Appendix A

Service Descriptions and Standards
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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.
## PROGRAM ACRONYMS:

### Name Acronyms

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<td>AC</td>
<td>AmeriCorps</td>
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<tr>
<td>CCE</td>
<td>Community Care for the Elderly</td>
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<td>HCE</td>
<td>Home Care for the Elderly</td>
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<td>LSP</td>
<td>Local Services Program</td>
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<td>RELIEF</td>
<td>Respite for Elders Living in Everyday Families</td>
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<tr>
<td>SCP</td>
<td>Senior Companion</td>
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<tr>
<td>OAAI</td>
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<td>OAAIIII</td>
<td>Title III of the Older Americans Act</td>
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<td>OAAIIIB</td>
<td>Title III of the Older Americans Act, Part B</td>
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<tr>
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<td>Title III of the Older Americans Act, Part C, Subpart 1, Subpart 2, Subpart 3</td>
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<td>Title III of the Older Americans Act, Part E</td>
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<tr>
<td>OAAAVII</td>
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COMMON ISSUES 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.

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:

<table>
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<th>Minutes</th>
<th>Units</th>
<th>Hours</th>
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<tr>
<td>1-15</td>
<td>¼</td>
<td>½</td>
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<td>16-30</td>
<td>½</td>
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<td>31-45</td>
<td>¾</td>
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<td>46-60</td>
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<td>G. Persons and/or agencies providing services shall meet the following criteria, as appropriate:</td>
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<td>1. Have appropriate training for the program and service being delivered;</td>
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<td>2. Comply with licensure requirements;</td>
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<td>3. Comply with registration requirements;</td>
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<td>4. Comply with background screening requirements (Pursuant to Chapter 435, F.S. and Section 430.0402 (1) (a), F.S.;</td>
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<td>5. Comply with continuing education requirements;</td>
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<td>6. Obtain all required state or local permits;</td>
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<td>7. Comply with building codes and standards; and</td>
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<td>8. Obtain required insurance.</td>
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<td>H. All persons in direct contact with clients are required to:</td>
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<tr>
<td>1. Handle the client’s money only if permitted by the service provided;</td>
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<td>2. Not disclose confidential information; and</td>
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<tr>
<td>3. Not accept monetary or tangible gifts from clients or their family members.</td>
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<tr>
<td>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.</td>
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<td>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:</td>
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<td>2. Overview of the aging network;</td>
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Section 1: General Information

3. Communication techniques with elders;

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.

S. Direct payment is a cash reimbursement made directly to the client, caregiver, and/or designee for services or supplies purchased and preauthorized by the case manager or program coordinator. Services authorized and purchased from friends, family or neighbors, and arranged by clients or caregivers may not be subject to the service standards contained in this Handbook. Original receipts shall be presented to the case manager or program coordinator within 30 days of purchase. Clients or caregivers shall be reimbursed within 60 days of the submission of the 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.
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.
# DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK

## Appendix A: Service Descriptions and Standards

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Note: 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.

C1 = Congregate meals

July 2017

A-15
# TABLE OF SERVICES BY PROGRAM

**Key**
- ✦: A Service in the Program
- ◆: Requires Licensure
- ▲: Requires AHCA REGISTRATION
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(R): OAA Registered Service

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C2 = Home delivered meals
TABLE OF SERVICES BY PROGRAM

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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 | SC |
|-------------------------------------------------------------------------|----|-----|-----|-----|-----|---------|---------|---------|---------|-----------|-----------|---------|---------|
| A Matter of Balance (MOB)                                               |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Active Living Every Day                                                 |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Arthritis Foundation Exercise Program                                   |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Arthritis Foundation Tai Chi Program (Tai Chi for Arthritis)            |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Arthritis Self-Management Program                                       |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Brief Intervention and Treatment for Elders (BRITE)                     |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Chronic Disease Self-Management                                         |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Chronic Pain Self-Management                                            |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Diabetes Empowerment Education Program (DEEP)                           |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Diabetes Self-Management Program                                        |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Disease Information                                                     |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Enhance Fitness (EF)                                                    |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Enhance Wellness                                                        |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Fit & Strong                                                            |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Healthy Eating Every Day                                                |    |     |     |     |     |         |         |         |         |            |           |         |         |
| Healthy Ideas                                                           |    |     |     |     |     |         |         |         |         |            |           |         |         |

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</table>

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:

The following pages include detailed descriptions of the services provided through the Department of Elder Affairs program components.
PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB, OAAIIIE

PROGRAM AUTHORITY:

<table>
<thead>
<tr>
<th>Program Funding</th>
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<tr>
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<td>Sections 430.601-608, F.S.</td>
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<td>LSP</td>
<td>Specific Appropriations</td>
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<td>Older Americans Act, Title III, Part B, Section 321 (a)(5) 42 U.S.C. 3030d</td>
</tr>
<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E, Section 373 (b)(4)</td>
</tr>
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</table>

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.
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 included in the cost of the service.

4. Adult day care centers are encouraged to participate in the Child and Adult Care Food Program and receive cash reimbursement for meals and snacks served that meet USDA guidelines. Adult day care centers may not, however, receive reimbursement through the Child and Adult Care Food Program for meals funded by any other payor source, including Older Americans Act Title IIIC funds, or Statewide Medicaid Managed Care Programs.

5. Each meal shall meet the following criteria:

   a. Comply with the current Dietary Guidelines for Americans published by the secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture;

   b. Provide 1/3 of the dietary reference intake/adequate intake for age 70+ female as established by the Food and Nutrition Board of National Academy of Sciences;

   c. Follow the menu development procedures as described in the service description for congregate meals; and
Section 2: Services

**d.** Centers participating in the Child and Adult Food Care Program must follow the Child and Adult Food Care Program meal pattern requirements.

**e.** A daily attendance log with time in and time out shall be maintained.

**6.** CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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For HCE, the client file shall document why the caregiver is unable to perform the service.
PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB, OAAIIIE

PROGRAM AUTHORITY:

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<td>Sections 430.601-608, F.S.</td>
</tr>
<tr>
<td>LSP</td>
<td>Specific Appropriations</td>
</tr>
</tbody>
</table>
| 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 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).
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 meals are included in the cost of the service.

4. Adult day health care centers are encouraged to participate in the Child and Adult Care Food Program and receive cash reimbursement for meals and snacks served that meet USDA guidelines. Adult day health care centers may not, however, receive reimbursement through the Child and Adult Care Food Program for meals or snacks funded by any other payor source, including Older Americans Act, Title III-C funds, or Statewide Medical Managed Care Programs.

5. Each meal shall meet the following criteria:

   a. Comply with the current Dietary Guidelines for Americans published by the secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture;

   b. Provide 1/3 of the dietary reference intake/adequate intake for age 70+ female as established by the Food and Nutrition Board of National Academy of Sciences;
c. Follow the menu development procedures as described in the service description for congregate meals; and

d. Centers participating in the Child and Adult Food Care Program must follow the Child and Adult Food Care Program menu requirements.

e. A daily attendance log with time in and time out shall be maintained.

f. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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For HCE, the client file shall document why the caregiver is unable to perform the service.
PROGRAM FUNDING SOURCE(S): HCE

PROGRAM AUTHORITY:

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<tr>
<td>HCE</td>
<td>Sections 430.601-608, F.S.</td>
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</table>

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 month. If the client is hospitalized or in any other temporary institution for 30 days or less, the basic subsidy check will be sent to the caregiver, as if the client were in the home.

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;
3. Be accepted or designated by the recipient as a caregiver;

4. Be physically present at all times 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;

5. 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

6. 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. ↓

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<tr>
<th>PROGRAM</th>
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PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB, OAAIIIE, OAAIIIEG, OAAVII

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<td>OAAVII</td>
<td>Older Americans Act, Title VII</td>
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</table>

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.
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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**July 2017**

**A-31**
### CIRTS Reporting Requirements

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<th>Program</th>
<th>Service</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

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<th>Program Funding</th>
<th>Specific Authority</th>
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<tr>
<td>Rulemaking</td>
<td>Section 430.08, F.S.</td>
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<tr>
<td>ADI</td>
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<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321 (a)(5)(A) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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;

10. Arrange, schedule and maintain scheduled services;

11. Document activities in the case record;

12. Reconcile and voucher activities;

13. Assist with HCE monthly contact to confirm caregiver eligibility; and

14. 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 as a result 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.

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 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 on a daily basis. 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 included on the next page.
<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB

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<td>LSP</td>
<td>Specific Appropriations</td>
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<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321 (a)(5)(A) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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.
### Section 2: Services  
#### Case Management

**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 provide assistance to the families of clients to resolve concrete and emotional problems and to relieve temporary stresses encountered as a result 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.

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;

**c.** Recruiting/training staff and volunteers;

**d.** Attending training;

**e.** Conducting workshops;
Section 2: Services

<table>
<thead>
<tr>
<th></th>
<th>Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>f.</td>
<td>Billing, filing, vouchering, entering data into CIRTS and reconciling case narratives and time sheets to billing hours;</td>
</tr>
<tr>
<td>g.</td>
<td>General program administration functions which include routine supervision of case managers or other program direct service staff or volunteers;</td>
</tr>
<tr>
<td>h.</td>
<td>Reviews or home visits conducted as a result of AAA, DOEA, or OAA monitoring activities;</td>
</tr>
<tr>
<td>i.</td>
<td>Home visits and telephone calls made but not received by client/caregiver; and</td>
</tr>
<tr>
<td>j.</td>
<td>“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</td>
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</table>

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.

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 on a daily basis. 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. CIHTS reporting requirements are below.

### CIHTS REPORTING REQUIREMENTS

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): OAAIIIEG

PROGRAM AUTHORITY:

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<td>Rulemaking</td>
<td>Section 430.08, F.S.</td>
</tr>
<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E, Section 372 (b)</td>
</tr>
</tbody>
</table>

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 IIIIE Coordinator or other designated staff is required.

3. CIRTS reporting requirements are included on the next page. ↓
## CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>Program</th>
<th>Service</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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PROGRAM FUNDING SOURCE(S): AC, CCE, HCE, LSP, OAAIIIIB, OAAIIIES

PROGRAM AUTHORITY:

Program Funding                      Specific Authority
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

OAAIIIIB                            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.
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.

6. CIRTS reporting requirements are included on the next page. ↓
### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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For HCE, the client file shall document why the caregiver is unable to perform the service.
Section 2: Services

Chore (Enhanced)

PROGRAM FUNDING SOURCE(S): AC, CCE, HCE, LSP, OAIIIB, OAIIIES

PROGRAM AUTHORITY:

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</tr>
<tr>
<td>OAIIIE</td>
<td>Older Americans Act, Title III, Part E, Section 373 (f)</td>
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</table>

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.

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. CIRTS reporting requirements are included on the next page.
<table>
<thead>
<tr>
<th>PROGRAM</th>
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For HCE, the client file shall document why the caregiver is unable to perform the service.
PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIIB, SCP

PROGRAM AUTHORITY:

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</tr>
<tr>
<td>SCP</td>
<td>Corporation for National and Community Service Senior Companion Program</td>
</tr>
</tbody>
</table>

A. DESCRIPTION: Companionship is visiting a client who is socially and/or geographically isolated, for the purpose of relieving loneliness and providing continuing social contact with the community. This service includes activities such as engaging the client in casual conversation, providing assistance 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 are not permitted solely to provide transportation services to another service. 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.

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 of time.

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.

4. CIRTS reporting requirements are included on the next page. ↓
## CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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* Special Senior Companion Program to Capture Agency Dollar Match

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**DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK**

**Appendix A: Service Descriptions and Standards**

**Section 2: Services**

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

PROGRAM AUTHORITY:

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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 as a result 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.

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 on a daily basis.

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 OAAIIID 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.
5. CIRTS reporting requirements are below.

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Counseling (Mental Health/Screening)

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

PROGRAM AUTHORITY:

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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.
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 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: 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 on a daily basis.

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.
   • The contractor must verify and maintain documentation of provider qualifications for service.
5. CIRTS reporting requirements are below

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PROGRAM FUNDING SOURCE(S): ADI, LSP, OAAIIIB, OAAIIIE, OAAIIIEG, OAA7

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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.

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. CIRTS reporting requirements are included on the next page. ↓
## CIRTS Reporting Requirements

<table>
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<tr>
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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.

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

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. CIRTS reporting requirements are included on the next page. ↓
## Emergency Alert Response

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<thead>
<tr>
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<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIIB, SCP

PROGRAM AUTHORITY:

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

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.
D. **RECORD KEEPING AND REPORTING REQUIREMENTS:**

1. **Unit of Service:** One one-way trip per person escorted.

2. Escort units may not be counted in addition to the transportation unit if the escort service is provided by the vehicle driver.

3. CIRTS reporting requirements are below.

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<td>SCP</td>
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<td>CCES*</td>
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</table>

* Special Senior Companion Program to Capture Agency Dollar Match.
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 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. Provider must maintain program fidelity to the original program design by The Arthritis Foundation through Tai Chi for Health Institute.

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. CIRTS reporting requirements are below.

<table>
<thead>
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<tr>
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<tr>
<td>---------</td>
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<tr>
<td>OA3D</td>
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</tbody>
</table>

Website for updated fidelity and training information: [http://taichiforhealthinstitute.org/programs/tai-chi-for-arthritis/](http://taichiforhealthinstitute.org/programs/tai-chi-for-arthritis/)
PROGRAM FUNDING SOURCE(S): OAAIIIID

PROGRAM AUTHORITY:

Program Funding  Specific Authority
Rulemaking        Section 430.08, F.S.

OAAIIIID  Older Americans Act, Title III, Part D

A. DESCRIPTION: The Arthritis Self-Management (Self-Help) Program was 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.
Section 2: Services

Arthritis Self-Management (Self-Help) Program

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.

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. **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.

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

4. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
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Website for updated fidelity and training information: [https://www.selfmanagementresource.com/about](https://www.selfmanagementresource.com/about)
PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

<table>
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</tr>
<tr>
<td>OAAIIID</td>
<td>Older Americans Act, Title III, Part D</td>
</tr>
</tbody>
</table>

A. DESCRIPTION: Spanish Arthritis Self-Management program (Programa de Manejo Personal de la Artritis) was 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.

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

4. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
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Website for updated fidelity and training information:

[https://www.selfmanagementresource.com/about](https://www.selfmanagementresource.com/about)
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 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 two hour weekly sessions for eight to 10 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.
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 eight to 10-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 eight to 10-week workshop.

5. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
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<th>OAA CLIENT REQUIREMENTS</th>
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Website for updated fidelity and training information: [http://www.mwlatino.uic.edu](http://www.mwlatino.uic.edu)
PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

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<td>Section 430.08, F.S.</td>
</tr>
<tr>
<td>OAAIIID</td>
<td>Older Americans Act, Title III, Part D</td>
</tr>
</tbody>
</table>

A. DESCRIPTION: The Diabetes Self-Management Program was 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:
       1. Minimum 10 participants (8 in rural and low populated areas)
       2. 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.

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.

4. CIRTS reporting requirements are below

<table>
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Website for updated fidelity and training information: https://www.selfmanagementresource.com/programs/small-group/diabetes-self-management/
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: Programa de Manejo Personal de la Diabetes was 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:
   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.

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 for payment.

4. CIRTS reporting requirements are below.

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<tr>
<td>OA3D</td>
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Website for updated fidelity and training information:
https://www.selfmanagementresource.com/programs/small-group-spanish/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: Un Asunto de Equilibrio was adapted from Boston University Roybal Center by Maine’s Partnership for Healthy Aging. It 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. This is the Spanish version of A Matter of Balance. The materials are translated to Spanish.

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. TV, DVD player, participant workbooks, and the 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

      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.

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 a Master Trainer or two 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 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.

4. CIRTS reporting requirements are below. ↓

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Website for updated fidelity and training information: [http://www.mainehealth.org/mob](http://www.mainehealth.org/mob)
PROGRAM FUNDING SOURCE(S): OAAIIIID

PROGRAM AUTHORITY:

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<tr>
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A. DESCRIPTION: A Matter of Balance Program was 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: Minimum 8 participants and 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.
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.

4. CIRTS reporting requirements are below. ↓

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<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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Website for updated fidelity and training information:
[http://www.mainehealth.org/mob/](http://www.mainehealth.org/mob/)
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: 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.
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 be able to 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 on a daily basis 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.

7. CIRTS reporting requirements are on the next page.
### CIRTS Reporting Requirements

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<tr>
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Website for updated fidelity and training information: [https://www.ncoa.org/resources/program-summary-stepping-on/](https://www.ncoa.org/resources/program-summary-stepping-on/)
Section 2: Services

Tai Chi/Tai Ji Quan: Moving for Better Balance

PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

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<td>Older Americans Act, Title III, Part D</td>
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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.
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.

5. Workshop participant size is a minimum of 10 and a maximum of 20 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 10 participants and a maximum of 20 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.

4. CIRTS reporting requirements are below. ↓

<table>
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<tr>
<th>PROGRAM</th>
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Website for updated fidelity and training information:

https://tjqmbb.org/
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 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)
   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.

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. CIRTS reporting requirements are below. ↓

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Website for updated fidelity and training information: 
PROGRAM FUNDING SOURCE(S): OAAIIIID

PROGRAM AUTHORITY:

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<td>OAAIIIID</td>
<td>Older Americans Act, Title III, Part D</td>
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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.
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 six-week session. The entire six weeks need to be completed prior to submitting for payment.

4. CIRTS reporting requirements are below. ↓
### CIRTS REPORTING REQUIREMENTS

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<tr>
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Website for updated fidelity and training information: https://www.selfmanagementresource.com/programs/small-group/chronic-pain-self-management/
PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

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</table>

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
   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.

5. CIRTS reporting requirements are below.

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Website for updated fidelity and training information:
[https://www.selfmanagementresource.com/programs/small-group-spanish/tomando-control-de-su-salud/](https://www.selfmanagementresource.com/programs/small-group-spanish/tomando-control-de-su-salud/)
PROGRAM FUNDING SOURCE(S): OAAIIIID

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</table>

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.
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 on a daily basis.

6. CIRTS reporting requirements are below.

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Website for updated fidelity and training information:
PROGRAM FUNDING SOURCE(S): OAAIIID

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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 reasons for their poor eating choices and 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.

   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. CIRTS reporting requirements are below.

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<th>CIRTS REPORTING REQUIREMENTS</th>
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Website for updated fidelity and training information:
http://www.activeliving.info/training-support.cfm
PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

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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.

