placement; and
3. Assist elders who need a higher level of service to remain in their homes.

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Section IV: Program Requirements

Client Assessment

The demographic portion of the 701(A) Condensed Assessment form must be completed for each client for enrollment in the RELIEF program.

RELIEF clients will be enrolled in CIRTS based on demographics portion of the form including the following information to be collected: social security number, owner ID, county of service, first name, last name, and date of birth, home address including: street address, zip code, city, and state.

RELIEF Clients may be eligible for dual enrollment in other programs except for the Medicaid Long-Term Care Program. Clients enrolled in other program will also need to be enrolled in CIRTS under the RELIEF Program.

RELIEF Clients enrolled in CIRTS will be required to be terminated within the system if services have been terminated using the following CIRTS Codes:

1. Termination by Client (TRBC)
2. Terminated Client Died (TRCD)
3. Terminated Active – Moved to Managed Long-Term Care (TRML)
4. Terminated Client Placed NH (TRNH)

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Section IV: Program Requirements Volunteer Management

General Volunteer Qualifications

Volunteer qualifications shall be included in all position descriptions and recruitment advertisements. Qualified volunteers shall:

1. Be age 18 and older;
2. Pass a Level II Criminal History Background screening (initiated through; the “Care Provider Background Screening Clearinghouse” or “Clearinghouse” website and updated every five years) in accordance with [Florida Statute \(F.S.\), Chapter 430.0402](#) .
3. Commit to serve at least 4 hours per week;
4. Commit to serve at least 3 days per week as determined by the needs of the client.

Volunteer Recruitment

A volunteer recruitment plan shall be developed and updated annually to ensure the recruitment of enough volunteers to meet the contracted service hours. The recruitment plan shall include volunteers that are representative of the communities they serve ensuring a diversity of volunteers.

Volunteer Enrollment

Volunteers are required to complete an application to serve in the program. Provider Agencies must screen and interview volunteers as well as conduct required background screening in accordance with *Appendix E of the Handbook*. Volunteers may not begin training or any other related service until receiving Criminal History Background clearance.

Volunteer Training

A volunteer training plan shall be developed and updated annually to include training topics and dates for required orientation and in-service training. Orientation, in-service and service-learning training components shall address a broad range of topics regarding elder and respite-care issues including:

1. Physiological, psychological and social aspects of aging;
2. Health and personal-care assistance;
3. Elder abuse, neglect and exploitation;

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Section IV: Program Requirements Volunteer Management

4. Communication techniques;
5. Problem behaviors and problem solving; and
- 6 Review of applicable RELIEF policies and procedures.

Volunteer Orientation

Volunteers are required to complete orientation before providing any direct service to clients. RELIEF volunteers are not considered employees of the Department. Pre-service orientation training must provide information that improves the volunteer's knowledge and ability to serve clients including, but not limited to:

1. A general explanation of the program;
2. General agency information;
3. Agency policy information on personnel, confidentiality, record keeping, performance reviews and other administrative requirements;
4. Information to acquaint with the agency staff and with other volunteers;
5. A description of the objectives of their respite service;
6. Information concerning the roles and activities involved in being a RELIEF volunteer;
7. Information about available community service to enable the volunteer to be better advocates for their clients;
8. General information regarding the economic, social and psychological aspects of aging; and
9. Prevention of elder abuse, neglect, and exploitation (ANE)

Volunteer In-Service Training

Provider agencies shall ensure that volunteers participate in at least 20 hours of pre-service training before providing any services to clients. After completing pre-service training, volunteers are required to complete a minimum of three (3) hours of in-service training each quarter. An in-service training on reporting suspected ANE shall be provided to volunteers annually. Volunteer training may be conducted individually or in group settings, and in job-shadowing settings, to assist volunteers in learning practical aspects of working with clients. Volunteers shall be provided information regarding training goals including scheduled meeting dates.

The purpose of in-service training is to:

1. Give more detailed instruction on working with elders who have special or exceptional issues;
2. Share information and guidance on matters pertinent to aging;

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3. Provide information about community resources which can be accessed by clients; and
4. Provide feedback to volunteers about service, and for volunteers to share experiences and best practices serving clients. Volunteers Management

Volunteer Training Reimbursement

All volunteer orientation and in-service training hours are reimbursable. Volunteer training hours must be recorded on the standard RELIEF Program Time and Travel Log and approved by the designated volunteer supervisor. Volunteer orientation and in-service training logs, training agendas and sign-in sheets are also required as part of volunteer training documentation. A volunteer's full signature is required for all training documentation.

Volunteer Stipends

Provider agencies may provide volunteers with a stipend not to exceed the current federal minimum wage. A volunteer stipend is provided for a period of service (per hour) and is not an hourly wage, but may be considered as income. Volunteer service hours must be recorded on the standard RELIEF Program Time and Travel Log and approved by the designated volunteer supervisor.

Volunteer Assignments

Volunteers shall be assigned to clients in a way that benefits both the volunteer and client. Volunteers may be placed with multiple clients, based upon the demand for services and the ability of the volunteer to provide services. Two volunteers may not serve the same client unless one is a short-term substitute for the other. All assignments must include the following:

1. Involve person-to-person relationships with the clients served;
2. Be meaningful and rewarding the volunteer; and
3. Reflect individual volunteer preferences as well as provide meaningful services to the family unit and elder.

All volunteer assignments must be recorded using the RELIEF assignment sheet as documentation. Assignment sheets shall include information related to the client being served, the days and times of service, allowable activities and information regarding how to contact the designated volunteer supervisor shall be provided. Assignment sheets must be signed by the client, the volunteer and volunteer supervisor. Copies of the assignment sheet shall be provided to volunteers and clients, and maintained in the volunteer file.

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Section IV: Program Requirements

Volunteer Supervision

Volunteers shall receive proper supervision to maintain a consistently high level of performance and to ensure that the volunteers operate within the guidelines established by the provider agency. Volunteer position descriptions shall include the name of the staff member (s) authorized to supervise volunteer activities. Supervision of activities shall include, but are not limited to the following:

1. Visiting on-site periodically to monitor the volunteer's performance within the assignment and the progress of the client to determine the appropriateness of the assignment;
2. Helping volunteers arrange for community services that benefit the clients;
3. Maintaining a one-on-one relationship between the volunteers and the clients they serve; and
4. Conducting orientation and regular in-service training to explain policies to enhance skills related to assignments and provide information on community services.

Volunteer Performance Appraisals

Volunteers shall receive a performance review at least once during each calendar year. Provider agencies must inform the volunteers of the timing, content, and process of the performance review. The performance evaluation shall acknowledge any volunteer's work that has exceeded expectations, as well as identify any areas that may need improvement. The completed performance review shall be documented and maintained in the individual volunteer file. At a minimum performance reviews shall measure:

1. Performance/task assignments;
2. Reliability and promptness;
3. Relationships with staff, clients, caregivers, and other volunteers;
4. Willingness to follow policies and procedures; and
5. Attendance at required meetings/training.

Section VI: Program Requirements

Volunteer Recognition

Provider agencies shall develop an annual volunteer recognition plan and host at least one annual volunteer recognition event to spotlight the contributions of volunteers and recognize them for their service and accomplishments. Volunteer recognition may also be conducted on a regular basis and in conjunction with monthly in-service training and other special events.

Provider agencies should also seek to spotlight volunteer efforts in the local newspapers, in newsletters, on social media and other available distributions. Provider agencies shall also participate in the Department of Elder Affairs volunteer recognition efforts during “Volunteer Appreciation Month” held each April.

Volunteer Records

Provider agencies shall ensure the collection and maintenance of current and accurate data for each volunteer. Volunteer records must be stored in locked files. A RELIEF Volunteer File Checklist shall be used as a reference to ensure each file contains the following signed and completed forms:

1. Position Description;
2. Volunteer Application;
3. Reference Check Documentation;
4. Level II Criminal History Documentation;
5. Confidentiality Statement;
6. Statement of Understanding (allowable and prohibited activities);
7. Respite Assignment Plans;
8. Time and Travel Logs;
9. Training logs;
10. Grievance procedure; and
11. Other Volunteer related documentation.

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Section VI: Program Requirements

Program Reporting Requirements

Service Unit

The service unit for the RELIEF program shall be measured as one (1) hour of respite care and/or one (1) hour of pre-service or in-service training. All service units must be documented on the standard RELIEF Program Time and Travel Log and approved by the designated volunteer supervisor.