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. ↓

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<td>MMISI (INDIV)</td>
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<td>NO REQUIREMENT</td>
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Website for updated fidelity and training information: https://www.picf.org/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: 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
D. PROVIDER QUALIFICATIONS:

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 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. CIRTS reporting requirements are below.

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<th>CIRTS REPORTING REQUIREMENTS</th>
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<td>OA3D</td>
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Website for updated fidelity and training information:
http://careforelders.org/healthyideas
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.
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.
Section 2: Services

Brief Intervention and Treatment for Elders (BRITE)

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.

4. CIRTS reporting requirements are below.

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<th>CIRTS REPORTING REQUIREMENTS</th>
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<td>PROGRAM</td>
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<tr>
<td>OA3D</td>
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</table>

Website for updated fidelity and training information:

[http://brite.fmhi.usf.edu/BRITE.htm](http://brite.fmhi.usf.edu/BRITE.htm)
PROGRAM FUNDING SOURCE(S): OAAIID

PROGRAM AUTHORITY:

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<td>Rulemaking</td>
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<td>OAAIID</td>
<td>Older Americans Act, Title III, Part D</td>
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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 orders must take place first. During the course of 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.
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.

Followup/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.
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.
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 home 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. CIRTS reporting requirements are on the next page. ↓
### Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)

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<td>PEARLE – ENROLLMENT</td>
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<td>PEARL1 - SESSION 1</td>
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<td>OA3D</td>
<td>PEARLD – DISCHARGE/ FOLLOWUP</td>
<td>MONTHLY AGGREGATE REPORTING BY CLIENT</td>
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</table>

Website for updated fidelity and training information: [http://www.pearlsprogram.org/](http://www.pearlsprogram.org/)
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: 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. In order 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).

2. Instructor may choose to have additional sessions if needed; however unit of service is based on the 12-week format.
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.

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. CIRTS reporting requirements are included below.

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<td>OA3D</td>
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Website for updated fidelity and training information: [http://www.activeliving.info/training-support.cfm](http://www.activeliving.info/training-support.cfm)
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 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.
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. CIRTS reporting requirements below.

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Website for updated fidelity and training information: [https://www.aeawave.com/Arthritis.aspx](https://www.aeawave.com/Arthritis.aspx)
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:

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. CIRTS reporting requirements are below.

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Website for updated fidelity and training information: [http://www.projectenhance.org/enhancefitness.aspx](http://www.projectenhance.org/enhancefitness.aspx)
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.
C. PROVIDER QUALIFICATIONS:

1. 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. In order to be trained individuals must participate in 8-hour full day training.

2. 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.

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. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
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<th>OAA CLIENT REQUIREMENTS</th>
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Website for updated fidelity and training information: [https://www.fitandstrong.org/](https://www.fitandstrong.org/)
PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

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<td>Rulemaking</td>
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<tr>
<td>OAAIIID</td>
<td>Older Americans Act, Title III, Part D</td>
</tr>
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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 phones 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.

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. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
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(indiv)

Website for updated fidelity and training information: [https://www.ncoa.org/resources/program-summary-healthy-moves-for-aging-well/](https://www.ncoa.org/resources/program-summary-healthy-moves-for-aging-well/)
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.
Section 2: Services

Physical Fitness

3. Providers are encouraged to keep a physician’s certification or a client waiver on file for participants.

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. CIRTS reporting requirements are below.

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Website for updated fidelity and training information: https://www.ncoa.org/center-for-healthy-aging/physical-activity/physical-activity-programs-for-older-adults/
PROGRAM FUNDING SOURCE (S): OAAIIID

Stay Active and Independent for Life (SAIL)

PROGRAM AUTHORITY:
Program Funding: Specific Authority

OAAIIID: Older Americans Act, Title III, Part D

Rulemaking Section 430.08, F.S.

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 as a result 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 a one day (8 hour) 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.
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. CIRTS reporting requirements are below.

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<th>CIRTS REPORTING REQUIREMENTS</th>
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Website for updated fidelity and training information:
http://www.doh.wa.gov/YouandYourFamily/InjuryandViolencePrevention/ OlderAdultFalls/StayActiveandIndependentforLifeSAIL
PROGRAM FUNDING SOURCE (S): OAAIIID

PROGRAM AUTHORITY:

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<td>Older Americans Act, Title III, Part D</td>
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</table>

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.
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. CIRTS reporting requirements are below. ↓

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<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
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Website for updated fidelity and training information:  
PROGRAM FUNDING SOURCE(S): OAAIIID, OAAIIIE

PROGRAM AUTHORITY:

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<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
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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.

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
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.

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. CIRTS reporting requirements are below. 

<table>
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<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
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Website for updated fidelity and training information: [https://www.powerfultoolsforcaregivers.org/](https://www.powerfultoolsforcaregivers.org/)
PROGRAM FUNDING SOURCE(S): OAAIIID

PROGRAM AUTHORITY:

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<tr>
<td>OAAI</td>
<td>Older Americans Act, Title I, Section 102, (14)</td>
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</table>

A. DESCRIPTION: Disease information is the provision of information to clients, families, caregivers and the general public about chronic conditions and diseases; prevention measures and services, treatment, rehabilitation and coping strategies for those factors which cannot change. This can be done on a one-on-one or group basis.

This service **cannot** be used to distribute or provide general information to clients. This service **must** be an evidence-based disease prevention and health promotion program and must meet the three-tier criteria set forth by ACL.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Disease information is not the same as information provided under the OAA Title IIIB service of Information. Providing information on diseases of the elderly is a specific service designed to enable elders to take steps to cope with, understand, and alleviate or prevent further progression or deterioration associated with a disease.

2. Materials used to provide elders with information on the prevention, diagnosis or treatment of diseases shall originate from qualified agencies and organizations that have used trained and licensed experts to develop such materials (flyers, brochures, handouts, video, slide presentations, etc.).

3. Distribution of information is not considered as an evidence-based disease prevention and health promotion service.

4. 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: Licensed health care professionals shall be used to conduct lectures, seminars or workshops to provide evidence-based programs. When appropriate, trained laypersons outside of the medical profession can be used to provide services upon approval from the Area Agency on Aging or designee.

The provision of disease information cannot be used for health screening. Health screenings has its own service description which must be followed. A qualified healthcare professional (credentialled) shall provide the evidence-based disease prevention and health promotion service.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. **Unit of Service—Individual:** An episode is an activity with one client served, regardless of the amount of information or evidence-based disease and health promotion service provided

2. **Unit of Service—Group:** An episode, regardless of the number of persons served.

3. Individual client records are not required, but a record of the numbers of clients served shall be maintained. Such records may include sign-in sheets, registration logs or estimates based on the number of materials distributed.

4. **For OAA IIDD, 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. CIRTS reporting requirements are below.

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PROGRAM FUNDING SOURCE(S): LSP, OAAIIID

PROGRAM AUTHORITY:

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</tr>
<tr>
<td>OAAI</td>
<td>Older Americans Act, Title I, Section 102, (14)</td>
</tr>
</tbody>
</table>

A. DESCRIPTION: Health risk assessment is defined as an assessment utilizing one or a combination of tools to test older persons for certain risk factors that are known to be associated with a disease or condition. Many factors are modifiable, including diet, risk-taking behaviors, coping styles and lifestyle choices (such as smoking and overeating), and can be measured or identified through risk appraisal questionnaires. The health risk assessment helps the individual to determine the addictive nature of many factors in a client’s life. This can be done on a one-on-one or group basis.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS: Tools used to test an older adult for certain risk factors that are known to be associated with a disease or condition can be self-administered by the client (i.e., Checklist). These tools need to be validated by a licensed health care professional or professional health care organization prior to use or distribution.

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: Licensed health care professionals should be used to conduct client assessments or lectures, seminars or workshops in which the main focus of the event is to provide the audience with information on risky health behaviors and to provide no-cost health assessments.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. **Unit of Service---Individual:** An episode is one client who receives an assessment.

2. **Unit of Service---Group:** An episode is one lecture, workshop, or seminar regardless of the number of persons who attend and receive an assessment.

3. Individual client records are not required but record of numbers shall be maintained, such as sign-in sheets, registration logs or an estimated number of assessments distributed.

4. For OAAIIID, 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.
   - 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. CIRTS reporting requirements are on the next page.
### CIRTS Reporting Requirements

<table>
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<tr>
<th>PROGRAM</th>
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**DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK**

Appendix A: Service Descriptions and Standards

**Section 2: Services**

**Health Risk Screening**

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

**PROGRAM AUTHORITY:**

<table>
<thead>
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<td>OAALI</td>
<td>Older Americans Act, Title I, Section 102, (14)</td>
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**A. DESCRIPTION:** Health risk screening services utilize diagnostic tools to screen clients for the presence of a particular disease or condition. This service is designed for early intervention and detection. Referral is required when screening results indicate professional services are needed or a request is made by the client being served. Health risk screening procedures screen for disease and ailments (for example, hypertension, glaucoma, cholesterol, cancer, vision loss, HIV/AIDS, STDs, osteoporosis, hearing loss, diabetes and nutrition deficiencies, etc.).

**B. DELIVERY STANDARDS/SPECIAL CONDITIONS:** Persons found to be at risk for certain diseases or ailments as determined by the specific health risk screening, shall be counseled to seek the appropriate professional opinion for further evaluation. Documentation indicating client was advised to seek professional opinion shall be maintained.

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: Licensed health care professionals with appropriate liability insurance shall be used to conduct health screenings.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service - Individual: An episode is an individual screening test.

2. A record of the number of clients participating in screenings shall be maintained via sign-in sheets or other methods. Documentation indicating clients determined to be at risk who were counseled and advised to seek professional opinion shall also be maintained.

For the OAIIID program, note the following:

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.

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

3. CIRTS reporting requirements are below. ↓

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<th>Program Funding</th>
<th>Specific Authority</th>
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<tbody>
<tr>
<td>Rulemaking</td>
<td>Section 430.08, F.S.</td>
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<tr>
<td>OAAIIID</td>
<td>Older Americans Act, Part D 42 U.S.C. 3030m, n</td>
</tr>
<tr>
<td>OAAI</td>
<td>Older Americans Act, Title I, Section 102, (14)</td>
</tr>
</tbody>
</table>

A. DESCRIPTION: Home injury control is defined as services aimed at preventing or reducing physical harm due to falls or other preventable injuries of elders in their homes. This can be done on a one-on-one or group basis.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Home injury control may include in-home screening of high risks environments; instructional sessions conducted in the home for injury prevention measures; and group educational seminars on injury prevention.

2. Needed safety equipment/repairs and home modifications cannot be purchased with OAA IIID funds. Attempts should be made to secure donated items or refer the client to a program that provides such equipment, repairs or home modifications.

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: Professionals or qualified laypersons (certified in the field of service) with experience in home injury control, fire safety and poison control, as well as individuals who have taken an injury prevention training (need to show proof that they have taken such course that they could facilitate instruction, can be used to conduct lectures, seminars, or workshops in which the main focus of the event is to provide the audience with information on falls and injury prevention.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. **Unit of Service---Individual**: An episode is one in-home screening and/or instructional session regardless of the amount of information provided.

2. **Unit of Service---Group**: An episode is an instructional session or educational seminar regardless of the number of clients in attendance.

3. A record of the number of clients shall be maintained. This may include sign-in sheets, registration logs or other methods.

4. For the OAAIIIID 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.
   - 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. CIRTS reporting requirements are below

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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</tr>
<tr>
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<td>(GROUP)</td>
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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 on a daily basis.

2. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>CIRTS REPORTING REQUIREMENTS</th>
</tr>
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<tbody>
<tr>
<td>PROGRAM</td>
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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 on a daily basis.

2. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>CIRTS REPORTING REQUIREMENTS</th>
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<tbody>
<tr>
<td>PROGRAM</td>
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<td>Specific Appropriations</td>
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<tr>
<td>OAAI</td>
<td>Older Americans Act, Title I, Section 102, (14) 42 U.S.C. 3001</td>
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<tr>
<td>OAAIIID</td>
<td>Older Americans Act, Title III, Part D 42 U.S.C. 3030m, n</td>
</tr>
</tbody>
</table>

A. DESCRIPTION FOR LSP: Health promotion services offer individual and group sessions that assist participants to understand how lifestyle may impact physical and mental health and to develop personal practices that enhance total well-being. Services are provided at multipurpose senior centers, congregate meal sites and other appropriate places that target elders who are low income, minorities or medically underserved. Services related to health promotion include health risk assessments, routine health screenings, physical activity, home injury control services, mental health screenings for prevention and diagnosis, medication management screening and education, gerontological counseling, and the distribution of information concerning diagnosis, prevention, treatment, and rehabilitation of aged-related diseases and chronic disabling conditions, such as osteoporosis and cardiovascular diseases.

B. DESCRIPTION FOR OAA IIID: Health promotion services offer individual and group sessions that assist participants to understand how lifestyle impacts physical and mental health and to develop personal practices that enhance total well-being. Services are provided at multipurpose senior centers, congregate meal sites and other appropriate places that target elders who are low income, minorities or medically underserved.
C. **DELIVERY STANDARDS/SPECIAL CONDITIONS:** Materials used to provide elders with health promotion services shall come from qualified agencies and organizations that have used trained and licensed experts to develop such materials (flyers, brochures, handouts, video, slide presentations, etc.) Materials shall be approved by the AAA or designee before being used in any health promotion activity.

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

D. **PROVIDER QUALIFICATIONS:** Licensed health care professionals are to be used to conduct lectures, seminars or workshops in which the main focus of the event is to provide the audience with information on health promotion at no cost. When appropriate, trained laypersons outside of the medical profession can be used to provide services to elders upon approval from the AAA or designee.

E. **RECORD KEEPING AND REPORTING REQUIREMENTS:**

1. **Unit of Service—Individual:** An episode is an activity with one client served, regardless of the amount of information provided.

2. **Unit of Service for LSP – Group:** An episode, regardless of the number of persons served. Examples of one unit of service are:
   
a. One presentation, regardless of number of attendees;
   
b. One program-wide distribution of information;
   
c. One article prepared and printed in a newsletter or newspaper;
   
d. radio or television presentation; or
   
e. One exhibit at a health fair, whose audience or attendees are known to include older adults.

3. Individual client records are not required but record of numbers shall be maintained, such as sign-in sheets, registration logs or estimate based on number of materials distributed.
4. For the OAAIIID 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.

- 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. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): CCE, LSP,

OAAIIIB PROGRAM AUTHORITY:

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<td>LSP</td>
<td>Specific Appropriations</td>
</tr>
<tr>
<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(17) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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; obtaining therapy; 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.

D. **RECORD KEEPING AND REPORTING REQUIREMENTS:**

1. **Unit of Service—Individual:** One hour of direct service with or on behalf of a client, accumulated on a daily basis.

2. **Unit of Service—Group:** One hour of direct service with or on behalf of clients, regardless of the number of clients participating.

3. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIIB

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
OAAIIIIB Older Americans 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.
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 care 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.

4. CIRTS reporting requirements are included on the next page.
## CIRTS REPORTING REQUIREMENTS

<table>
<thead>
<tr>
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<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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<td>HHA</td>
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</table>

For HCE, the client file shall document why the caregiver is unable to perform the service.
PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

<table>
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<th>Program Funding</th>
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<td>LSP</td>
<td>Specific Appropriations</td>
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<tr>
<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(5)(C) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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:

1. 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.

2. 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:

1. **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.

2. Units of services provided to a couple represent one (1) unit for each hour of service. The units cannot be doubled.

3. 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.

4. Providers shall maintain a written record of activities and report any unusual incidents or changes in the client’s appearance or behavioral changes.

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

6. CIRTS reporting requirements are included on the next page. ↓
## Section 2: Services

### Homemaker

#### CIRTS Reporting Requirements

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<th>Max Units</th>
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## Program Funding Source(s): AC, CCE, HCE, LSP, OAAIIIB, OAAIIIES

## Program Authority:

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</tr>
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<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
</tr>
</tbody>
</table>

### 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.
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 worker hour 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; or.

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. ↓
## CIRTS Reporting Requirements

<table>
<thead>
<tr>
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PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB, OAAIIIE

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<td>OAAIIIB</td>
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</tr>
<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
</tr>
</tbody>
</table>

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, with the exception of 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:

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. Have an understanding of 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.↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): ADI, CCE, HCE, LSP, OAAIIIB, OAAIIIE

PROGRAM AUTHORITY:

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<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
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</table>

A. DESCRIPTION: Intake involves the administration of standard intake and screening instruments for the purpose of 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.
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 on a daily basis

2. Records shall be kept to assist the provider in identifying appropriate referrals and gaps in services.

3. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB

PROGRAM AUTHORITY:

Program Funding Specific Authority
Rulemaking Section 430.08, F.S.

LSP Specific Appropriations

OAAIIIB 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. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIIB, OAAIIIEG, OAAIIIES

PROGRAM AUTHORITY:

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<td>OAAIIIE</td>
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</table>

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.
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 a number of 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. For practical purposes, the following uniform Legal Problem Categories and Codes adopted by legal providers within Florida will be utilized: Consumer/Finance; Education; Employment; Family; Juvenile; Health; Housing; Income Maintenance; Individual Rights; and Miscellaneous.
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.

c. Simple wills and advance directives are not considered priority issue areas, unless legal assistance is justified in this area to meet essential needs.

D. PROVIDER QUALIFICATIONS: In order 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.

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 throughout 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.

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.

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. Demonstrate capacity and expertise in major priority categories or areas of law that affect the target populations.

g. 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.
E. RECORD KEEPING AND REPORTING REQUIREMENTS:

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

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. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB, OAAIIIES

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

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).
B. **DELIVERY STANDARDS/SPECIAL CONDITIONS:** The issuance of commodities shall be done in cooperation with Florida Department of Agriculture’s Temporary Emergency Food Assistance Program.

C. **PROVIDER QUALIFICATIONS:** The provider qualifications are commensurate with the products or services being provided.

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. **CIRTS reporting requirements are below. ↓**

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIID

PROGRAM AUTHORITY:

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<td>OAAI</td>
<td>Older Americans Act, Title I, Section 102, (14)</td>
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</table>

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.

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 IIIID.

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 OAAIIID: 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 OAAIIID: 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.)
   b. 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. OAAIIID 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.
   - 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. CIRTS reporting requirements are included below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE*</th>
<th>REPORTING OF SERVICES</th>
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</table>

*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.
PROGRAM FUNDING SOURCE(S): ADI
PROGRAM AUTHORITY:

Program Funding Specific Authority
Rulemaking Section 430.08, F.S.
ADI Sections 430.501-504, F.S.