Programmatic Reports

Provider agencies are responsible for responding in a timely fashion to routine and special requests for information and reports required by the Department. Reports and information that may be requested include but is not limited to: monthly service records, volunteer time sheets, training reports, and program highlights that show impact of program services.

Monthly Service Records

The provider agency shall complete and submit a RELIEF Monthly Service Record and CIRTS report in accordance with the established deadlines. Monthly Service Records are completed based on RELIEF Program Time and Travel Logs that have been signed and dated by both the volunteer and volunteer supervisor.

Client Information and Registration Tracking System (CIRTS) Reports

Provider agencies shall input RELIEF (CIRTS Code: RELF) specific service (CIRTS Code: RESP) data into CIRTS to ensure data accuracy. The Contractor shall use CIRTS generated reports which include the following:

1. Client Reports
2. Monitoring Reports
3. Services (Unit) Reports
4. Fiscal Reports

Only direct service hours documented on the RELIEF Program Time and Travel Log and reported on the Monthly Service Record shall be reported in CIRTS. Training hours documented on RELIEF Program Time and Travel Log and reported on the Monthly Service Record are not required to be reported in CIRTS.

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Section VI: Program Requirements

AAAs shall provide access and CIRT training to all provider agencies. In accordance with DOEA NOTICE # 040114-1-I-SWCBS, AAAs shall direct all direct questions, comments suggestions and issues regarding CIRT to the established CIRT email address:

CIRTComments@elderaffairs.org

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Section VI: Program Requirements

RESPONSIBILITIES OF STAKEHOLDERS:

A. DOEA:

- 1. Purpose:** The purpose of DOEA in the RELIEF program is to budget, coordinate, and develop policy at the state level necessary to carry out the RELIEF program.
- 2. Responsibilities:** The responsibilities of DOEA are listed below:
 - a.** Develop an allocation formula for distributing RELIEF funds to Planning and Service Areas (PSAs);
 - b.** Allocate RELIEF funds to service providers through the Area Agencies on Aging (AAAs);
 - c.** Establish policies and procedures for AAA, and RELIEF provider agencies;
 - d.** Evaluate the quality and effectiveness of services and client satisfaction with the RELIEF program, as required;
 - e.** Develop program reports;
 - f.** Provide for staff development and training;
 - g.** Provide and monitor program policies and procedures for the PSAs;
 - h.** Review and make recommendations for improvement on program reports;
 - i.** Provide technical assistance to the AAAs in program planning and development and ongoing operations, as needed;
 - j.** Process payments to the contracted agencies; and
 - k.** Provide ongoing technical assistance.

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Section VI: Program Requirements

B. AREA AGENCIES ON AGING (AAA):

1. **Purpose:** The purpose of the AAA in the RELIEF program is to monitor and fund Provider Agencies
2. **Responsibilities:** The AAA's responsibilities are listed below:
 - a. Develop PSA level allocation formula for distribution of funds;
 - b. Plan for, advertise, and approve funding for provider agencies;
 - c. Designate provider agencies and establish vendor agreements at the AAA level, when applicable;
 - d. Provide technical assistance to provider Agencies and vendors to ensure provision of quality services;
 - e. Assess provider agency fiscal management capabilities;
 - f. Monitor and evaluate contracts, for programmatic and fiscal compliance;
 - g. Submit payments to contractors;
 - h. Review Provider agency volunteer time sheets and reconcile against the RELIEF Monthly Service Record;
 - i. Arrange technical assistance and training for Provider Agencies at least annually;
 - j. Establish procedures for handling recipient complaints concerning such adverse actions as service termination, suspension, or reduction in services;
 - k. Ensure compliance with Client Information and Registration Tracking System (CIRTS) regulations;
 - l. Monitor performance objective achievements in accordance with targets set by the Department; and

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Section VI: Program Requirements

- m. Conduct client satisfaction surveys to evaluate and improve service delivery.

C. PROVIDER AGENCY:

1. **Purpose:** The purpose of the Provider Agency in the RELIEF program is to recruit, screen and manage volunteers and provide in-home respite services to clients.
2. **Responsibilities:** The Provider Agency's responsibilities are to:
 - a. Ensure that coordination is established with all community-based health and social services for functionally impaired older persons funded wholly or in part by federal, state, and local funds to provide a continuum of care;
 - b. Provide DOEA copies of subcontracts or vendor agreements for RELIEF services, when applicable;
 - c. Recruit, screen, train, and supervise volunteers;
 - d. Conduct client assessment, match volunteers to clients, and document volunteer assignments;
 - e. Compile accurate Monthly Service Records, CIRTIS reporting and monthly invoice;
 - f. Arrange in-service training for staff, including volunteers and RELIEF service subcontractors, at least once a year. Monthly, or at least quarterly training is recommended;
 - g. Establish and follow procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services; and
 - h. Conduct client satisfaction surveys to evaluate and improve service delivery.

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

Chapter 7: Respite for Elders Living in Everyday Families (RELIEF) Program

Section VI: Program Requirements

LINES OF COMMUNICATION:

Provider Agencies shall request and receive technical assistance from the AAA. When additional interpretation is needed, the AAA should forward the request to DOEA. DOEA will address all requests and provide a timely response.

GRIEVANCE PROCEDURES:

Please refer to Appendix D, "Minimum Guidelines for Recipient Grievance Procedures," in this Handbook.

DOEA PROGRAM AND SERVICES HANDBOOK
2020 UPDATE
SUMMARY OF MAJOR CHANGES

Location	Page #	Summary of Major Changes
General		Recent notices of instructions and clarifications of policy have been incorporated.
		Chapter 3 of the Handbook was removed. Please note Chapter numbering updated accordingly (i.e. Chapter 3, Older Americans Act, previously Chapter 4)
		For questions related to Emergency Management, contact the DOEA Emergency Operations Coordinator or contract manager.
		Where appropriate, references to Rule 3A 40.103 changed to Department of Financial Services' Reference Guide to State Expenditures. Codes for Federal Regulation (CFR) also update where applicable.
Chapter 1		The general information regarding background screening exceptions and exclusions moved from Chapter 1 and added to Appendix E, the Background Screening Clearinghouse Instructions.
	13-31	Section I, General Information, Definitions were added and/or updated.
	35	The DOEA Mission statement was updated.
	43-48	Section II, Planning Process and Aging Network: 1. AAA: Item D, Advisory Council, moved to Chapter 3, Older Americans Act. 2. Area Wide Planning Responsibilities were updated. 3. Preparation of Area Plan Annual Updates of Area Plan
	51	Section III, Monitoring, Roles and Responsibilities, Item B, 5 was updated.
	62	Section III, Monitoring, DOEA AAA Monitoring, Focus Areas E, Client Data Integrity updated requiring client data be entered in CIRTIS promptly and correctly, and subrecipient monitoring and oversight for CIRTIS entry and accuracy.
Chapter 2 Intake	General	Where applicable, "semiannually review/visit" changed to "care plan review
	7-8	Section I, Screening and Assessment Forms, Summaries updated (i.e. active ADI, CCE, HCE with a 701B will only be rescreened/reassessed with a 701B, not the 701S). An annual 701S rescreening is required for APCL SMMC LTC clients.
	Page 11	Section II, Intake and Screening, Item D, APCL Maintenance and Prioritizing Enrollment of New Consumers was updated to include guidance for significant change and assignment of appropriate status codes when a consumer is no longer waiting for services.
	Page 12-13	Section II, Intake and Screening, Item 23, Consumer Enrollment in DOEA Funded Programs to Receive Services: Added language regarding consumers screened using 701S, released from APCL and assessed using 701B and guidance for continuation of services for CCE clients active in SMMC LTC..