A. DESCRIPTION: Model day care center is defined as a program specifically designed for persons with ADRD, and for persons with ADRD who may also be associated with various conditions such as intellectual or developmental disabilities.

Model day care centers provide a safe, non-institutional environment where participants congregate for the day and socialize with each other, as well as receive therapeutic interventions designed to maintain or improve their health and cognitive functioning. The program provides an array of planned activities specially designed and selected with the participant’s capability in mind. Model day care centers shall be affiliated with the memory disorder clinic assigned to the service area where the model day care center is located, in accordance with Chapter 430.502(7), Florida Statutes. Centers should pursue research opportunities to assist in the cure or understanding the challenges of ADRD. Model day care centers shall participate in recruiting for the Florida Brain Bank.

Model day care centers will provide or participate in training and education to caregivers, health and social service professionals and students as well as the general public. Staff will receive specific training to engage with persons/caregivers dealing with ADRD, IDD and other cognitive impairments.

B. DELIVERY STANDARDS/SPECIAL CONDITIONS:

1. Model day care services shall be made available to clients by providers for four-to-eight hours per day, one-to-five days a week. In some cases, model day care services may be offered on weekends.

2. A staff to client ratio of 1 to 5 shall be maintained at all times. Trained volunteers may be considered in meeting the 1 to 5 ratio. Training and support for caregivers is provided to assist them in coping with Alzheimer’s disease. Model day care centers shall provide at least three of the specialized services listed in the service definition.
Section 2: Services

3. Incontinence alone shall not preclude a client from participating in a model day care program.

4. Model day care centers shall offer support programs for family members attempting to cope with the effects of memory disorders.

5. Each center shall provide a setting for conducting research with the memory disorder clinics.

6. Upon beginning employment, staff and volunteers shall receive written information about interacting with individuals with Alzheimer’s disease or related dementia, an orientation plan with information about wandering behaviors and procedures for locating a client who has wandered from the center, and information on Silver Alert.

7. Staff and volunteers shall receive at least 30 hours of on-going instruction in the following areas:
   
   a. Health problems and care of aged persons;
   
   b. Dealing with behaviors characteristic of memory disorders;
   
   c. Basic personal care procedures;
   
   d. First aid and handling of emergencies;
   
   e. Medical record keeping, policies and procedures; and
   
   f. Medical, psychological, social and physiological changes of clients with memory disorders.

8. Four hours of dementia-specific training must be provided within 3 months of employment, and 4 hours of dementia-specific training must be provided within 6 months of employment.

C. PROVIDER QUALIFICATIONS:

1. Model 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.
2. Model day care centers shall be affiliated with the memory disorder clinic assigned to the service area where the model day care center is located, in accordance with Chapter 430.502(7), Florida Statutes.

D. RECORD KEEPING AND REPORTING REQUIREMENTS:

1. Unit of Service: One hour of actual client attendance at the model 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. Meals cannot be counted as congregate meal units if included in the cost of the service.

4. Model day care centers may participate in the Child and Adult Care Food Program and receive cash supplements for meals and snacks that meet USDA guidelines. Model day care centers may not, however, receive benefits or reimbursements through the Child and Adult Care Food Program for meals served with Older Americans Act, Title IIIC funds.

5. Each meal shall meet the following criteria:

   a. Comply with the current dietary guidelines for Americans published by the secretaries of the U.S. Department of Health and Human Services and the U.S. Department of Agriculture.

   b. Provide 1/3 of the dietary reference intake/adequate intake for an age 70+ female as established by the Food and Nutrition Board of National Academy of Sciences.

   c. Follow the menu development procedures as described in the service description under “Congregate Meals.”

   d. Centers participating in the Child and Adult Food Care Program must follow the Child and Adult Food Care Program menu requirements.

6. Model day care centers shall maintain the following records:

   a. A daily attendance log of all participants;

   b. Weekly nursing and progress notes for all clients in the program;

   c. All orders for medication, record of medication administration and modified diets;

   d. Care plans addressing identified dementia specific needs of clients, their caregivers and/or designees;
Section 2: Services

Model Day Care

e. Documentation of training provided to model day care staff and health care/social service personnel and caregivers who are not employees of the center; and

f. A record of co-payments and contributions received.

7. CIRTS reporting requirements are below ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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<td>Specific Authority</td>
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<td>Specific Appropriations</td>
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<td>OAAIIIC1</td>
<td>Older American Act, Title III, Part C, 42 U.S.C. 3030e</td>
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<td>Older Americans Act, Title III, Part C, Subpart 2, Sections 336, 337, 42 U.S.C. 3030f, g</td>
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<tr>
<td>Material Safety Data Sheets</td>
<td>Occupation Safety and Health Administration (OAHA) 1910.1200(G)</td>
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</table>
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 particular attention to low-income minority and rural clients.
PROGRAM FUNDING SOURCES: LSP, OAAIIIC1

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.
Section 2: Services  

Nutrition Services: Congregate Meals

3. Each meal provided must meet the following criteria:

   a. Follow the menu development procedures described in Chapter 4 which ensure compliance with the current Dietary Guidelines for Americans published by the secretaries of the Department of Health and Human Services and the Department of Agriculture;

   b. Provide a minimum of 1/3 of the dietary reference intakes/adequate intake for an age 70+ female as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences; and

   c. Ensure that all meal sites offering a buffet style meal service have at least the following:

      i. Measured serving utensils for each menu item;

      ii. Posted menu near the serving line;

      iii. Menu analysis, signed and dated by qualified dietitian, conducted on the buffet style meal indicating it meets the menu requirements available for participant review, and

      iv. Staff/volunteers to man the buffet and encourage healthy eating habits and portions.
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 follows:
      • Once per year by the nutrition consultant (licensed dietitian or licensed and registered dietitian,)
      • Once per year by the nutrition program service provider’s administrative staff member, and
      • Twice per year by the meal site manager or designee. Although quarterly meal site reviewers must use the 2016 NPCR form, only applicable sections should be completed.
d. Records on each participant that verifies eligibility;

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; and

i. Documentation of employee and volunteer training.

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 below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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</table>

* Used to reconcile NSIP reimbursement when funding is provided by a non-DOEA means. An example would be the United Way
PROGRAM FUNDING SOURCES: LSP, OAAIIIC1

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. This may include referral and follow-up if needed.

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 on a daily basis.

2. Records shall be kept which will assist the provider in identifying appropriate referrals and gaps in services.

3. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
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</table>
PROGRAM FUNDING SOURCES: CCE, OAAIIIC2, 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 the following criteria:

   a. Follow the menu development procedures described in Chapter 4 which ensure compliance with the current Dietary Guidelines for Americans published by the secretaries of the Department of Health and Human Services and the Department of Agriculture; and

   b. Provide a minimum of 1/3 of the dietary reference intakes/adequate intake for an age 70+ female as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if developed through nutrient analysis.
3. **Safe and Sanitary Handling:** All nutrition programs shall maintain facility and services in accordance with Chapter 64-11, Florida Administrative Code. These regulations outline all the requirements that ensure the safe and sanitary methods of food procurement, production, protections and distribution. Nutrition programs are responsible for adherence to Chapter 64E-11, Florida Administrative Code and at a minimum must have equipment that maintains the safe and sanitary handling of all menu items during the period between the completion of the cooking process through the end of the serving and delivery period.

   a. The time span between the completion of food preparation and the delivery to the homebound client should, to the extent possible, not exceed four (4) hours.

   b. All hot home delivered meals for the noon meal shall be delivered to the client no earlier than 10:30 a.m. and no later than 2:30 p.m.

   c. All food shall be individually packaged in a material that promotes appropriate temperature retention.

   d. Cold and hot food shall be packaged and packed separately.

   e. Food utensils shall be completely wrapped or packaged to protect them from contamination.

   f. Food containers should be sectioned so that food does not mix, leak or spill.

   g. All food shall be packed in secondary insulated food carriers that maintain food temperatures at 140°F or higher or at 41°F or lower.

   h. 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.

   i. Food carriers must be constructed as to prevent food contamination by dust, insects, animals, vermin or infection.
### Section 2: Services

<table>
<thead>
<tr>
<th>Section 2: Services</th>
<th>Nutrition Services: Home Delivered Meals</th>
</tr>
</thead>
<tbody>
<tr>
<td>j.</td>
<td>Food carriers must be clean and sanitized or use carriers with inner liners that can be sanitized.</td>
</tr>
<tr>
<td>k.</td>
<td>Temperatures of all hot and cold potentially hazardous food items must be documented at delivery for each provider at least monthly for each county. Whenever temperature non-compliance is identified, weekly temperatures must be documented until corrective action has been achieved.</td>
</tr>
<tr>
<td>l.</td>
<td>Appropriate temperatures of potentially hazardous food items must be maintained prior to serving a client the meal; however, at no time should potentially hazardous cooked food be maintained at excessively high temperatures. Food items maintained at excessively high temperatures lose their nutritional and aesthetic value.</td>
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</tbody>
</table>

4. **Frozen Meals:** When frozen meals are delivered to participants, the temperature shall be a maximum of 20° F, or the food shall be frozen solid. The nutrition provider shall complete a DOEA form 217 for each participant to ensure that:

- **a.** The participant or caregiver has the needed equipment in the home (electricity, a stove with a working oven, a working microwave oven, or a working toaster oven, and a freezer to store the meals);

- **b.** The participant or caregiver has both the physical and mental capability to follow cooking directions and use the equipment;

- **c.** The frozen meals are dated and clearly labeled. Instructions for storage and cooking shall be provided in large print;

- **d.** The importance of following meal preparation directions shall be emphasized to clients on a regular, on-going basis; and

- **e.** Participants who may be unable to follow the instructions should not receive frozen meals in the home.

- **f.** More than one meal may be delivered each day, provided 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.
5. **Cold Meals:** When cold meals are delivered to participants, the temperature shall be a maximum of 41°F. For cold meals that require reheating for consumption, the nutrition provider shall complete a DOE Form 217 for each participant to ensure that:

   a. The participant or caregiver has the needed equipment in the home (such as a stove with a working oven, a working microwave oven, or a working toaster oven);

   b. The participant or caregiver has both the physical and mental capability to follow cooking directions and use the equipment;

   c. The expiration date is clearly labeled on the meal. Instructions for storage and cooking shall be provided in large print;

   d. The importance of following meal preparation directions shall be emphasized to clients on a regular, on-going basis; and

   e. Participants who may be unable to follow the instructions should not receive cold meals that require reheating for consumption in the home.

   f. More than one meal may be delivered each day, provided proper storage and heating facilities are available in the home (as evidenced by a completed DOE 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.

C. **PROVIDER QUALIFICATIONS:** Home-delivered meals shall be delivered by organizations that have demonstrated the following:

1. Ability to deliver meals to the participants’ homes efficiently and reasonably;

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:**
   
a. Temperature of all hot and cold potentially hazardous food items must be monitored at delivery for each provider at least monthly for each county. Whenever temperature non-compliance is identified, weekly temperatures must be monitored until corrective action has been achieved.

b. If multiple providers serve meals in a county, then each provider shall fulfill this requirement.

c. Temperature checks shall be monitored for each route on a random and rotating basis to ensure that all potentially hazardous food is served at the proper temperature.

d. Documentation of these temperature checks shall be maintained by providers and monitored by the AAAs.

e. Thermometers should be calibrated weekly

3. Meals served to participants shall be included in the Nutrition Services Incentive Program (NSIP) meal count according to NSIP requirements.

4. 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.

5. 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.

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

6. CIRTS reporting requirements are included on the next page. ↓
<table>
<thead>
<tr>
<th>PROGRAM</th>
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*Used to reconcile NSIP reimbursement when funding is provided by non-DOEA means. An example is the United Way.
PROGRAM FUNDING SOURCES: CCE, LSP, OAAIIIC1, OAAIIIC2, OAAIIID

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:

1. A Florida licensed dietitian and/or licensed registered dietitian shall provide this service on an individual basis. (Section 468.516, F.S.)

2. The initial counseling session, to the fullest extent possible, must be face-to-face.

3. A written or verbal diet order from the client’s physician shall be on file prior to providing nutritional counseling. In the event the licensed dietitian is unable to obtain written or verbal authorization from the health care provider, the licensed dietitian may use professional discretion in providing nutrition counseling.

4. Clients for nutritional counseling may be identified through a screening/intake process (i.e., 701S, 701A, 701B or 701C), by self-referral, or by referral from a caregiver or other concerned party.

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: 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 applicable written participant records that shall include 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 OAAIIIID 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.

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

4. CIRTS reporting requirements are on the next page.
## CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
PROGRAM FUNDING SOURCES: LSP, OAAIIIC1, OAAIIIC2

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:

1. Nutrition education shall be planned and directed by a Florida licensed dietitian and/or licensed registered dietitian (Chapter 468.504, Florida Statutes). Cooperative extension agents or trained meal site or wellness coordinators, under the direction of the licensed dietician and/or licensed registered dietitian, may provide such education activities. Documentation of persons trained must be maintained.

2. Nutrition education is provided at each site and distributed to each home-delivered meal client a minimum of once a month. Encourage individuals who distribute nutrition services to provide, to homebound older individuals, available medical information approved by health care professionals. Information may include informational brochures, and information on how to get vaccines, including vaccines for influenza, pneumonia, and shingles, in the individuals’ communities.

3. Congregate sessions shall be a minimum of 15 minutes in length.
Section 2: Services

Nutrition Services: Nutrition Education

4. The provider’s licensed dietitian and/or licensed registered dietitian shall develop a written annual nutrition education plan that documents subject matter, presenters and materials to be used. The AAA may develop a single educational curriculum, which may be used by multiple sites.

5. Nutrition program licensed dietitian and/or licensed registered dietitian, shall ensure that the nutrition education content and materials are developed consistent with the nutritional needs, literacy levels and vision and hearing capacities, as well as the multi-cultural composition of participants.

**Documentation:** Each nutrition service provider shall maintain written documentation for monitoring purposes that includes the date of the presentation, name and title of presenter, lesson plan or curriculum, and the number of persons in attendance. The documentation requirement for materials delivered to homebound participants shall include the date of distribution, copy of distributed material, and number of participants receiving the information.

6. **Provider Qualifications:** A licensed dietitian and/or licensed registered dietitian shall develop or coordinate, review and approve nutrition education content and materials prior to presentation. Coordination shall include, at a minimum, the following:

   a. Selection of topics and trainers;
   b. Review or provide materials to be used for nutrition education; and
   c. Training of persons who will conduct nutrition education, if applicable.

C. **RECORD KEEPING AND REPORTING REQUIREMENTS:**

1. **Unit of Service:** Each nutrition education session participant counts as a unit of service.

2. CIRTS reporting requirements are included on the next page. ↓
### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

<table>
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</tr>
<tr>
<td>CCE</td>
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<td>Sections 430.601-608, F.S.</td>
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<td>LSP</td>
<td>Specific Appropriations</td>
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<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(11), (23) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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.

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.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP

PROGRAM AUTHORITY:

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</tr>
<tr>
<td>LSP</td>
<td>Specific Appropriations</td>
</tr>
</tbody>
</table>

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. CIRTS reporting requirements are included on the next page. ↓
## CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
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PROGRAM FUNDING SOURCE(S): AC, LSP, OAAIIIB, OAAIIIC1, OAAIIIC2, OAAIIIE, OAAIIIEG

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<td>OAAIIIB</td>
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<td>OAAIIIC1</td>
<td>Older Americans Act, Title III, Part C, Subpart 1, Section 331 42 U.S.C. 3030e</td>
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<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
</tr>
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</table>

A. DESCRIPTION: Outreach is an access service and is a required service or function in Title IIIB and Title IIIC. 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 particular attention to low-income minority and older clients residing in rural areas.
Section 2: Services

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.

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 DOEA funded services.

2. CIRTS reporting requirements are included on the table below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIB

PROGRAM AUTHORITY:

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<th>Program Funding</th>
<th>Specific Authority</th>
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<tr>
<td>CCE</td>
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<td>Older Americans Act, Title III, Part B, Section 321, (a)(5) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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 the purpose of 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.

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.

4. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICE</th>
<th>OAA CLIENT REQUIREMENTS</th>
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PROGRAM FUNDING SOURCE(S): CCE

PROGRAM AUTHORITY:

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<tbody>
<tr>
<td>CCE</td>
<td>Sections 430.201-207, F.S.</td>
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</tbody>
</table>

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. CIERTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>CIERTS REPORTING REQUIREMENTS</th>
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<tbody>
<tr>
<td>PROGRAM</td>
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</table>
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. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>CIRTS REPORTING REQUIREMENTS</th>
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<tbody>
<tr>
<td>PROGRAM</td>
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<tr>
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</table>
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.

<table>
<thead>
<tr>
<th>CIRTS REPORTING REQUIREMENTS</th>
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<tbody>
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</table>
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. ↓

<table>
<thead>
<tr>
<th>CIRTS REPORTING REQUIREMENTS</th>
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<tbody>
<tr>
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PROGRAM FUNDING SOURCE(S): CCE, HCE, LSP, OAAIIIIB

PROGRAM AUTHORITY:

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<tr>
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<tr>
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<td>Sections 430.601-608, F.S.</td>
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<td>LSP</td>
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</tr>
<tr>
<td>OAAIIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(11), (23) 42 U.S.C. 3030d</td>
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</table>

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.
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. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): LSP, OAIIIB

PROGRAM AUTHORITY:

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<td>Specific Appropriations</td>
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<tr>
<td>OAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(1), (7) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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. CIRTS reporting requirements are included on the next page. ↓
### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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PROGRAM FUNDING SOURCE(S): LSP, OAAIIIIB, OAAIIIE, OAAIIIEG

PROGRAM AUTHORITY:

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<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E</td>
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</table>

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 making arrangements for appointments, assistance with forms and paperwork requirements, and making arrangements for travel and escort services.
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 to identify organizations to which a referral has been made and of the follow-up results.

3. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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Section 2: Services

Respite Care (Facility-Based)

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

PROGRAM AUTHORITY:

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<td>CCE</td>
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<td>Sections 430.601-608, F.S.</td>
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<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E, Sections 373(b)(4)</td>
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<tr>
<td>SCP</td>
<td>Corporation for National and Community Service Senior Companion Program</td>
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</tbody>
</table>

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.
Section 2: Services

Respite Care (Facility-Based)

2. The primary caregiver (relative or non-relative) shall be unpaid and provide care on a 24-hour basis with little or no relief to be eligible for DOEA-funded respite care services. Paid (salaried or hourly) caregivers may not receive respite care. 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.