Location	Page	Summary
Chapter 2, Cont.	46	Section III, Case Management Requirement, Retention of Case Record, language added.
	50	Section III, Case Management Requirement: Item E, Electronic Records updated to add requirement for EVV system..
	62	Section V, Attachment 2, Care Plan (DOEA Form 203A) revised. The form was revised to complement CIRTS care plan data entry.
	63-85	Section V, Attachment V, Care Plan Instructions were updated.
	86	Section VI, Incident Reporting Requirements were added.
Chapter 3 OAA	19	Section III, Service Requirements, General Policies, Coordination with Medicaid Capitated Long-Term Care Programs, Item A amended to add guidance regarding MLTC client participation in OAA recreational activities.
	23	Section III, Service Requirements, Information and Assistance changed to Reasonable Access to Information and Referral. The requirements and description were updated.
	29	Section III, Service Requirements, a definition for outreach efforts was added
	41	Section III, Service Requirements, AAA Advisory Council Requirements were updated.
	45	Section III, Service Requirements, AAA Advocacy, Program Development, Outreach and Leadership requirements were updated.
	83	Section III, Service Requirements, Determining Client Satisfaction, Item D, Advisory Council, language added requiring client satisfaction results be reviewed by the AC.
	87-163	Section III, Service Requirements, Nutrition Program Policies were updated. Updated sections include: • Selection of Nutrition Program Service Providers, Item E, Nutrition Provider Responsibilities When Establishing New C-1 Sites. • Approved Certified Food Protected Manager Training Programs • Contracts with Profit Making Organizations • Section III, Service Requirements, Emergency Meals language updated in accordance with NOI 020520-1-I-SWCBS • Food Preparation and Safety Standards. • Contributions for Nutrition Services • Home Delivered Meals
	165	Section III, Service Requirements, List of OAA IIID Services Offered was updated:
Chapter 4- CCE	5	Section II, Services Provided Under the CCE Program, guidance added regarding CCE intake services.
	11	Section IV, Program Requirements, Priority Groups language was updated.
	16	Section IV, Programs Requirements, Service Provision updated in accordance with NOI 060619-1-I-SWCBS
	21	Section IV, Program Requirements, Responsibilities of Stakeholders, Item C, Lead Agency responsibilities regarding procurement updated.

Chapter	Page	Summary
Chapter 5 ADI	3	Section I, Purpose of ADI Program Components updated and references to model day deleted throughout the chapter.
	5	Section II, ADI Service Eligibility requirements were updated.
	10	Section IV, Services Provided Under the ADI Program, Other ADI program Components updated for Memory Disorder Clinics
	14	Section IV, Services Provided Under the ADI Program, Item 5, Alzheimer Disease Advisory Committee language removed from the chapter.
	15	Section V, Program Requirements, B. AAA Purpose and Responsibilities, Competitive Solicitation language was updated.
	18	Section V, Program Requirements, Coordination of Services, Items C, Service Providers program requirements were updated..
Chapter 6 HCE	General: Language referenced in NOIs 022219-1-I-SWCBS and 020620-2-I-SWCBS were added to Chapter 6.	
	6	Section III, Services Provided Under the HCE Program, Restrictions, updated related to special subsidies
	8	Section III, Services Provided Under the HCE Program, Item C, Setting Subsidy Amounts, Hospitalization, language updated for subsidy allowance for client during hospitalization.
	31	Section IV, Program Requirement, Service Coordination with Other DOE A Service Programs, updated regarding HCE dual enrollment in HCE and SMMC.
Chapter 7 RELIEF	3	Section I, Purpose of the Relief Program: The programs purpose and description updated to include hours allowed for in-home respite services.
	5	Section III, Services Provided Under the RELIEF Program: The list of program activities provided in the program was updated.
	8	Section IV, Program Requirements, General Volunteer Qualifications were updated.
	9	Section IV, Program Requirements, Volunteer In-Service Training: Required in-service hours added.

Appendix A	General: The OAA IIID Services were updated as follows:	
	• Mental Health, Applied Suicide Intervention Skills Training (ASIST) was added • Disease Information, Health Promotion, Health Risk Assessment, Health Risk Screening, Home Injury Control were deleted. • Website links to OAA IIID services updated as needed.	
	19	Section II, Services, Adult Day Care, record keeping and reporting requirements for congregate meals were updated.
	24	Section II, Services, Basic Subsidy, Delivery Standards/Special Conditions were updated to include language reporting period when a client is out of home (i.e. hospitalization, institutional care).
	31	Section II, Services, Case Management, Record Keeping and Reporting Requirements updated for case management billing activity.
	59	Section II, Services, Escort, Recording Keeping and Reporting Requirement, Unit of Service reporting was updated
	60	Section II, Services Tai chi Program, Delivery Standards and Providers qualifications were updated.
	94	Section II, Services, ASIST service and program description added
	137	Section II, Services, Housing Improvement, Record Keeping and Report Requirements, Unit of Service type changed to episode.
	141	Section II, Services, Intake, Delivery Standards/Special Conditions updated to include guidance for ADI intake.
	144	Section II, Services, Legal Assistance, Provider Qualifications updated requiring the development of statewide reporting on legal services.
	156	Section II, Services, Nutrition Services, Congregate Meals Delivery Standards/Special conditions were updated. The CIRTIS reporting requirements were updated accordingly..
Appendix B	161	Section II, Services, Nutrition Services, Home Delivered Meals, Delivery Standards/Special Conditions and Record Keeping/Reporting Requirements were updated. Updates include guidance set forth in NOI 021020-1-I-SWCBS. CIRTIS reporting requirements updated accordingly.
	5	Section III, Overview: Language was updated in accordance with NOI 060619-1-I-SWCBS, ADI/CCE Co-payment Information.
	13	Section VI, Termination of Services Due to Delinquent Payments language was updated regarding termination of clients for inability to pay assessed co-payment
		Provider Co-Payment Goal and AAA Holdback Procedures were removed.
Appendix C CIRTIS	25-26	Co-Pay schedules for an individual and couples were updated.
	4	Section II, Reporting Requirements: Program enrollment information was updated.

Appendix D	No changes to Appendix D	
Appendix E Background Screening	General: References to “employees” in Appendix E were changed to “candidate” where applicable.	
	3-5	Section I, Introduction and Requirements were updated. Updates include requirement of candidates and providers to complete Level 2 background screening through the DOEA portal; guidance related to volunteers who assist less than 20 hours per month.
	7	Section II, Instructions, Account Registration and Generating, User Agreement. The section was modified to include Portal Registration Overview and guidance for utilizing the Clearinghouse..
	25	The Background Screening Affidavit of Compliance – Candidate, DOEA Form 236 was updated.

Location	Page	Summary of Major Change

BACKGROUND SCREENING

Affidavit of Compliance - Candidate

AUTHORITY: This form is required of all candidates who are direct service providers when claiming an exception to Level 2 background screening set forth in sections 430.0402(2) and (3), Florida Statutes, or to comply with the attestation requirements set forth in section 435.05(2), Florida Statutes.

This form is required by **all candidates** to comply with:

- The attestation requirement of **section 435.05(2), Florida Statutes**, which states that “every employee required to undergo Level 2 background screening must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to this chapter and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer;” **AND**
- The proof of screening within the previous 5 years in **section 408.809(2), Florida Statutes**, which requires proof of compliance with Level 2 screening standards that have been screened through the *Care Provider Background Screening Clearinghouse* created under **section 435.12, Florida Statutes**, or screened within the previous 5 years by the Agency, Department of Health, Department of Elder Affairs, the Agency for Persons with Disabilities, Department of Children and Families, or the Department of Financial Services for an applicant for a certificate of authority to operate a continuing Care retirement community under **Chapter 651, Florida Statutes**, if that agency is not currently implemented in the Care Provider Background Screening Clearinghouse.

This form must be maintained in the candidate's personnel file, if hired, or with the Human Resources Department. If this form is used as proof of screening for an administrator or chief financial officer to satisfy the requirements of an application for a health care provider license eligibility or monitoring purposes, please attach a copy of the screening results and submit the application.

The term “candidate” as used herein refers collectively to **all persons** required by law to undergo background screening. This includes, but is not limited to, persons who are determined to be a direct service provider. A direct service provider is a person at least 18 years of age who, pursuant to a program to provide services to the elderly, has direct face-to-face contact with a client while providing services and has access to the client’s living areas, funds, personal property, or personal identification information as defined in F.S. 430.0402(1)(b), Florida Statutes. A direct service provider also includes coordinators, managers, and supervisors of residential facilities and volunteers.