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:

1. **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.

2. Unit of service for the Senior Companion Program: One worker hour.

3. A daily attendance log with time in and time out shall be maintained.

4. CIRTS reporting requirements are included on the next page. ¶
### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>Reporting of Services</th>
<th>OAA Client Requirements</th>
<th>Max Units</th>
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<td>HCE</td>
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<td>LSP</td>
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<td>SCP</td>
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<td>RESF</td>
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<td>ZERO UNIT ENTRY REQUIRED ANNUALLY</td>
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* Special Senior Companion Program to Capture Agency Dollar Match.
Section 2: Services

PROGRAM FUNDING SOURCE(S): AC, ADI, CCE, HCE, LSP, OAAIIIB, OAAIIIE, RELIEF, SCP

PROGRAM AUTHORITY:

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<tr>
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<td>AmeriCorps National Service Volunteer Program</td>
</tr>
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<tr>
<td>LSP</td>
<td>Specific Appropriations</td>
</tr>
<tr>
<td>OAAIIIB</td>
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</tr>
<tr>
<td>OAAIIIE</td>
<td>Older Americans Act, Title III, Part E, Sections 373(b)(4)</td>
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<tr>
<td>RELIEF</td>
<td>Respite for Elders Living in Everyday Families</td>
</tr>
<tr>
<td>SCP</td>
<td>Corporation for National and Community Service Senior Companion Program</td>
</tr>
</tbody>
</table>

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 of time.
Section 2: Services

Respite Care (In-Home)

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.

2. Respite care shall meet the needs of the client and caregiver and be inclusive of the services that will allow the caregiver to leave the premises. For instance, if the client requires help with personal care, the respite service shall include this as part of the respite service. The primary caregiver (relative or non-relative) shall be unpaid and provide care on a 24-hour basis with little or no relief to receive DOEA-funded respite care services. Paid (salaried or hourly) caregivers may not receive respite care. Respite care may be provided for caregivers who are employed, regardless of program funding source. 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.

3. CIRTS reporting requirements are below. ↓

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
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*Special Senior Companion Program to Capture Agency Dollar Match.
PROGRAM FUNDING SOURCE(S): LSP, OAAIIIB, OAAIIIC2, OAAIIIE, OAAIIIEG

PROGRAM AUTHORITY:

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<td>OAAIIIC2</td>
<td>Older Americans Act, Title III, Part C, Subpart 2, Section 339, (2)(J)</td>
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</table>

A. DESCRIPTION: Screening/assessment is defined as administering standard assessment instruments for the purpose of 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 on a daily basis. 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.

2. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
<th>OAA CLIENT REQUIREMENTS</th>
<th>MAX UNITS</th>
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PROGRAM FUNDING SOURCE(S): CCE, LSP, OAAIIIB

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<td>LSP</td>
<td>Specific Appropriations</td>
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<td>OAAIIIB</td>
<td>Older Americans Act, Title III, Part B, Section 321, (a)(5)(C) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

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.

2. **CIRTS reporting requirements are included on the next page.** 

\[\text{July 2017 A-240} \]
## Section 2: Services

### Shopping Assistance

<table>
<thead>
<tr>
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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 of time.

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 IIIE coordinator or designated staff is required.

3. CIRTS reporting requirements are below.

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</table>

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. CIRTS reporting requirements are included on the next page. ↓
### Skilled Nursing Services

#### Section 2: Services

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</table>

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.
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. CIRTS reporting requirements are on the next page. ↓
## CIRTS Reporting Requirements

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

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.
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. CIRTS reporting requirements are below.

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>REPORTING OF SERVICES</th>
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<td>Older Americans Act, Title III, Part B, Section 321, (a)(5) 42 U.S.C. 3030d</td>
</tr>
</tbody>
</table>

A. **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.

B. **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.

C. **PROVIDER QUALIFICATIONS:** Volunteers are encouraged to provide telephone reassurance.

D. **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. CIRTS reporting requirements are included on the next page.
## Telephone Reassurance

### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>PROGRAM</th>
<th>SERVICE</th>
<th>Reporting of Services</th>
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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
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.
### CIRTS Reporting Requirements

<table>
<thead>
<tr>
<th>Program</th>
<th>Service</th>
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Appendix B

Co-Payment for Service Guidelines for
Community Care for the Elderly and Alzheimer's Disease Initiative
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</table>
LEGAL AUTHORITY:

A. **Florida Statutes, Section 430.204(8):** Community Care for the Elderly (CCE) Program. "Provider agencies are responsible for the collection of fees for services in accordance with rules adopted by the Department. Provider agencies shall assess fees for services rendered in accordance with those rules. To help pay for services received from CCE, a functionally-impaired elderly person shall be assessed a fee based on an overall ability to pay. The fee to be assessed shall be fixed according to a schedule established by the Department in cooperation with Area Agencies on Aging (AAA), Lead Agencies, and service providers."

B. **Florida Statutes, Section 430.503:** Alzheimer's Disease Initiative (ADI); fees and administrative expense. "Provider agencies are responsible for the collection of fees for services in accordance with rules adopted by the Department. Provider agencies shall assess fees for services rendered in accordance with those rules. To help pay for services received pursuant to the Alzheimer's Disease Initiative, a functionally impaired elderly person shall be assessed a fee based on an overall ability to pay. The fee to be assessed shall be fixed according to a schedule to be established by the Department. Services of a specified value may be accepted in lieu of a fee. The fee schedule shall be developed in cooperation with the Alzheimer's Disease Advisory Committee, Area Agencies on Aging, and service providers."

C. **Florida Administrative Code, 58C-1.007:** Co-Payments and Contributions

Contracting agencies that enter into a contract to provide services under the CCE program are responsible for collection of co-payments and contributions from clients receiving services.

1. The contracting agency must determine a dollar amount that the applicant must be assessed for those services based on an overall ability to pay. Partial payments may also be assessed.

2. Pursuant to Section 430.204(8), F.S., the dollar amount must be calculated by applying the current federal poverty guidelines published annually by the U.S. Department of Health and Human Services.

D. **Florida Administrative Code, 58D-1.006(9):** Collect co-payments for services pursuant to Section 430.503(2), F.S. Co-payments must be determined pursuant to Rule 58C-1.007, F.A.C.
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. Therefore, 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.
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 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. 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.

C. 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.

D. Clients who are assessed a co-payment shall not pay an amount that exceeds the full cost of services received.

E. 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.

F. 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.

G. The co-payment to be charged is based on the gross income of the client or the client and live-in spouse.
H. 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 2 and 3 for schedules).

I. A client’s gross income is income derived from the following:

1. Social Security;
2. Veteran’s Administration;
3. Disability payments including workers’ compensation;
4. Retirement pensions (railroad, union, government);
5. Interest, dividend, or annuity income including civil service;
6. IRAs and CDs;
7. Rental property income;
8. Estate/trust fund income;
9. Alimony;
10. Regular contributions from another person;
11. Temporary Assistance for Needy Families (TANF); and
12. Other income.

J. Income information shall be considered confidential.

K. Clients may be terminated for non-payment of co-payments in accordance with procedures developed by the provider. Case managers should refer terminated clients to other service providers, if possible. The requirement to terminate client services for non-payment of co-payments can be waived by the agency director if the total amount of co-payments waived does not exceed ten percent (10%) of the provider’s targeted annual co-payment goal amount. (Refer to O below)
L. 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. CCE clients who are caregivers for HCE clients;

3. 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);

4. And individuals and couples with less than $1.00 monthly income.

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.

M. Services Exempt from Co-Pay Assessment: information, referral/assistance, and intake services are exempt from the co-pay assessment requirement.

N. 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.
O. Provider agencies, in conjunction with AAA, shall establish an annual co-payment goal (amount to be collected from clients). Providers shall project the annual co-payments to be collected from each active client in all income ranges prior to the start of each fiscal year. Ten percent (10%) of the annual goal may be waived. The remaining ninety percent (90%) is the agency’s annual co-payment goal. AAA may hold back five percent (5%) of the provider’s contract amount. The amount held back shall be released to the provider after fifty percent (50%) of the adjusted annual goal is collected, but no later than February 15 of the fiscal year. Holdback amounts not earned by providers as of February 15 may be reallocated to other providers meeting or exceeding fifty percent (50%) of their annual goal.

P. 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.

Q. A review of assets is required for individuals and couples whose incomes fall below the Supplemental Security Income (SSI) range according to the current year’s federal Financial Eligibility Standards for SSI-related programs. This information is compiled by the Department of Children and Families and is made available to AAAs and providers by the Department. The review will help determine if applicants for services may be eligible for Medicaid or other assistance. Clients (and their spouses, if applicable) who meet the income criteria and Medicaid functional impairment criteria shall have their assets reviewed. These clients, or clients with spouses, shall be referred for a full eligibility determination. Assets are not, however, used in determination of the co-pay amount.
R. 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;

6. Certificates(s) of Deposit;

7. IRAs;

8. Revocable burial contracts;

9. Trusts;

10. Stocks/bonds/mutual funds; and

S. Real property (not homestead). 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.

T. 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.
U. 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.

V. 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.
DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Appendix B: Co-Payment for Service Guidelines --- ADI and CCE Programs

Determination of Client's Ability to Pay

Determination of Client's Ability to Pay:

Completion of the financial worksheet shall be the method used to determine the client's ability to pay. The completed financial worksheet constitutes documentation of the co-pay determination procedure. If the client is married and lives with the spouse, the spouse's income shall also be considered in the co-pay determination process. Fundamental to the success of this procedure is the client's understanding of the purpose and requirements of the co-payment assessment process.

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;

2. It is collected to offset some or all of the costs of the services received by the client;

3. It is based on the client's ability to pay;

4. It is determined by completing the financial worksheet and assessed co-pay form;

5. Income and assets are self-declared;

6. A co-pay amount for all of the services received each month will be charged;

7. Clients shall be informed of their right to request a review of their ability to pay the assessed amount;

8. Clients shall be informed of their right to file a grievance relative to actions to terminate services due to non-payment of assessed co-payment; and

9. 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.
DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Appendix B: Co-Payment for Service Guidelines --- ADI and CCE Programs

Determination of Clients Ability to Pay

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 1) by following the steps below:

1. Determine whether the client is exempt from assessment, as detailed in Overview, Section K;
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.

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. Non-payment of co-payments: Failure to pay co-payments when billed shall result in termination of services.
Determination of Client's Ability to Pay

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.
**COLLECTION OF CO-PAYMENTS:**

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

**A. Method:**

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

**B. Designation and Billing of Responsible Parties:**

1. The client's or the identified financially responsible party's name shall be recorded in the client's file.
2. Should the court appoint 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. As long as 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.
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, as long as 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.
Termination of Services Due to Delinquent Payments of Assessed Co-Payments

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

A. For the purpose of co-payment collection, 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. Providers shall establish their own procedures and timelines for recouping delinquent payments. Consideration should be given to the cost of pursuing unpaid claims, the amount of unpaid claims, and whether it is worth the time and expense.

C. Providers will develop their own termination procedures for clients who do not pay assessed co-payments. Once a client is terminated, the action must be noted in the Client Information and Registration Tracking System (CIRTS) using the code “TRNP” (termination for non-payment).

D. Provider agency directors may elect to waive the assessed co-payment, if it is felt that termination of services would not be in the best interests of the client. 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.

2. If the client has been provided services as a high risk Adult Protective Services referral, the assessment must be completed before the end of the 31-day service period. If the client refuses to provide information on income to determine the ability to pay, services are terminated, unless the co-pay assessment is waived.
Termination of Services Due to Delinquent Payments of Assessed Co-Payments

3. Acceptance of partial payment of assessed co-payments may affect termination procedures for the month in which partial payment is accepted. Partial payments are discouraged because services cannot legally be terminated. However, if extenuating circumstances exist, the agency may agree to establish a partial payment plan with specified start and end dates for receipt of full payment. Examples of extenuating circumstances include:

   a. Client’s retirement pension or other source of regular income was not received;

   b. Client is hospitalized and unable to pay bills timely; or

   c. Client has an increase in out-of-pocket expenses related to medical conditions.

4. 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.

*NOTE:* A re-determination of co-payments could be done as opposed to negotiating a partial payment plan with the client experiencing financial hardship or extenuating circumstances.
PROVIDER ANNUAL CO-PAYMENT GOAL AND AAA HOLDBACK PROCEDURES:

Provider agencies in conjunction with the AAA shall establish an annual co-payment target goal to collect from clients. Area Agencies on Aging may hold back contract funds until fifty percent (50%) of the annual goal is collected.

A. Provider agencies will project an annual co-payment goal using data from the monthly income amount of all active clients.

1. All of the active clients’ monthly income amounts are compared to the ranges in the co-payment schedule to determine the monthly co-payment amount owed for the services prior to the start of each fiscal year.

2. An annual amount is projected by multiplying the number of clients (individuals and couples) in each income range times the co-pay amount times 12 months. The totals for each income range are then added together to establish the annual co-pay goal amount.

EXAMPLE:

<table>
<thead>
<tr>
<th>Range</th>
<th>Clients</th>
<th>Co-Pay Annual Amount</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1-733</td>
<td>60 X</td>
<td>$1 X 12</td>
<td>$720</td>
</tr>
<tr>
<td>$734-766</td>
<td>40 X</td>
<td>$9 X 12</td>
<td>$4,320</td>
</tr>
</tbody>
</table>

Complete for all clients' (individuals and couples) income ranges and total annual amount column.

3. LAN administrators will provide a report for each provider showing the number of clients in each range based on the client monthly income data in CIRTS. This report will be used to compute the annual goal.

4. Provider agencies may waive up to ten percent (10%) of the annualized goal in co-payments for clients. The remaining ninety percent (90%) is the provider’s annual co-payment target goal amount to be collected.
B. **Area Agencies on Aging may holdback five percent (5%) of individual CCE and ADI provider contract amounts.**

The five percent (5%) contract amount may be held back from one or more of the requests for payment in the first seven months of the fiscal year. If this is done, the following applies:

1. Providers meeting fifty percent (50%) of their annual target goal by February 15 will receive all of their held back funds.

2. If a provider does not meet fifty percent (50%) of the target goal by February 15, the AAA will reallocate held back funds to other providers in the Planning and Service Area (PSA) that have achieved their target goal. If no provider in a PSA has achieved its target goal, the AAA shall release the hold back amount to the Department for reallocation to other PSAs.
REVIEW AND GRIEVANCE PROCESS:


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.
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.
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, which documents the assessment of the client's ability to pay, or a statement in the case narrative of the reason for waiver of assessment of co-payments.

2. The co-pay form must have the assessed co-pay amount, the client's signature and date.

3. A copy of written or notation of verbal notice of change of financial circumstances, if applicable.

4. A statement in the case narrative regarding the client's non-payment of co-payments 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.


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.

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 non-payment of assessed co-payments.

6. Number of clients 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 5.
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 5) to the Department no later than August 30 of each year.
COMMUNITY CARE FOR THE ELDERLY (CCE) and ALZHEIMER’S DISEASE INTITATIVE (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.

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

3. ASSESSED CO-PAYMENT MONTHLY AMOUNT (FROM CO-PAYMENT SCHEDULE)$ ________
4. **ASSET INFORMATION** – Fill in all sources.

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

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 _______________
## 2017 Co-Pay Schedule for Individual

<table>
<thead>
<tr>
<th>Monthly Income Range</th>
<th>Co-Pay</th>
<th>Percent of Income</th>
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3 percent of income: 3.00%
### 2017 CO-PAY SCHEDULE FOR COUPLE

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<th>Co-Pay</th>
<th>Percent of Income</th>
<th>Monthly Income Range From</th>
<th>Co-Pay</th>
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<td>$2,559</td>
<td>2.57%</td>
<td>$4,142</td>
<td>$4,178</td>
<td>2.95%</td>
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<td>$2,560</td>
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<td>$4,177</td>
<td>$4,213</td>
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<td>$2,588</td>
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<td>$2,616</td>
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<td>$2,644</td>
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<td>2.61%</td>
<td>$4,282</td>
<td>$4,319</td>
<td>2.97%</td>
</tr>
</tbody>
</table>

*3 percent of income: 3.00%*
2017 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 (HCE) 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.
   b. Supplemental Security Income (SSI): Include the amount of the monthly SSI check.
   c. Veterans Administration (VA) benefit: Include the monthly amount of the benefits check.
   d. Disability Payments: Include Worker’s Compensation and the monthly amount of any payments received, excluding Supplemental Security Income (SSI) and Veterans Administration (VA) benefits.
   e. 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.
f. 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.

g. Rental Property Income: Include any income from rental property (must be at fair market value).

h. 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.

i. Alimony: Include any income received monthly from court ordered alimony support payment.

j. 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.

k. Temporary Assistance for Needy Families (TANF): Include amount of assistance.

l. 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 chart (Attachment A) to find the income range for individual client or couple and enter the co-pay amount for the client’s income range on line 3.
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 as burial funds.

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.

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 particular 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 client or responsible party sign and date form after reading the affirmation statement. Complete information as indicated for person preparing the worksheet.
### COMMUNITY CARE FOR THE ELDERLY AND ALZHEIMER’S DISEASE INITIATIVE
### ANNUAL CO-PAY COLLECTION REPORT

<table>
<thead>
<tr>
<th>PROVIDER NAME, ADDRESS &amp; PHONE #:</th>
<th>CONTRACT #:</th>
<th>REPORT PERIOD:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CONTRACT PERIOD:</td>
<td>FROM:</td>
</tr>
<tr>
<td></td>
<td>PSA:</td>
<td>TO:</td>
</tr>
</tbody>
</table>

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:

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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</tr>
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<tr>
<td>IV.</td>
<td>Attachment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care Plan Comparison to CIRTS Chart</td>
<td>C-7</td>
</tr>
</tbody>
</table>
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).

Specific Legal Authority:

Program: Reference:

A. OAA Refer to specific legal authority cited in Chapter 4
B. CCE Refer to specific legal authority cited in Chapter 5
C. ADI Refer to specific legal authority cited in Chapter 6
D. LSP Refer to specific legal authority cited in Chapter 3
E. EHEAP Refer to specific legal authority cited in Chapter 3
F. HCE Refer to specific legal authority cited in Chapter 7
REPORTING REQUIREMENTS:

A. Case-managed clients, OAA or LSP clients receiving Registered Services, all individuals receiving services through OAA Title IIIE programs, and individuals receiving transportation through LSP and OA3B must be entered in CIRTS.

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. 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 IIIE, 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.