Personal identification information defined in F.S. 817.568(1)(f), F.S. means “any name or number that may be used, alone or in conjunction with any other information, to identify a specific individual, including any:

1. Name, postal or electronic mail address, telephone number, social security number, date of birth, mother’s maiden name, official state-issued or United States-issued driver’s license or identification number, alien registration number, government passport number, employer or taxpayer identification number, Medicaid or food assistance account number, bank account number, credit or debit card number, or personal identification number or code assigned to the holder of a debit card by the issuer to permit authorized electronic use of such card;
2. Unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation;
3. Unique electronic identification number, address, or routing code;
4. Medical records;
5. Telecommunication identifying information or access device; or
6. Other number or information that can be used to access a person’s financial resources.”
- 7.

EMPLOYER: IF A CANDIDATE IS HIRED AND IS DETERMINED TO BE A DIRECT SERVICE PROVIDER, THIS COMPLETED FORM MUST BE RETAINED IN THE EMPLOYEE’S FILE. IF AN EXCEPTION TO BACKGROUND SCREENING IS CLAIMED, A COPY OF THE REQUIRED EVIDENCE MUST BE ATTACHED TO THIS FORM.

STEP ONE: Complete identification information.

Candidate Name	Position Applied For
Employer	

STEP TWO: The candidate must review the following list of disqualifying offenses set forth in Chapters 430 and 435, Florida Statutes.

You must attest to meeting the requirements for employment and you may not have been arrested for and awaiting final disposition of, have been found guilty of, regardless of adjudication, or have entered a plea of nolo contendere (no contest) or guilty to, or have been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of state law or similar law of another jurisdiction:

Criminal offenses listed in section 435.04, F.S.

- (a) Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.
- (b) Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.
- (c) Section 415.111, relating to adult abuse, neglect, or exploitation of aged persons or disabled adults.
- (d) Section 782.04, relating to murder.
- (e) Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, or aggravated manslaughter of a child.
- (f) Section 782.071, relating to vehicular homicide.
- (g) Section 782.09, relating to killing of an unborn quick child by injury to the mother.
- (h) Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.
- (i) Section 784.011, relating to assault, if the victim of the offense was a minor.
- (j) Section 784.03, relating to battery, if the victim of the offense was a minor.
- (k) Section 787.01, relating to kidnapping.
- (l) Section 787.02, relating to false imprisonment.
- (m) Section 787.025, relating to luring or enticing a child.
- (n) Section 787.04(2), relating to taking, enticing, or removing a child beyond the state limits with criminal intent pending custody proceedings.
- (o) Section 787.04(3), relating to carrying a child beyond the state lines with criminal intent to avoid producing a child at a custody hearing or delivering the child to the designated person.
- (p) Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.
- (q) Section 790.115(2)(b), relating to possessing an electric weapon or device, destructive device, or other weapon on school property.
- (r) Section 794.011, relating to sexual battery.
- (s) Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.
- (t) Section 794.05, relating to unlawful sexual activity with certain minors.
- (u) Chapter 796, relating to prostitution.
- (v) Section 798.02, relating to lewd and lascivious behavior.
- (w) Chapter 800, relating to lewdness and indecent exposure.
- (x) Section 806.01, relating to arson.
- (y) Section 810.02, relating to burglary.
- (z) Section 810.14, relating to voyeurism, if the offense is a felony.
- (aa) Section 810.145, relating to video voyeurism, if the offense is a felony.
- (bb) Chapter 812, relating to theft, robbery, and related crimes, if the offense is a felony.
- (cc) Section 817.563, relating to fraudulent sale of controlled substances, only if the offense was a felony.
- (dd) Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or disabled adult.

(ee) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled adult.

(ff) Section 825.103, relating to exploitation of an elderly person or disabled adult, if the offense was a felony.

(gg) Section 826.04, relating to incest.

(hh) Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

(ii) Section 827.04, relating to contributing to the delinquency or dependency of a child.

(jj) Former s. 827.05, relating to negligent treatment of children.

(kk) Section 827.071, relating to sexual performance by a child.

(ll) Section 843.01, relating to resisting arrest with violence.

(mm) Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer means of protection or communication.

(nn) Section 843.12, relating to aiding in an escape.

(oo) Section 843.13, relating to aiding in the escape of juvenile inmates in correctional institutions.

(pp) Chapter 847, relating to obscene literature.

(qq) Section 874.05(1), relating to encouraging or recruiting another to join a criminal gang.

(rr) Chapter 893, relating to drug abuse prevention and control to include the use, possession, sale, or manufacturing of illegal drugs, only if the offense was a felony or if any other person involved in the offense was a minor.