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 Emergency Home Energy Assistance for the Elderly Program (EHEAP) and waiver programs. Reporting methods are:

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.

   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 located in Appendix A — Service Descriptions and Standards.
Electronic Completion of Client Assessment in CIRTS

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 through the use of 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 of 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.

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.

<table>
<thead>
<tr>
<th>CARE PLAN FIELD</th>
<th>CIRTS FIELD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security #</td>
<td>SSN</td>
</tr>
<tr>
<td>Client Name</td>
<td>First/Last Name</td>
</tr>
<tr>
<td>Case Manager</td>
<td>Owner/provider</td>
</tr>
</tbody>
</table>

**SERVICES NEEDED BLOCK**

- **Date** (from the problem column)  
  - **Date** (located next to the Srvc Column)
  - **Service**
  - **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
  - **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 personal care 3 hours per week per the Care Plan, the Care Plan screen Services Planned block would indicate 3 in the “Units” field. CIRTS will insert “HRS” in the “Typ” field. Enter “Wk” for “Frp”, since weekly is indicated on the Care Plan. If a client receives respite 3 hours 2 times a week, enter 6 in the “Units” field. CIRTS will insert “HRS”. Indicate “Wk” in “Frp” field, 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.)
  - **Frp** (Increment of time used such as month or week)
  - **NOTE**: DURATION IS NOT ENTERED IN CIRTS
  - **Date Service Began/Ended**
  - **Start Date/End Date**
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.
Appendix D

Minimum Guidelines for Recipient Grievance Procedures
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<td>D-9</td>
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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, with the exception of 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 of time 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.
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:

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:

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;
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:

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;
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
Introduction

- **All** Applicants who meet the Direct Service Provider definition are required to complete a Level 2 screening with an attached photograph through the Care Provider Background Screening Clearinghouse (Clearinghouse).

- **All** Direct Service Provider Applicants/Employees of any of the Department of Elder Affairs (Department/DOEA) Programs 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 Applicants/Employees within the *Specified Agency* “Employee/Contractor Roster” tab of the Clearinghouse.

- An Employer may hire an Applicant into a position that requires background screening before the Employee completes the screening process. This period is for training and orientation purposes, but the Employee cannot provide direct service until the screening process is finalized, and the status is “Eligible” within the DOEA-Aging Network Clearinghouse.

- Use of the Clearinghouse must be limited to direct service providers as defined by 430.0402(b), F.S.
  - Failure to comply with any Background Screening Requirement is a violation of Section 430.0402, F.S.
Each User must access to Clearinghouse website and is required to abide by the following rules:

- **Create a unique account.** (There’s 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 the Corrective Action Plan are submitted to the Agency for Health Care Administration 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.
  - 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.
Appendix E: Background Screening Clearinghouse Instructions

Introduction/Requirements

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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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 Clearinghouse Results Website at https://apps.ahca.myflorida.com/SingleSignOnPortal

Once on the website:
A. Select “New User Registration”
B. Check the confirmation box and select continue.
C. Enter all required information as indicated by the red asterisk (*) and select “Register” to continue.
D. Once your user account is successfully created, select “Return to Login” to request access to the Clearinghouse result website.

Portal Users Requirements

The Portal Login page will provide an authorized user access to external systems maintained by the Agency for Health Care Administration (AHCA) in order 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.”
   o If your Provider information is not located in the drop-down selection, please contact the Department via email for instructions using the contact information provided below:
      Contact – Background Screening Unit
      Email Address – doeanelogin@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.”
   o If it does not, select Delete and choose the appropriate “Provider Name.”
   “Submit Request and Generate User Agreement with a copy of Drivers License.”

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. 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.
Clearinghouse Results Website Portal Access:


B. Select: Program Access; Background Screening Clearinghouse – DOEA; Application Access; Background Screening Clearinghouse

Applicant Profile Page

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

Search for Screening Results: The “Search Page” allows you to review the eligibility status of an Applicant if the Applicant has undergone a screening or has a screening in-process with the Clearinghouse. If the Applicant does not have a screening, you must first initiate a screening. If the Applicant is found, the “Applicant’s Profile Page” will appear.

Note: If you know an Applicant does not possess a screening, you may select the, “Initiate Screening Tab” located on the navigation bar.

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

Initiate Agency Review: If an Applicant possesses an “Eligibility Statement” from another Specified Agency within the Clearinghouse, a Provider may request an agency review at no cost. To initiate an agency review for an Applicant, select “Initiate Agency Review” and follow prompts.

Note: This will allow the Specified Agency to make an eligibility determination for employment purposes. Benefits of requesting an agency review include the following:

- “Agency Review” requests are FREE to the Provider and Applicant.
- The Applicant or Employee 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 an agency review.
Initiate Resubmission: The retention of fingerprints in the Clearinghouse provides cost savings for Applicants 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 an Applicant, select “Initiate Resubmission,” and follow prompts.

Completing the Applicants profile:

To complete the “Applicant’s Profile Page,” the Clearinghouse User is required to:

A. Ensure the “Clearinghouse Screening Available” indicator states “Yes”;
B. Ensure the “Privacy Policy” has been signed and acknowledged;
C. Ensure the “Social Security Number” is on the “LiveScan Request Form”;
D. Complete the “Requesting Provider” field within the Clearinghouse;
E. Provide Applicant with a “LiveScan Request Form,” before the fingerprinting process;
F. Instruct the Applicant to request a photograph from the LiveScan Vendor at the time of LiveScan fingerprinting; and
G. Return to the Clearinghouse Website upon receipt of email notification to check the Applicant’s status.
Appendix E: Background Screening Clearinghouse Instructions

Required Forms

All approved DOEA-Aging Network Employee/Volunteers and all approved SHINE Volunteers are required to sign the “Affidavit of Compliance Employee Form, Effective April 2016,” 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.

The following forms are a requirement for monitoring purposes:

- Signed and dated Privacy Policy;
- Screenshot of the OIG (Office Inspector General) Exclusions Search Results;
- Screenshot of the NNAR (National Nurse’s Aide Registry) database search results;
- “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 April 2016.
  - Applicant 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.
**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 Database.

**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 “Applicant Profile Page” and select “Add Employment/Contractor Record.”

B. Enter the required information and select “Save.” This will bring you back to the “Applicant Profile Page.”

C. 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 Applicant 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.”
Concerns

The Agency for Health Care Administration (AHCA) requires each agency to handle its unique Clearinghouse problems and concerns appropriately.

All *DOEA- Aging Network* Clearinghouse concerns are to be addressed as follows:

- Notification to the Background Screening Coordinator – Valerie Brinkley (850) 414-2093
- Email Address: [doeanetwork@elderaffairs.org](mailto:doeanetwork@elderaffairs.org)
- Subject Line: BGS Clearinghouse Concern
- Body of Email: State the exact problem and include a screenshot (if possible.) When inquiring about an Applicant, the following information is required:
  - Full Name
  - DOB

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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:
- Introduction and Tabs
- User Registration Guide
- Search and Profile Page
- Adding Employment
- Initiating an Agency Review
- Initiating a Resubmission

Clearinghouse Results Website Guide:
- Department of Elder Affairs

FORMS:
- Additional Information: (last bullet on left)

Regulations and Forms:
1. Clearinghouse Applicant Request Form
2. Privacy Policy
BACKGROUND SCREENING

Affidavit of Compliance - Employee

AUTHORITY: This form is required of all employees 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 may be used by all employees 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 employee's personnel file. 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, please attach a copy of the screening results and submit the licensure application.

The term “employee” 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. 817.568, 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."

**EMPLOYER:** IF AN EMPLOYEE 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.

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Position Applied For</th>
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Employer
STEP TWO: The employee 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 543.0435, 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 the Agency for Healthcare Administration (AHCA)

  Date of Decision: __________________________

☐ I have been granted an Exemption from Disqualification through the Florida Department of Health.

  Date of Decision: __________________________

** A copy of the Exemption from Disqualification decision letter must be attached**

If you are also using this form to provide evidence of prior Level 2 screening (fingerprinting) in the last 5 years and have not been unemployed for more than 90 days, please provide the following information. A copy of the prior screening results must be attached.

Purpose of Prior Screening: __________________________

Screening Conducted by: __________________________  Date of Prior Screening: __________

☐ Agency for Healthcare Administration  ☐ Department of Elder Affairs

☐ Department of Health  ☐ Department of Financial Services

☐ Agency for Persons with Disabilities  ☐ Department of Children and Family Services
STEP THREE: The employee 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 EMPLOYEE’S QUALIFICATION FOR AN EXCEPTION.
STEP FOUR: Each employee 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.

_________________________________________________  _______________________
Employee Signature                                      Date

EMPLOYER: ONCE THE ATTESTATION IS SIGNED, KEEP THIS COMPLETED FORM IN THE EMPLOYEE’S FILE.
Chapter 1

DOEA Sponsored Programs: General Information, Planning Process and Aging Network, Monitoring, and Program Reporting Requirements
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July 2017
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.
ORGANIZATION AND USE OF THE HANDBOOK:

A. **Chapters/Sections:** This handbook is organized into chapters, some of which include sections containing similar subject matter. Sections are further divided into parts containing specific subject matter. Some chapters are simply divided into sections of specific subject matter.

1. **Example:** For example, Chapter 2 contains sections related to case management activities and Chapter 4 contains sections concerning OAA programs.

2. **Program Specific:** Some chapters include information specific to a program area (e.g., Chapter 4—Older Americans Act or Chapter 5—Community Care for the Elderly).

3. **Universal Coverage:** Other chapters of the handbook will include subjects which are universally applied to each program area such as Chapter 2—Intake, Screening, Prioritization, Assessment and Case Management.

B. **Handbook Organization:** The organization of the handbook by chapters and sections allows users to customize their review and select only the chapters and/or individual sections of the handbook they need.
**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.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK
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.
### 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:

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

B. **Quality Assurance:** DOEA monitors annually and provides ongoing technical assistance to ensure compliance with established standards.

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General Information

Authority for DOEA Programs

**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.

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BACKGROUND SCREENING

A. DOEA has specific statutory authority under state law to require Level 2 background screening of all direct service providers. Instructions for completing background screening are in Appendix E.

B. Exceptions to Level 2 Background Screening by the Department include the following:

1. A licensed physician, nurse, or other professional licensed by DOH who has been fingerprinted and undergone background screening as part of their licensure, if they are providing a service that is within the scope of their licensed practice. Verification of licensure status is available on the DOH website, located at http://ww2.doh.state.fl.us/IRM00PRAES/PRASLIST.ASP.

2. Attorneys in good standing with the Florida Bar, if they are providing a service within the scope of their licensed practice. Determinations of good standing with the Florida Bar can be made by entering the attorney’s name in the “Find a Lawyer” tab on the Florida Bar’s website located at http://www.floridabar.org/.

3. An individual who is the father, mother, stepfather, stepmother, son, daughter, brother, sister, grandmother, grandfather, great-grandmother, great-grandfather, grandson, granddaughter, uncle, aunt, first cousin, nephew, niece, husband, wife, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, stepson, stepdaughter, stepbrother, stepsister, half-brother, or half-sister of the client being served.

4. Volunteers who assist on an intermittent basis for less than 20 hours per month and who are not listed on the Florida Department of Law Enforcement’s (“FDLE”) Career Offender Search database or the Dru Sjodin National Sex Offender Public Website.
   - The service provider is required to verify that the volunteer is not listed in either database. The FDLE Career Offender Search Database is available at http://www.fdle.state.fl.us/coflyer/ . The Dru Sjodin National Sex Offender Public Website is available at: http://www.nsopr.gov/en .
   - If the individual’s name appears in either database, the individual is not eligible for an exception to Level 2 screening.
C. **Exclusion from Employment:**

1. An employer (service provider) may not hire, select, or otherwise allow an employee who requires background screening to have contact with any client until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment.

2. For training and orientation purposes only, an employer may hire an employee to a position that requires background screening before the employee completes the screening process. However, the employee may not have direct contact with clients until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.

3. Any employee who refuses to cooperate with the background screening process or refuses to submit the information necessary to complete the screening must be disqualified for employment for such position, or if employed, must be dismissed.

4. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact with any client, unless the employee is granted an exemption from disqualification by the Department. (It is the responsibility of the affected employee to contest his or her disqualification or to request an exemption from disqualification.)
   - If an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any client until the arrest has been resolved in such a way that the employer determines the employee is still eligible for employment.
   - The employer must terminate any personnel found to be in noncompliance with background screening requirements or place the employee in a position for which background screening is not required, unless the employee is granted an exemption from disqualification.

D. Refusal on the part of an employer to dismiss a manager, supervisor, or direct service provider who fails to comply with the background screening requirements shall result in the automatic denial, termination, or revocation of the employer's license or certification, rate agreement, purchase order, or contract, in addition to any other remedies authorized by law.
USE OF DEPARTMENT OF ELDER AFFAIRS LOGO:

A. **AAA Authorization:** Area Agencies on Aging may authorize the use of the most current DOEA logo in projects and presentations when DOEA funds are involved.

B. **Written Request:** The AAA shall provide written authorization for using the most current logo upon written request from a DOEA-funded entity.

C. **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 of more ADRC functions under 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.
6. **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.

7. **Allowable Cost:** Those categories of costs that can be charged to a grant or contract.

8. **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.

9. **Alzheimer’s Disease Initiative (ADI):** A state general revenue funded program for providing the following: respite care, model day care, memory disorder clinic services and a brain bank.

10. **Area Agency on Aging (AAA):**
   a. Under the authority of the Older Americans Act of 1965, as amended, DOE designates this entity within a PSA to develop and administer a plan for a comprehensive and coordinated system of services for older persons.
b. The AAA is authorized to accept contributions, gifts or grants to fund community care service systems.

11. **Area Plan on Aging (Area Plan for the Planning and Service Area)**
   a. 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 DOE&A.
   b. 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 DOE&A for approval prior to contracting for funding.

12. **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.

13. **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.

14. **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 examination of compliance with applicable terms, laws, and regulations.

15. **Below Poverty Level:** Having income below the amount annually established by the federal government as the poverty level.

16. **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

17. **Breach of Contract**: Material noncompliance with the terms of the contract.

18. **Budget**: A budget for the purposes of this handbook is a financial plan of action and an aid to program coordination and implementation.

19. **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).

20. **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.

   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.

21. **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.

22. **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.

23. **Client**: An individual being assessed or served in a DOEA program.
General Information

24. **Community:** 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.

25. **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.

26. **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.

27. **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.

28. **Contract:** A legally binding agreement between the state and another entity, public or private, for the provision of services.

29. **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.


30. **Contract Manager:** A person designated, respectively, by the Department or the AAA to manage the performance of the contract.

31. **Contribution:** A voluntary donation.

32. **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.

33. **Corrective Action:** Action taken by a recipient or subrecipient that corrects identified deficiencies, produces recommended improvements, or demonstrates that deficiencies or findings are either invalid or do not warrant action.

34. **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.

35. **Department:** The Florida Department of Elder Affairs (DOEA).

36. **Department of Children and Families (DCF):** The state agency responsible for social and financial assistance services for categorically eligible children and adults.

37. **Department of Economic Opportunity (DEO):** The state agency that provides a portion of the Low-Income Home Energy Assistance Program (LIHEAP) funding to DOEA to administer the Emergency Home Energy Assistance for the Elderly Program (EHEAP).

38. **Department of Health and Human Services (DHHS):** The federal agency, which includes the AoA, responsible for administering the Older Americans Act programs.

39. **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.
General Information

40. **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.

41. **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.

42. **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.

43. **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.

44. **Emergency Home Energy Assistance for the Elderly Program (E HEAP)**: 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).

45. **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.
46. **Evidence-Based Program**: A program recognized by the U.S. Department of Health and Human Services. Programs meet the following criteria:

   a. Demonstrated through evaluation to be effective for improving the health and well-being or reducing disease, disability, and/or injury among older adults;

   b. Proven effective with older adult population, using Experimental or Quasi-Experimental Design*; and

   c. Research results published in a peer-review journal; and

   d. Fully translated** in one or more community site(s); and

   e. Includes developed dissemination products that are available to the public.

   *Experimental designs use random assignment and a control group. Quasi-experimental designs do not use random assignment.

   **For purposes of the Title III-D definitions, being “fully translated in one or more community sites” means that the evidence-based program in question has been carried out at the community level (with fidelity to the published research) at least once before. Sites should only consider programs that have been shown to be effective within a real-world community setting.

47. **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 of someone other than the vulnerable adult; or

   b. 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

48. **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.
### Definitions

<table>
<thead>
<tr>
<th>Number</th>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>49.</td>
<td><strong>Federal Regulations:</strong></td>
<td>Non-statutory policies/procedures/requirements adopted by U.S. governmental agencies to fulfill and implement a statutory purpose.</td>
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<tr>
<td></td>
<td>a.</td>
<td>Regulations are published in the Federal Register and are codified in the Code of Federal Regulations (CFR).</td>
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<td></td>
<td>b.</td>
<td>These regulations have the force and effect of law and are binding on agencies or persons to which they apply.</td>
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<td>50.</td>
<td><strong>Fiscal Compliance:</strong></td>
<td>Assurance that funds are appropriately spent and that the work is completed to specified standards.</td>
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<td>51.</td>
<td><strong>Fiscal Year:</strong> A specified twelve-month period during which state and/or federal funding sources are expended. Specific fiscal years are listed below:</td>
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<tr>
<td></td>
<td>a.</td>
<td>The Federal Fiscal Year (FFY) - October 1 through September 30.</td>
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<td>b.</td>
<td>The State Fiscal Year (SFY) - July 1 through June 30.</td>
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<td>c.</td>
<td>OAA Title III Contract Year - January 1 through December 31.</td>
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<td>d.</td>
<td>Provider Fiscal Year - a specified twelve-month period determined by the provider agency.</td>
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<td>e.</td>
<td>OAA Title III Contract Year - January 1 through December 31.</td>
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<td>f.</td>
<td>Provider Fiscal Year - a specified twelve-month period determined by the provider agency.</td>
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<tr>
<td>52.</td>
<td><strong>Florida Abuse Hotline:</strong></td>
<td>The program/system administered by the Florida Department of Children and Families to identify and investigate abuse, neglect and exploitation cases.</td>
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<td>53.</td>
<td><strong>Focal Point:</strong></td>
<td>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.</td>
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<td>54.</td>
<td><strong>Frail:</strong></td>
<td>A condition of physical and/or mental disability, 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.</td>
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55. 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 will be asked questions to determine the following functional areas (also called assessment domains):

i. Mental health/behavior cognition;
ii. Physical health;
iii. Activities of Daily Living/Instrumental Activities of Daily Living;
iv. Nutrition status;
v. Health condition;
vi. Special services;
vii. Medications;
viii. Caregiver assessment;
ix. Social resources;
x. Environmental assessment; and
xi. Case managers perform assessments.

56. Functionally Impaired Elderly Person:

a. A person 60 years of age or older with physical or mental limitations which:

i. Restrict the individual’s ability to perform the normal activities of daily living; and

ii. Impede the individual’s capacity to live independently without provision of services

b. Functional impairment will be determined through a functional assessment completed with each applicant for CCE, HCE, & ADI services
57. **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 not only broad guidelines of general application, but also detailed practices and procedures. The primary authoritative body on the application of GAAP to state and local governments is the Governmental Accounting Standards Board.

58. **Greatest Economic Need:** Greatest economic need means the need resulting from an income level at or below the poverty level established by the Federal Office of Management and Budget.

59. **Greatest Social Need:** Greatest social need means 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.

60. **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.

61. **Home Care for the Elderly (HCE):**
   a. This program provides care for the elderly in family-type living arrangements in private homes.
   b. 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.
   c. The caregiver may provide these services for three or less relatives or nonrelatives.
62. **Home-bound**: Individuals who are confined to their homes for any period and are unable to leave the residence without assistance from another person.

63. **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.

64. **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).

65. **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.

66. **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.

67. **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.

68. **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 records checks through the Federal Bureau of Investigation, and may include local criminal records checks through local law enforcement agencies.
69. 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.

70. Matching Funds: Financial contribution by the grantee when required level of match is required for cost sharing.

71. Means Test: The use of an individual's income or resources to accept, deny or limit that person's receipt of services. The means test is prohibited for services under OAA.

72. Monitoring: The collection and analysis of contract agencies' performance 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
   c. Produced outcomes consistent with DOEA's statutory mission and focus.

73. Multipurpose Senior Center (MPSC):

   a. 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.
   b. These facilities may also be used for recreational and group activities for older persons.

74. 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.
75. **Nonprofit Organization:**

   a. A nonprofit organization is a corporation, trust, association, cooperative, or other organization which is:

      i. Operated primarily for scientific, education, service, charitable, or similar purposes in the public interest;

      ii. Not organized primarily for profit; and

      iii. 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.

76. **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.

77. **Older Americans Act (OAA):**

    a. Federal legislation that provides funding for a wide array of social services for persons age 60 and older. It was enacted in 1965 and has been amended periodically over time.

    b. The Act emphasizes the development of a comprehensive and coordinated service delivery system for the elderly; elimination of duplicating and overlapping functions; and, the integration of social and nutritional services.

    c. The Act calls for 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 older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas. Such methods must conform to state and AAA policies.
General Information

78. **OAA Title III B**: Older Americans Act section providing funding for supportive service programs, including multipurpose senior centers, for older persons.

79. **OAA Title III C1**: Older Americans Act section providing funding for congregate meals, outreach, and nutrition education for older persons.

80. **OAA Title III C2**: Older Americans Act section providing funding for home delivered meals, outreach, and nutrition education for older persons.

81. **OAA Title III D**: Older Americans Act section providing funding for evidence-based disease prevention and health promotion services for older persons.

82. **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.

83. **OAA Title V**: Older Americans Act section providing for the Senior Community Service Employment Program (SCSEP).

84. **OAA Title VII**: Older Americans Act section which incorporates separate authorizations of appropriations for the:

   a. Long-Term Care Ombudsman Program;

   b. Program for prevention of elder abuse, neglect, and exploitation; and Elder rights and legal assistance programs.

85. **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 sub recipients performing substantive work under those federal grants and agreements that are passed through or awarded to its sub recipients.
86. **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:
   a. 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;
   b. Unique biometric data, such as fingerprint, voice print, retina or iris image, or other unique physical representation;
   c. Unique electronic identification number, address, or routing code;
   d. Medical records;
   e. Telecommunication identifying information or access device; or
   f. Other number or information that can be used to access a person’s financial resources.

87. **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.

88. **Procurement**: The method used to select contractors and subcontractors (recipients, sub recipients, 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.

89. **Program Income**: Gross income earned by a recipient and sub recipient that is directly generated by the grant-supported project or activity, or earned because of the award.

90. **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.

91. **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.
92. **Recipient/Sub recipient:** A person or entity, which is not an employee, who performs all or part of those services under contract with the pass-through entity. Recipients and sub recipients typically determine program eligibility, are responsible for program decision-making and must adhere to compliance requirements. They have their performance measured against state and federal goals, and use federal and state program funds to carry out services under programs.

93. **Rural Area:** An area as defined by the United States Census Bureau’s Decennial Census, with county profiles as defined by the Rural Economic Development Initiative of Florida.

94. **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.

95. **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 his or her home environment; or, loss of the individual’s spouse or caregiver.

96. **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 at, or more than, a certain threshold ($500,000) of federal or state awards.

97. **State:** The State of Florida.
98. **State Plan on Aging:**

   a. A multi-year plan developed by the Department which describes the service needs of the elderly; 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.

99. **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.

100. **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.

101. **Technical Assistance:** The provision of information to recipient and sub-recipients with the goal of increasing the competence or capacity in an area. Technical assistance should be ongoing and proactive.

102. **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.

103. **Vendor:** An entity providing goods or services pursuant to an agreement and not meeting the definition of subrecipient/subcontractor.
### ABBREVIATIONS OR ACRONYMS:

<table>
<thead>
<tr>
<th>ABBREVIATIONS/ACRONYMS TERM</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>AAA</td>
<td>Area Agency on Aging</td>
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<tr>
<td>ACL</td>
<td>Administration for Community Living</td>
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<tr>
<td>AD</td>
<td>Alzheimer’s disease</td>
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<tr>
<td>ADI</td>
<td>Alzheimer's Disease Initiative</td>
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<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>ADRC</td>
<td>Aging and Disability Resource Center</td>
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<td>ALF</td>
<td>Assisted Living Facility</td>
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<tr>
<td>AoA</td>
<td>Administration on Aging</td>
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<tr>
<td>APCL</td>
<td>Assessed Priority Consumer List</td>
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<td>APD</td>
<td>Agency for Persons with Disabilities</td>
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<tr>
<td>CCE</td>
<td>Community Care for the Elderly</td>
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<tr>
<td>CIRTS</td>
<td>Client Information and Registration Tracking System</td>
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<tr>
<td>DEO</td>
<td>Department of Economic Opportunity</td>
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<tr>
<td>DCF</td>
<td>Department of Children and Families</td>
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<tr>
<td>DOEA</td>
<td>Department of Elder Affairs</td>
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<tr>
<td>EHEAP</td>
<td>Emergency Home Energy Assistance for the Elderly Program</td>
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# Abbreviations or Acronyms

<table>
<thead>
<tr>
<th>TERM</th>
<th>ABBREVIATIONS/ACRONYMS</th>
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<tbody>
<tr>
<td>F.A.C.</td>
<td>Florida Administrative Code</td>
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<td>F.S.</td>
<td>Florida Statutes</td>
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<tr>
<td>HCE</td>
<td>Home Care for the Elderly</td>
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<tr>
<td>IADL</td>
<td>Instrumental Activities of Daily Living</td>
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<tr>
<td>ICP</td>
<td>Institutional Care Program</td>
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<tr>
<td>LSP</td>
<td>Local Service Program</td>
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<tr>
<td>LTCOP</td>
<td>Long-Term Care Ombudsman Program</td>
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<tr>
<td>MDC</td>
<td>Memory Disorder Clinic</td>
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<tr>
<td>NSIP</td>
<td>Nutrition Services Incentive Program</td>
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<tr>
<td>OAA</td>
<td>Older Americans Act</td>
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<tr>
<td>PSA</td>
<td>Planning and Service Area</td>
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<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>RDI</td>
<td>Recommended Dietary Intake</td>
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<tr>
<td>SLMB</td>
<td>Special Low-Income Medicare Beneficiary</td>
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<tr>
<td>SMMC LTC</td>
<td>Statewide Medicaid Managed Care Long-term Care</td>
</tr>
<tr>
<td>SNAP</td>
<td>Supplemental Nutrition Assistance Program</td>
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<tr>
<td>SPA</td>
<td>Service Provider Application</td>
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</table>
PURPOSE OF SECTION 2:

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.
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 help Florida’s elders remain healthy, safe, and independent.

C. **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).
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 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.
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 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 any of the following methods to gather public input: scheduled constituent gatherings; surveys; focus groups; or meetings with public officials, advocates, service providers, and other 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.
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 staff strategies to meet unmet needs.

B. **DOEA Plan Creation/Revision:** For the creation and revision of the Department’s plans, staff collates 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.
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.

D. **Advisory Council:** Each AAA has an advisory council to advise the AAA on matters relating to the development and coordination of services for older persons. At least fifty percent of the advisory council’s membership must be 60 years of age or older.
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.
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 construct multipurpose senior centers, 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. Area plans are developed for a two, three or four-year period, as determined by the Department. 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; and
   2. Maintain compliance with the rules, regulations and policy guidance governing the Older Americans Act and all other programs sponsored by the Department.
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. Realistic appraisal of existing available organizational, community, and PSA resources.
4. An analysis, based on numbers 1, 2, and 3 above, to determine how best 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 measures.
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.
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.

D. **Review and Approval at the Local Level**:

   1. The AAA advisory council must have the opportunity to provide input into the development of the multi-year plan. The signature of the advisory council chairperson is required prior to the plan’s submission to DOEA.

   2. The AAA board of directors must review and approve the multi-year area plan. The signature of the board’s chairperson is required prior to the plan’s submission to DOEA.
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 area plan 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.
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.

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:
Planning Process & Aging Network  
Review and Approval of Area Plan / Annual Update

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.
PURPOSE OF SECTION 3:

This section addresses various aspects of monitoring and quality assurance for DOE 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 sub-recipients 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 sub-recipient’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 sub-recipients, 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 Fiscal Oversight and Subrecipient Monitoring;
6. Quality Assurance and Standards of Care; and
7. Legislatively Mandated Performance Outcome Measures.
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.
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 sub-recipients 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 sub-recipients and subcontractors of compliance requirements and monitoring their compliance.

   6. Reviewing sub-recipients’ and subcontractors’ single audit reports, issuing management decisions within six months of audit findings and ensuring that sub-recipients take effective and timely corrective action.

   7. Requiring sub-recipients and subcontractors to grant Department representatives’ access to original and complete records for monitoring.
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 subaward or contract agreement requirements, including compliance with laws and regulations related to receiving federal or state funds.
### 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 Rule 3A-40.103, F.A.C., 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 applicable OMB Circular. 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;
   
   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).
Monitoring

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<td>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.</td>
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<td>7. Be net of all applicable credits (program generated income).</td>
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<td>8. Be supported by the entity’s accounting records and be adequately documented.</td>
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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.

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 215 (formerly OMB Circular A-110):

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 equipment, including the award number;

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) and cost;
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.

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.
## Program Level Requirements

### 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. This type of income includes, but is not limited to, the following:

1. Fees for services performed;
2. Rental or lease of real or personal property acquired with program funds; and
3. Sale of commodities and program fabricated items.

Program income does not include interest on grant funds, rebates, credit discounts, refunds, and/or proceeds of the sale of equipment or property.
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. A pass-through entity is responsible for identifying the following in regards to a subrecipient:

1. CFDA/CSDA title and number;
2. Award name;
3. Name of awarding agency; and
4. Applicable compliance requirements.

Compliance includes ensuring that required audits are performed, as well as evaluating the impact of subrecipient activities and ability to comply with the law.
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?
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<td>8. <strong>Current and prior audit experience:</strong> Has the contractor had weaknesses in internal control over federal or state programs?</td>
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<td>9. <strong>Oversight exercised by funding agencies:</strong> 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?</td>
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<td>10. <strong>Board of Directors:</strong> 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?</td>
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<td>11. <strong>Subcontracting:</strong> Does the contractor subcontract key activities? Does the contractor have an effective monitoring function to oversee these subcontracts?</td>
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<td>12. <strong>Organizational changes:</strong> 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?</td>
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<td>13. <strong>Management structure:</strong> Is the organization centralized or decentralized? How much control does the organization have over decentralized functions?</td>
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<td>14. <strong>Legal actions:</strong> 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?</td>
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<tr>
<td>15. <strong>Defaulted contracts:</strong> Has the contractor defaulted on any of its contracts within the past five years? If so, what were the circumstances?</td>
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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.
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.
DOE A R E A AGENCY O N 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
   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
   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 IID
4. National Family Caregiver Support Program – OAA Title IIIE
5. Serving Health Insurance Needs of Elders
6. Elder Abuse Prevention – OAA Title VII

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
8. Procurement and Contracting

E. Information Management and Data Integrity: Client Data Integrity
Monitoring

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.
ATTACHMENT A: 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.
   - 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.
Monitoring

Attachment A: Governing Laws and Regulations

e. **Americans with Disabilities Act of 1990, Public Law (P.L.) 101-336:** 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.

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)

g. Section 504 of the Rehabilitation Act of 1973: Prohibits discrimination based on handicap in federally funded programs.


j. 45 CFR Part 84: Regulates implementation of uniform administrative requirements for grants and cooperative agreements to 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. 95224): Provides criteria for distinguishing whether a transaction is procurement or financial assistance.

e. 2 CFR Part 225 (OMB Circular A-87): Cost Principles for State, Local and Indian Tribal Governments.


h. 2 CFR 215 (formerly OMB Circular A-110): Regulates implementation of uniform administrative requirements for grants and agreements with institutions of higher education, hospitals and other nonprofit organizations.

i. 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.


5. **Audit Requirements**: Set forth contractual requirements for compliance with OMB Circular A-133 and Section 215.97, F.S., Florida Single Audit Act, if funding threshold is met.

a. OMB Circular A-133: Audits of States, Local Governments and Nonprofit Organizations.

6. **Statutory Authority for Federally-funded Programs:**

   a. **Older Americans Act of 1965**, as amended (P.L. 106-501): Title III-B (Supportive Services), Title III-C1 and III-C2 (Congregate and Home Delivered Meals), Title III-D (Health Promotion), Title III-E (National Family Caregiver Support), Title VII (Elder Abuse Prevention) and Nutrition Services Incentive Program (NSIP), Title V (Senior Community Service Employment Program, AmeriCorps).


   c. **Omnibus Budget Reconciliation Act of 1990**: Section 4360; Section 430.07, Florida Statutes.

   d. **Citizens Service Act of 2002**: amends the National AmeriCorps and Community Service Act of 1990; Domestic Volunteer Act of 1973; Section 430.07(8), Florida Statutes.


   **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)


   4. Section 430.071, F.S., Respite for Elders Living In Everyday Families (RELIEF)

   5. General Appropriations Act – Local Service Programs (LSP)

   6. DOEA Rules, Regulations and Notices of Instruction (NOIs)

   7. Agreements and/or contracts.
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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## Legal Basis and Specific Legal Authority

### LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

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Screening and Assessment Forms:

A. Screening and Assessment forms are used to conduct client screenings and assessments for all DOEA programs. The forms are listed below:

1. **Screening** Form (DOEA Form 701S)
2. **Congregate Meals** Assessment (DOEA 701C)
3. **Comprehensive** Assessment (DOEA 701B)
4. **Condensed** Assessment (DOEA 701A)

B. **Assessment Instructions (DOEA 701D):** Specific and detailed instructions for completing the assessment forms are included in the Assessment Instructions (DOEA 701D).

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. The 701S is an optional screening tool to place or annually rescreen individuals on an OAA APCL. 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 C1 program. A nutrition risk score is generated.

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).

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 IIIIE 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 IIIIE Respite (Adult Day Health Care, Adult Day Care, Direct Pay Respite, In-Home Respite or Facility-Based Respite) or OAA Title IIIES, 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 IIIEG Caregiver Support Program that require data for the annual federal report and eligibility for the OAA Title IIIEG program.

4. LSP services that are operated under OAA standards.

E. **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.

F. **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 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

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The following client scenarios are provided as examples to illustrate the screening and assessment requirements:

<table>
<thead>
<tr>
<th>CIRTS Program Status Codes</th>
<th>Initial Screening / Assessment</th>
<th>Re-screening / Re-assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>APCL ADI, CCE, HCE, SMMC LTC</td>
<td>701S</td>
<td>701S annually</td>
</tr>
<tr>
<td>APCL OAA (IIIB, IIIC, IIIE, IIIEG) only 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.”</td>
<td>Follow OAA targeting criteria 701S optional - The 701S generates a priority score and rank.</td>
<td>Follow OAA targeting criteria 701S optional – If the 701S is used to maintain the OAA APCL, then it must be completed annually to maintain the APCL status.</td>
</tr>
<tr>
<td>APCL LSP</td>
<td>Follow program criteria used to implement the specific LSP project (either CCE or OAA criteria apply)</td>
<td>Follow program criteria used to implement the specific LSP project (either CCE or OAA criteria apply)</td>
</tr>
<tr>
<td>APCL SMMC LTC and ACTV ADI, CCE, and HCE</td>
<td>701S, 701B</td>
<td>701S annually and 701B annually by case manager</td>
</tr>
<tr>
<td>APCL ADI, CCE, HCE and ACTV OAA C1</td>
<td>701S</td>
<td>701S annually and 701C annually</td>
</tr>
<tr>
<td>APCL OAA registered services and ACTV OAA C1</td>
<td>701C or optional 701S</td>
<td>701C annually or optional 701S</td>
</tr>
<tr>
<td>Screening and Assessment Summaries</td>
<td>701B</td>
<td>701B annually by case manager</td>
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<tr>
<td>---------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>APCL for any program and ACTV in ADI, CCE, or HCE</td>
<td></td>
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<tr>
<td>APCL for any program and ACTV in OAA receiving a registered service</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>APCL for any program or ACTV OAE3G and ACTV in OA3E receiving at least one service that requires client specific reporting</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV ADI, CCE, HCE, SMMC LTC</td>
<td>701B</td>
<td>701B annually</td>
</tr>
<tr>
<td>ACTV any Department funded program (including OAA or LSP) and receiving Case Management</td>
<td>701B</td>
<td>701B annually</td>
</tr>
<tr>
<td>ACTV OAA receiving registered service(s)</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV O3C2</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV OAA C1 only</td>
<td>701C</td>
<td>701C annually</td>
</tr>
<tr>
<td>ACTV OAA receiving registered service and ACTV OA3E</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV OAA receiving registered service and ACTV OAA C1</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV OA3E receiving at least one service that requires client specific reporting only</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV OA3EG</td>
<td>701A</td>
<td>701A annually</td>
</tr>
<tr>
<td>ACTV LSP, if case managed</td>
<td>701B</td>
<td>701B annually</td>
</tr>
<tr>
<td>ACTV LSP, not case managed</td>
<td>Follow OAA criteria</td>
<td>Follow OAA criteria</td>
</tr>
</tbody>
</table>
INAKE 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.