(ss) Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

(tt) Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

(uu) Section 944.40, relating to escape.

(vv) Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

(ww) Section 944.47, relating to introduction of contraband into a correctional facility.

(xx) Section 985.701, relating to sexual misconduct in juvenile justice programs.

(yy) Section 985.711, relating to contraband introduced into detention facilities.

(ZZ) Section 741.28 relating to domestic violence.

Criminal offenses found in section 430.0402, F.S.

(a) Section 409.920, relating to Medicaid provider fraud.

(b) Section 409.9201, relating to Medicaid fraud.

(c) Section 741.28, relating to domestic violence.

(d) Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(e) Section 817.234, relating to false and fraudulent insurance claims.

(f) Section 817.505, relating to patient brokering.

(g) Section 817.568, relating to criminal use of personal identification information.

(h) Section 817.60, relating to obtaining a credit card through fraudulent means.

(i) Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(j) Section 831.01, relating to forgery.

(k) Section 831.02, relating to uttering forged instruments.

(l) Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(m) Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

Criminal offenses found in other sections.

(n) Section 775.21, sexual predator.

(o) Section 775.261, Career offender.

(p) Section 943.0435, Sexual offender; unless the requirement to register as a sexual offender has been removed pursuant to section 943.04354.

I have been granted an Exemption from Disqualification through one of the following Specified Agencies:

☐ Department of Elder Affairs	☐ Department of Financial Services
☐ Agency for Healthcare Administration	☐ Department of Health
☐ Agency for Persons with Disabilities	☐ Department of Juvenile Justice
☐ Department of Children and Family Services	☐ Division of Vocational Rehabilitation

Date of Decision: _____

**** A copy of the Exemption from Disqualification decision letter must be attached****

STEP THREE: The candidate must complete this section if claiming an exception to level 2 background screening conducted by the Department of Elder Affairs. If not claiming an exception, then skip to Step Four.

If you are claiming that you qualify for an exception to level 2 background screening pursuant to sections 430.0402(2) or (3), Florida Statutes, and thereby, you are not required to undergo background screening through the Department of Elder Affairs, please indicate the type of exception and attach the required evidence.

EXCEPTION:

- ☐ Attorney - _____ (initials) An attorney in good standing with the Florida Bar if you are providing a service within the scope of your licensed practice.

Evidence: A copy of the screen shot of your membership in good standing with the Florida Bar.

- ☐ Relative - _____ (initials) A relative of the client.
Evidence: Circle your relationship to the client: husband, wife, father, mother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepfather, stepmother, stepson, stepdaughter, stepbrother, stepsister, half brother, or half sister.

- ☐ Volunteer - _____ (initials) A volunteer who assists for less than 20 hours per month and you are not listed on the FDLE Career Offender Search database or the Dru Sjodin National Sex Offender Public Website.

Evidence: A copy of your search results screen shot from each criminal database showing no records were found.

EMPLOYER: IT IS THE EMPLOYER'S RESPONSIBILITY TO VERIFY THE AUTHENTICITY AND ACCURACY OF ANY DOCUMENTATION REQUIRED AS EVIDENCE OF AN CANDIDATE'S QUALIFICATION FOR AN EXCEPTION.

STEP FOUR: Each candidate determined to be a direct service provider must complete the required attestation below.

Claiming an Exception: If you are claiming that you qualify for an exception to level 2 background screening, you are not required to undergo background screening through the Department, and you must sign the attestation below.

Not Claiming an Exception: If you are *not* claiming one of the exceptions to level 2 background screening listed in Step Three, you must complete level 2 background screening through the Department. Once you have been determined qualified for service by the Department, you must sign the attestation below.

ATTESTATION

Under penalty of perjury, I _____, hereby swear or affirm that I meet the requirements for qualifying for employment pursuant to the background screening standards set forth in Chapter 435 and section 430.0402, Florida Statutes. In addition, I agree to immediately inform my employer if arrested or convicted of any of the disqualifying offenses while employed by my employer.

Candidate Signature

Date

EMPLOYER: ONCE THE ATTESTATION IS SIGNED, KEEP THIS COMPLETED FORM IN THE CANDIDATE'S FILE.