   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. It may be completed over the phone or in person.

   c. An attempt to contact the individual with the goal to complete a 701S is made within three business days after receipt of a client referral. 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 conducting 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).
APCL MAINTENANCE AND PRIORITIZING ENROLLMENT OF NEW CONSUMERS:

A. Assessed Priority Consumer List (APCL)

1. APCL is maintained in the CIRTS when SMMC LTC services or services funded by Department are not available.

2. Potential consumers or referring parties must be:

   a. Informed about the assessed priority consumer lists;

   b. Provided suggestions regarding other agencies or sources of assistance, including Medicaid, Food Assistance (formerly known as Food Stamps), and private pay options; and

   c. Provided contact information and encouragement to call for re-screening if their situations change.

3. Screening of potential consumers must be performed by trained and certified staff.

4. Information for consumers waiting for SMMC LTC or DOEA-funded services is entered in the CIRTS enrollment screen with the program status of APCL.

5. The priority score and rank are automatically generated in CIRTS.

6. Only one APCL is maintained for SMMC LTC and/or each DOEA-funded program in each Planning and Service Area.

B. Consumer Enrollment on an APCL

1. Individuals enrolled on an APCL will be screened using DOEA Form 701S.

2. Individuals may be enrolled on an APCL for more than one program after consideration of consumer need, program eligibility and targeting requirements.
3. Regarding consumers receiving case management and dually enrolled (in ADI, CCE, HCE, LSP, or OAA) with CIRTS Enrollment Screen program status codes set to “APCL” and “ACTV”:

   a. Consumers, regardless of priority score or rank, will be assessed by the case manager annually using 701B.

   b. Case managers have the responsibility to conduct semi-annual care plan reviews and annual reassessments. If case management is provided under LSP, then the requirements are the same as those for other DOEA-funded case managed consumers. If case management is not provided, then OAA requirements apply.

   c. 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 and/or Income. The new assessment will reflect a priority score and rank on the APCL.

4. Consumers with a CIRTS Enrollment Screen program status code set to “APCL” and not enrolled or receiving services are re-screened annually by the ADRC using Form 701S.

5. Regarding consumers receiving one or more OAA registered services with CIRTS Enrollment Screen program status codes set to “ACTV” for OAA and “APCL” for any other DOEA-funded program:

   a. Consumers, regardless of priority score or rank, will be reassessed annually using the 701A. As noted, this also applies to LSP if the service providers operate under OAA requirements.

   b. Consumers enrolled in OAA or LSP for Congregate Meals or Nutrition Counseling, and on the APCL for another DOEA-funded program, must be re-screened annually using Form 701S. The 701S will generate a nutrition risk score when the nutrition section of the 701S is completed, after the person answers question 28, “Do you need other assistance for food?”. The nutrition section is required when the person answers “Yes” to the question “Do you need other assistance for food?”. The nutrition section is optional when the person answers “No” to the question “Do you need other assistance for food?”. Since the 701C will only generate a nutrition risk score, it cannot be used for APCL management for other DOEA funded programs.
c. 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.

6. Regarding consumers who were screened using Form 701S, are released from the APCL and assessed using 701B:

a. ADI, CCE and HCE applicants may continue with program enrollment regardless of the 701B priority score or rank.

b. 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.

7. When a consumer is no longer waiting for services, the program status code must be appropriately modified to termination. Termination from the APCL occurs when a person is no longer interested in waiting for services, is no longer able to receive services, begins receiving services, or begins the eligibility process.

C. Consumer Enrollment in DOEA-funded Programs to Receive Services

Consumer enrollment in DOEA-funded programs is based on available funding, specific program eligibility, targeting, and prioritization criteria as stated in law, rule and DOEA contracts.

1. **OAA:** OAA targeting and program eligibility requirements apply to consumers enrolled in OAA Title IIB (supportive services), Title IIIC (nutrition services), Title IID (preventive health services) and Title IIIE (caregiver services).

2. **CCE:** Pursuant to Section 430.205(5), F.S. Adult Protective Services referrals in need of immediate services to prevent further harm will be given primary consideration for receiving services in the CCE program. APS high-risk clients (Priority 8) must receive case management and crisis-resolution services within 72 hours of the APS referral per DOEA policy.
3. **ADI, CCE, HCE, and LSP:** Approval to begin the eligibility process for ADI, CCE, HCE, and LSP is determined by the availability of funds and the priority score or rank of individuals. The order of priority (except for CCE APS high risk referrals) is as follows:

   a. Individuals designated as Imminent Risk (Priority 7) of being placed in a nursing home (including individuals designated as Aging Out).

   b. Individuals designated as Aging Out (Priority 6); and

   c. Individuals with the highest priority score starting with individuals with a priority score or rank of 5.

4. **CCE:** Clients identified through the assessment as potentially Medicaid eligible are required to be screened for Medicaid services by the ADRC.

5. Approval to begin the eligibility process for SMMC LTC is authorized by the Department’s notification of an EMS release to the ADRCs.
CASE MANAGEMENT REQUIREMENT:

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.

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PURPOSE AND GOALS OF CASE MANAGEMENT:

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.

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.
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:

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.

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

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.
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:
      1. Refuses to continue services; or
      2. 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.
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:

A. 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 client’s immediate community.
2. **Major Duties:** Case managers’ major duties are as follows:

a. **Client Assessment:** After the new client is screened 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. 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.

b. **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.
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.

### B. 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.
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.

3. **Provider Qualifications:**
   a. Minimum qualifications for case aides include a high school diploma or General Educational Development (GED) diploma.
DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 2: Intake, Screening, Prioritization, Assessment, and Case Management

Service Requirements

Case Management Requirement:
Job Description Inclusion Requirements

b. Job related experience may be substituted for a high school diploma or GED diploma upon approval of the AAA.

C. Case Manager Supervisor:

1. Major Duties: Case manager supervisor’s major duties are as follows:

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.

i. Respite Care: Ensures that respite care is arranged for caregivers as needed.
### Service Requirements

<table>
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<tr>
<th>Case Management Requirement:</th>
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<tbody>
<tr>
<td>Job Description Inclusion Requirements</td>
</tr>
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</table>

| 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.
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.
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;
   
   e. Loss of spouse, family member or close friend; or
   
   f. Loss in income.
### 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).

### 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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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. (Refer to Section 5 of this chapter—Case Record for more information on confidentiality).
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 0-105, with the lowest value being Rank 1.

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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. Confidentiality: Every caution shall be taken to protect client confidentiality. Only necessary information (e.g., medical history for health services) must be communicated to agencies involved in the care plan. All HIPAA regulations (the federal Health Insurance Portability and Accountability Act of 1996) will be followed always.
F. **Client-Centered Care Planning:** Case managers shall perform the following client-centered tasks regarding care planning:

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.

G. **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.

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.

2. **DOEA Funded Services:** Other services come from the service providers in the local community care service system, which are funded through the Department.

3. **Resource Directory:** The case manager should have access to a local community care service system resource directory to assist in selecting and arranging for services.

4. **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.

H. **Care Plan Format:** Refer to Attachment 4 of this chapter for instructions on development of the care plan.

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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.
B. **Care Plan Update to Case Narrative:** The case manager’s responsibilities for case narrative are as follows:

1. **Address Goals:** Address each problem/gap 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.
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.

   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.
CASE RECORD:

PURPOSE OF CASE RECORD:

A. Case Record Purpose: 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. 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.

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.

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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. **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.

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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.

   b. If services were delayed or not provided, the reason why must be stated and all actions taken to provide service must be recorded.

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.

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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.
**RETENTION OF CASE RECORDS:**

Client case records shall be retained for a period of six (6) years after case closure or longer, if required by federal regulations.

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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 Sections: Case narratives shall consist of the following two sections:

A. Section 1—Contact Summary: The following information shall be included in the contact summary:

1. Date of Contact
2. Type of Contact:

<table>
<thead>
<tr>
<th>Contact</th>
<th>Abbreviation</th>
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<tbody>
<tr>
<td>a. Office Visit</td>
<td>OV</td>
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<tr>
<td>b. Telephone Call</td>
<td>TC</td>
</tr>
<tr>
<td>c. Field Visit</td>
<td>FV</td>
</tr>
<tr>
<td>d. Home Visit</td>
<td>HV</td>
</tr>
</tbody>
</table>

3. Staff Name: Name of staff making the contact and person contacted.

B. 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.

4. **Service Barriers:** Problems encountered in service delivery.

5. **Special Circumstances:** Unique circumstances affecting the case.

6. **Semiannual Contacts:** Each active problem listed in the care plan addressed for each client semiannual 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.

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. **Semiannual 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.
GRIEVANCE PROCEEDINGS:

Please refer to Appendix D, “Minimum Guidelines for Recipient Grievance Procedures” included in this Handbook.

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### ABBREVIATIONS FOR TERMS USED IN THE CASE MANAGEMENT PROGRAM COMPARISON MATRIX

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Stands for</th>
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<tbody>
<tr>
<td>ADI</td>
<td>Alzheimer's Disease Initiative</td>
</tr>
<tr>
<td>ADLs</td>
<td>Activities of Daily Living</td>
</tr>
<tr>
<td>IADLs</td>
<td>Instrumental Activities of Daily Living</td>
</tr>
<tr>
<td>CCE</td>
<td>Community Care for the Elderly</td>
</tr>
<tr>
<td>HCE</td>
<td>Home Care for the Elderly</td>
</tr>
<tr>
<td>ICP</td>
<td>Institutional Care Program</td>
</tr>
<tr>
<td>LSP</td>
<td>Local Service Program</td>
</tr>
<tr>
<td>NH</td>
<td>Nursing Home</td>
</tr>
<tr>
<td>OAA</td>
<td>Older Americans Act</td>
</tr>
<tr>
<td>QMB</td>
<td>Qualified Medicare Beneficiary</td>
</tr>
<tr>
<td>SLMB</td>
<td>Special Low-Income Medicare Beneficiary</td>
</tr>
<tr>
<td>SSI</td>
<td>Supplemental Security Income</td>
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## Program Service Requirements

**Attachment 1: Case Management Program Comparisons**

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<td>Include client, caregiver, and case manager signatures.</td>
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<td>Update at next semiannual visit for changes.</td>
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<td>List frequency and duration of case management as a service.</td>
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<td><strong>For case managed clients, follow the standards for CCE.</strong></td>
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### Program Service Requirements

#### Attachment 1: Case Management Program Comparisons

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<th>PROGRAM</th>
<th>CASE NARRATIVE</th>
<th>FORMS</th>
<th>GRIEVANCE</th>
<th>HANDBOOK</th>
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| 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 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 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 |
| 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 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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Follow the service provisions as specified in the contract agreement.
## Attchement 1: Case Management Program Comparisons

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### CARE PLAN

**CONSUMER:**  
**SOCIAL SECURITY NUMBER:** ____________________________  
**CASE MANAGER:** ____________________________  
**PROVIDER:** ____________________________  
**WORKER ID:** ____________________________

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<tr>
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<th>Non-DOEA (ND) / DOEA (D) Planned</th>
<th>Provider: Non-DOEA (ND) / DOEA (D)</th>
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I have participated in developing this care plan through discussions 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:** ____________________________

*DOEA Form 203A, July 2017*
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CARE PLAN INSTRUCTIONS

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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 client care 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 addressing 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, and the expected outcome.

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 DOEA and non-DOEA funded services and activities, and

   e. Be for a specific time, addressing short-term as well as long-term problems.

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B. The Four Steps in Developing a Care Plan:

1. Use the assessment information;

2. Actively involve the client, caregiver and/or designee and existing support systems;

3. Apply professional knowledge and judgment in using all community and family resources, and

4. Apply client choices and reflect the client’s preferences.

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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;
- c. Supports the client currently has in place, as well as current and potential service gaps;
- d. Caregiver issues, and
- e. Environmental issues.

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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.

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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;

   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 and the phone book, and

   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.
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 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.

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 and achievement of specific goals.

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, 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.
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. Worker ID

   The worker identification code links the user’s ORACLE ID with a provider name and validates the user’s access to different screens in CIRTS. A Worker ID must be entered for each person who needs access to CIRTS.
6. Care Plan Date:

The date the care plan form is prepared is a reference point for determining semiannual 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 CIRTS, at the time of reassessment.

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.

7. 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 on the care plan, and address them in the case narrative.

3. Challenges and barriers indicated in the assessment help to explain why the problem exists.

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 F 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.

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 and Duration:

1. Record the frequency and duration 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.
   b. Duration is how long a service will be provided.
      i. Services are planned for however long they are needed.
         ii. Case management can be planned for a year.
      iii. Other ongoing services can be planned for six months up to a year, since care plans are reviewed semiannually and annually.
      iv. Services required temporarily or short-term should be planned for shorter periods, such as six weeks to three months.

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 and duration 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 and duration 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.

v. Thus, recognize unmet needs on the care plan and document them in the case narrative.

vi. Document all efforts to secure non-DOEA funded services in the case narrative.

vii. Enter the begin date and end date for needed and planned services.

viii. The begin date for needed services must be equal to or prior to the begin date of planned services.

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. Specify a duration of three months or less, if it appears the client’s situation may be temporary.

c. Record permanent changes to the care plan on the form and enter them in CIRTS.

4. Document on the care plan and 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 or duration are being made.

F. Desired Outcomes:

1. Enter ST (short-term) or LT (long-term) in the “Desired Outcome” box of the care plan.

a. The desired outcome is established for the client based upon the individual’s overall status, not select problems.
b. In most situations, the desired outcome is either short-term or long-term.

c. In some instances, it is appropriate to enter both ST and LT in the Desired Outcome box because the individual’s overall situation requires varying degrees of assistance.

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.

   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 bath tub, but also allow the person to be as active as possible.

4. **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 Services Programs (LSP), Respite for Elders Living in Everyday Families (RELIEF) and Long-Term Care Ombudsman Council (LTCOC). The provider refers to the source and the funding method.

2. The following are some examples:

a. **Non-DOEA Funded: Example:**

   - Family and friend: Granddaughter, niece, son, neighbor
   - Local government and Commissioners, taxing entities: Board of County Government, County Taxing District (Health Care Taxing District in Palm Beach), Medicare, Medicaid
   - City Resources, City
**Department of Elder Affairs Programs and Services Handbook**  
Chapter 2: Intake, Screening, Prioritization, Assessment and Case Management

**Attachment 4: Care Plan Instructions**  
Completing the Care Plan Form

<table>
<thead>
<tr>
<th>Associations/Religious/Other</th>
<th>American Diabetes Association, Lutheran Social Services, United Health Maintenance Organization, Volunteer, IBM Corporation, Employee Assistance Program, Private Insurance</th>
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<tbody>
<tr>
<td>Other Non-Profit/Other</td>
<td>United Way, Habitat for Humanity, Food Bank</td>
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<tr>
<td>Long-term Insurance</td>
<td>Benefits covered under long term care</td>
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**b. DOEA Funded Provider:**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Funding Source</th>
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<tbody>
<tr>
<td>Older Americans Act (OAA)</td>
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<tr>
<td>Community Care for the Elderly (CCE)</td>
<td>State</td>
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<tr>
<td>Alzheimer’s Disease Initiative (ADI)</td>
<td>State</td>
</tr>
<tr>
<td>Home Care for the Elderly (HCE)</td>
<td>State</td>
</tr>
<tr>
<td>Local Services Program (LSP)</td>
<td>State</td>
</tr>
<tr>
<td>Respite for Elders Living in Everyday Families (RELIEF)</td>
<td>State</td>
</tr>
<tr>
<td>Serving Health Insurance Needs of Elders (SHINE)</td>
<td>Federal</td>
</tr>
</tbody>
</table>

**c.** Assistance may be needed immediately, but not for an extended period.

**H. Date Services Began (B) 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. Enter 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. Enter the date and “RV” when a problem, frequency or duration, 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 in the unit cost column.
   a. The approved rates are based upon those included and approved in the area plan.
   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 CIRTS 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. Monthly Cost/Value:

1. Enter the amount derived from the unit rate multiplied by the planned frequency for costs of DOE-funded services and activities and for values of non-DOE funded services and activities.

2. Record the letter, “c” (cost) or “v” (value) beside the amount entered.

3. Update this information as services begin, end or their frequencies or unit costs change.

4. Necessary changes should be made in CIRTS at least annually.

L. DOEA-Funded Monthly Care Plan Cost: Enter the total amount for all DOE-funded care plan services documented in the Monthly Cost/Value column.

M. Annualized DOEA-Funded Care Plan Cost: Multiply the number of units planned per week by 52 weeks per year, by the unit cost. Add the total cost of individual periodic purchasing to the annualized care plan cost.

N. Non-Annualized DOEA-Funded Care Plan Cost:

1. Enter the cost of individual purchasing episodes documented in the “Unit Cost/Individual Purchase” column, then show on the plan as the non-annualized DOEA-funded care plan cost.

2. An example of an individual purchasing episode is the repair of a roof or the purchase of a washing machine.
3. Include HCE special subsidy purchases not made monthly.

O. **Co-Pay Monthly Amount:** Multiply the monthly co-pay amount by twelve, i.e., $27.00 \times 12 = $324.00.

P. **Annualized Non-DOEA Funded Resource:**

1. Enter the total amount for all non-DOEA funded care plan services documented in the Monthly Cost/Value column.

2. The costs of non-DOEA funded sources are not incurred by the state or federal government elderly programs. Thus, non-DOEA funded costs are shown separately.

3. Non-DOEA funded costs provide crucial information, indicating the value of the agency’s use of other resources.

Q. **Non-Annualized Non-DOEA Funded Resource:** Enter the value of contributed individual periodic purchasing documented in the Unit Cost/Individual Purchase column, then add the value to the annualized non-DOEA funded resource.

R. **Care Plan Total:** Enter the total amount of the care plan, including costs, value of resources and the co-pay amount.

S. **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.
   
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:

Method One:

A. Long-Term Problems:

Use one page for each long-term problem, (a page per problem).

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.

2. Each change or update is shown on a new line of the care plan form.

B. Short-Term Problems:

Use another page to list short-term problems (i.e. 3 to 6 months).

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.

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.
Method Two:

A. List each problem (short or long-term) on one page in chronological order, including information from the assessment summary related to its challenges and barriers, and the client’s coping skills and adaptability.

B. Any revisions will also be included chronologically.

C. When revising a care plan, using this method:
   a. Identify every new entry with the problem number of the original problem statement.
   b. Record a date for each revision followed by “RV” in the “Date Problem Resolved or Revised” column.
   c. If the problem is resolved, record the date of resolution and “RS.”

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.
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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I. 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 CIRTS at least annually.

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II. 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:

1. 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.

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.
CASE RECORD:

A. 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.
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.

**B. Standards for Case Records Maintenance:**

1. Client records must be stored in a locked file at the agency.

2. The client must be informed that information collected about the client is required for service provision; the information will be treated in a confidential manner; and will be protected from loss, defacement, or unauthorized access.

3. The client and the caregiver should be told that case record information is available for their review and for the review of individuals they authorize.

4. After case closure, client records shall be retained for a period of six years or longer, if required by federal regulations.

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VIII. 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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Chapter 3

Description of DOEA Coordination with Other State and Federal Programs
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**OVERVIEW:**

The programs referred to in this chapter are grant-funded programs, programs that are funded through specific appropriation, and/or programs whose funding and rulemaking authority are not under the jurisdiction of the Department of Elder Affairs (DOEA). In such cases, DOEA participates as a partner in these programs. What follows is a summary of these programs with references where more detailed information may be obtained. Information about these programs may also be found on the DOEA website at [http://elderaffairs.state.fl.us](http://elderaffairs.state.fl.us).

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| 1. SMMC LTC                 | • Section 1915(a), (b), (c) of the Social Security Act as amended  
|                             | • Part IV of Chapter 409, F.S.                                |
| 2. PACE                     | Federal Balanced Budget Act of 1997  
|                             | 42 CFR 460  
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| I. SCSEP                    | • Title V of the Older Americans Act  
|                             | • 42 U.S.C. 3001 et seq. as amended by  
|                             | Public Law 106-501                                           
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|                             | • Section 430.07, F.S.                                       |
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ADULT CARE FOOD PROGRAM:

The Adult Care Food Program is a component of the United States Department of Agriculture’s (USDA) Child and Adult Care Food Program. The program provides meal reimbursement for up to three meals/snacks served to eligible participants in approved adult day care facilities or other eligible facilities.

Centers eligible to receive meal reimbursement include the following:

- Licensed Adult Day Care Centers and public or proprietary centers (Proprietary centers must receive Medicaid Title XIX funding for at least 25% of their participants.);
- Mental Health Day Treatment or Psychosocial Centers;
- In-Facility Respite Centers under contract with Department-funded programs;
- Habilitation Centers approved by the Department of Children and Families, operated by a municipal, county, state, or federal government agency;
- Private non-profit organization federally tax-exempt institution (have tax-exempt status under the Internal Revenue Code of 1986); or
- For-profit organizations (must receive compensation under Title XIX Medicaid Program) of the Social Security Act.

Additionally, at least 25% of enrolled participants of a for-profit organization must receive Title XIX benefits.

Centers may be reimbursed for up to three meals per participant per day. Allowable feeding combinations include:

- Two meals (breakfast, lunch, or supper) and one snack; or
- One meal (breakfast, lunch, or supper) and two snacks

The goal of the program is to assist eligible organizations providing elders and functionally impaired adults with nutritious and wholesome meals within a community-based setting. The meals are provided to improve the nutritional status of participants and better enable them to remain in their homes and community.
AMERICORPS:

AmeriCorps is a network of national service programs that engages a multi-generational corps of members (volunteers) who receive a living allowance and commit to one year of service in exchange for an education award. Members serve on a full-time, part-time or quarter- time basis annually for 1,700 hours, 900 hours and 450 hours, respectively. AmeriCorps programs recruit members and community volunteers for intensive service to meet critical needs in education, public safety, health and the environment. AmeriCorps services provided by the Department include respite, education and community outreach to elders, caregivers and families.

The Department receives funding for the Legacy Corps program from the University of Maryland, Department of Health Services Administration, through a National Direct AmeriCorps grant from the Corporation for National and Community Service (CNCS). DOEA partners with Easter Seals South Florida for the Legacy Corps program, which focuses on in-home respite services for low-income seniors with Alzheimer's Disease or related disorder, with an emphasis on serving veterans. This project area was selected by the University of Maryland because of the local Hispanic demographic. The contract was granted to Easter Seals South Florida, based on its interest and ability to recruit, train and retain AmeriCorps members and community volunteers. The Department provides grant oversight, contract management and technical assistance to the local service provider ensuring all AmeriCorps service provisions, contractual obligations and programmatic and financial reporting requirements are met.

AmeriCorps grants are authorized by the National and Community Service Act of 1990, as amended, and Section 430.07(8), Florida Statutes. Grantees must comply with the requirements of the Act and its implementing regulations. Grantees must also comply with the applicable federal and state cost principles, administrative requirements, and audit requirements as outlined in the program contract and AmeriCorps Program Director’s Manual.
COMPREHENSIVE ASSESSMENT AND REVIEW FOR LONG-TERM CARE SERVICES (CARES):

The CARES Program performs federally mandated functions for Medicaid long-term care programs and is administered by the Agency for Health Care Administration through an interagency agreement with DOEA. The primary responsibilities of the CARES Program are:

1) To conduct pre-admission screening on all nursing facility applicants age 21 and older for the presence of serious mental illness or intellectual disability.

   This pre-admission screening program is called PASRR (Pre-Admission Screening and Resident Review). CARES must ensure that long-term care services are provided in the setting most appropriate to the needs of the person and that premature institutionalization is prevented. CARES must also ensure that specialized services are provided to those individuals who require specialized services. Pre-admission screening is conducted by CARES registered nurses and/or social workers.

2) To determine medical eligibility for adults applying for Medicaid to pay for the cost of nursing facility care or home and community-based services.

   CARES registered nurses and/or social workers conduct comprehensive assessments and medical review of applicants to determine the medical level of care needed for the applicant. Recommendations for level of care are reviewed by physicians and/or registered nurses prior to approval.

   CARES determines medical eligibility for the following Medicaid programs:

   - Adult Cystic Fibrosis Waiver
   - Familial Dysautonomia Waiver
   - Institutional Care Program
   - Project Aids Care Waiver
   - Program of All-Inclusive Care for the Elderly (PACE)
   - Statewide Medicaid Managed Care Long-Term Care Program
   - State Mental Health Hospital Program
   - Traumatic Brain and Spinal Cord Injury
3) To assist the elderly and adults with disabilities by working closely with several Florida state agencies:
   - The Department of Children and Families - The agency responsible for determining Medicaid financial eligibility for nursing facility and home and community-based services. They also oversee the state mental health program.
   - The Agency for Persons with Disabilities – The state intellectual disability authority.
   - The Agency for Health Care Administration - The single state agency for Medicaid.

4) To provide education and training on CARES functions to members of the Aging Network or to the public upon request.
EMERGENCY HOME ENERGY ASSISTANCE FOR THE ELDERLY PROGRAM (EHEAP):

A. The Emergency Home Energy Assistance for the Elderly Program (EHEAP) is funded by the U.S. Department of Health and Human Services (HHS) through a contract with the Florida Department of Economic Opportunity (DEO) to assist low-income households, with at least one person aged 60 or older, experiencing a home energy emergency.

B. DOEA administers the program through contracts with Area Agencies on Aging (AAAs).

C. These funds are intended to make payments to utility companies and fuel suppliers for heating and cooling purposes; for the purchase of blankets, portable heaters, fans, and air conditioners; for the repair or replacement of existing heating or cooling equipment; or the payment of deposits, late fees, disconnect and reconnection fees, for the provision of temporary emergency shelter, and for resolution of other heating and cooling emergencies. Eligible households may be provided one benefit per season, payable to the vendor.

D. In the event of a weather-related/supply shortage event, additional assistance may become available if authorized by the President, the Governor, or DEO.

E. Monitoring, training and technical assistance are performed by DOEA and AAA staff.
Other Program Components | Local Service Program

**LOCAL SERVICES PROGRAM:**

Local Services Program provides additional funding to expand long-term care alternatives enabling elders to maintain an acceptable quality of life in their own homes and avoid or delay nursing home placement.
LONG-TERM CARE OMBUDSMAN PROGRAM:

The Florida Long-Term Care Ombudsman Program (LTCOP) performs investigations to determine the presence of conditions which constitute a threat to the rights, health, safety, or welfare of the residents of long-term care facilities through a statewide system of 13 districts which are under the leadership of the State Ombudsman.

Ombudsmen identify, investigate and resolve complaints made by, or on behalf of, residents of nursing homes, assisted living facilities and adult family care homes. In addition, the program:

A. Monitors and comments on the development and implementation of federal, state and local laws, regulations and policies that pertain to the rights, health, safety, and welfare of residents in long-term care facilities;

B. Provides information and referrals regarding long-term care facilities or other issues affecting long-term care residents;

C. Conducts administrative assessments of all long-term care facilities annually. The assessment focuses on factors affecting the rights, health, safety and welfare of residents; and

D. Helps with the development of resident and family councils to protect the residents’ well-being.

The Long-Term Care Ombudsman Program is administratively housed within DOEA.

Anyone may report a concern on behalf of a resident of a long-term care facility—nursing home, assisted living facility or adult family-care home. Concerns may also be received on behalf of residents living in facilities offering extended congregate care. There is no fee for any ombudsman service, and there are no financial or residency requirements for those reporting concerns to the program.
MEDICAID HOME AND COMMUNITY-BASED SERVICES (HCBS) PROGRAMS:

Medicaid waiver and similar programs are home and community-based programs designed to allow individuals to attain or maintain their highest practicable physical, mental, and psychosocial well-being, and live in the least restrictive environment possible. Florida’s Agency for Health Care Administration (AHCA) is the single state Medicaid agency designated by the Centers for Medicare and Medicaid Services (CMS) with responsibility for Medicaid programs.

Through cooperative agreements with AHCA, DOEA is partially responsible for monitoring the Statewide Managed Medicaid Care program (SMMC), and wholly responsible for that of the PACE program, both detailed as follows:

A. Long-term Care (SMMC LTC).

1. **Description**: The SMMC provides home- and community-based services and nursing facility services to older persons (65+) and disabled individuals (ages 18-64) who need nursing facility level care.

2. **Eligibility**: Persons must meet the age, income, and asset and medical eligibility criteria of individuals seeking Medicaid assistance for nursing homes.

3. **Services Provided**: Adult Companion Services; Adult Day Health Care, Assisted Living, Attendant Nursing Care, Case Management, Home Accessibility Adaption, Home Delivered Meals, Homemaker, Hospice, Intermittent and Skilled Nursing, Medical Equipment and Supplies, Medication Management, Nursing Facility, Nutritional Assessment/Risk Reduction, Personal Care, Personal Emergency Response System, Respite Care, Therapies (Occupations, Physical, Respiratory, and Speech), Non-Emergency Transportation. For further information, please refer to the AHCA’s web site at [http://ahca.myflorida.com/smmc](http://ahca.myflorida.com/smmc).
B. Program of All-Inclusive Care for the Elderly (PACE):

1. **Description:** The Program of All-Inclusive Care for the Elderly (PACE) is implemented through a joint effort between the Centers for Medicare and Medicaid Services and the state. PACE targets individuals who would otherwise qualify for Medicaid nursing home placement and provides them with a comprehensive array of home and community-based services.

   a. PACE Organizations receive both Medicare and Medicaid capitated payments and are responsible for providing the full continuum of medical and long-term care services.

   b. PACE Organizations also receive an enhanced capitation payment from Medicare for their enrollees with Medicare.

   c. PACE has a unique service delivery system, with many services being delivered through adult day care centers, and case management provided by inter-disciplinary teams.

2. **Services Provided:** In addition to services covered under SMMC LTC, the PACE project covers all medically necessary services as determined by the applicable interdisciplinary team, not just those covered by Medicaid/Medicare.

3. **Eligibility:** To be eligible for PACE, an individual must be age 55 or older, eligible for Medicare or Medicaid with income and assets up to the Institutional Care Program (ICP) level, meet ICP medical eligibility criteria and live in the PACE service area.

4. For further information, please refer to DOEA's web site at http://elderaffairs.state.fl.us/index.php
Other Program Components                                Senior Community Service Employment Program (SCSEP)

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM (SCSEP):

The Senior Community Service Employment Program (SCSEP) is a program administered by the Department of Labor that serves unemployed, low-income persons who are 55 years of age or older and who have poor employment prospects. The program trains them in part-time community service assignments and assists them in developing skills and experience to facilitate their transition to unsubsidized employment.

The program has three purposes:

A. To foster and promote useful part-time opportunities in community service assignments for unemployed low-income persons who are 55 years of age or older, particularly persons who have poor employment prospects;

B. To foster individual economic self-sufficiency; and

C. To increase the number of older persons who may enjoy the benefits of unsubsidized employment in both the public and private sectors.

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**SENIOR CORPS-SENIOR COMPANION PROGRAM:**

The Senior Companion Program is a national community service peer-volunteer program. Senior Companion volunteers provide services to elders at risk of institutionalization due to chronic illnesses, disabilities or isolation. Low-income volunteers receive a stipend to help defray expenses, a local transportation reimbursement, and an annual medical checkup. Volunteers are 55 years of age or older who meet 200% of the Department of Health and Human Services poverty guidelines, to conform to the Edward M. Kennedy Serve America Act of 2009. The volunteers receive a $2.65/hour stipend to defray expenses of volunteering at least 15 hours a week. The stipend does not affect the volunteer’s eligibility for any government assistance programs and provides volunteers an opportunity for improved health because of volunteering, as well as additional funds to assist with personal expenses, such as food and prescription medications. Recipients of Senior Companion volunteer services are elders, 60 years of age or older, who are at risk of institutionalization due to chronic illness, disability or isolation.

The Corporation for National and Community Service awards the Senior Companion grant to the Department and specifies the number of Volunteer Service Years (annual hours to be served) that will be funded. Local government agencies and not-for-profit organizations are selected based on their ability to recruit and retain the necessary number of volunteers, as well as provide required local match funding.

The Senior Companion grant is authorized by and subject to the National and Community Service Act of 1990 as amended, codified as 42 U.S.C. 12501 *et seq.* and 45 C.F.R. 1207 and 2551 *et seq.* Grantees must comply with the requirements of the Act and its implementing regulations. Grantees must also comply with the applicable federal and state cost principles, administrative requirements, and audit requirements as outlined in the DOEA contract and Senior Companion Operations Handbook.
SERVING HEALTH INSURANCE NEEDS OF ELDERS (SHINE):

SHINE (Serving Health Insurance Needs of Elders) is a program offered by DOEA in partnership with the local Aging and Disability Resource Centers (ADRC) at no cost to the beneficiary, their families and caregivers. Specially-trained volunteers can help clients with the following services:

- Help a client understand their Medicare benefits;
- Determine which Medicare Prescription Drug Plan best fits a client’s needs;
- Assist with questions about Medigap, long-term care insurance policies, and other health insurance programs for seniors;
- Assist Medicare beneficiaries in specific areas such as home health benefits, Medicare claims and appeals, and other Medicare issues;
- Provide details about benefits available in a client’s local area and refer them to other helpful programs; and
- Offer educational presentations or public speeches on a variety of health insurance topics.

SHINE is part of the National State Health Insurance Assistance Program (SHIP) network.

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OFFICE OF PUBLIC AND PROFESSIONAL GUARDIANS (OPPG):

The Office of Public and Professional Guardians (OPPG), formerly the Statewide Public Guardianship Office was established by the Legislature to provide for the establishment of offices of public guardians for providing guardianship services for incapacitated persons when no private guardian is available. On March 10, 2016, the Legislature expanded the duties to include oversight and discipline of professional guardians.

Guardianship is the process designed to protect and exercise the legal rights of individuals who lack the capacity to manage at least some of their property, or to meet at least some of the essential health and safety requirements of the person. Before a guardianship is established, it must be determined that the alleged incapacitated person lacks the capacity to make decisions. Guardianship should be the last resort.

People who need guardianship may have the following conditions:

A. Dementia;

B. Alzheimer's disease;

C. A developmental disability;

D. Chronic illness; or

E. Other such conditions that generally cause functional limitations, such as traumatic brain injury or mental health disability.

The purpose of the Public Guardianship Act is to provide a public guardian only to those persons whose needs cannot be met through less drastic means of intervention. The Office of Public and Professional Guardians designates Florida’s public guardians, who serve indigent persons who lack the ability to make their own decisions and have no willing or qualified family or friend to act as their guardian. In 2013, the public guardianship program expanded to cover all of Florida’s 67 counties. A current list of public guardians and the counties served is located on the Office of Public and Professional Guardians’ web page at: http://elderaffairs.state.fl.us.
In addition, the Office of Public and Professional Guardians is responsible for the registration, oversight and discipline of all professional guardians. The annual registration of professional guardians includes documentation of the statutory bonding and educational requirements, as well as receipt and review of credit and criminal investigations. The Office of Public and Professional Guardians is responsible for communicating with the courts and advising them of the registration compliance of every professional guardian. With the expanded duties given by the legislature, the Office of Public and Professional Guardians is responsible for investigation of all allegations of misconduct by a professional guardian. A guardian found to have taken actions determined by statute and the Department as misconduct will be subject to disciplinary action, ranging from expanded education and monitoring, to removal of registration statewide.

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Chapter 4

Title III and Title VII of the Older Americans Act (OAA)
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Purpose and Goal of the Title III and Title VII of the Older Americans Act Program and Services

**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 nine (9) separate sections with similar headings. These sections are as follows:

A. Section 1: General Policies
B. Section 2: Area Agencies on Aging
C. Section 3: Service Providers
D. Section 4: OAA, Title IIIB—Supportive Services
E. Section 5: OAA, Title III C—Nutrition Program Policies
F. Section 6: OAA, Title III D—Disease Prevention and Health Promotion Services Program
G. Section 7: OAA, Title VII—Vulnerable Elder Rights Protection Activities
H. Section 8: OAA, Title III B—Multipurpose Senior Centers
I. Section 9: OAA, Title III E—National Family Caregiver Support Program
SERVICES PROVIDED THROUGH TITLE III AND VII OF THE OLDER AMERICANS ACT PROGRAMS:

The services provided through the Older Americans Act Title III and Title VII programs are outlined in this chapter under “Service Requirements” in nine (9) separate sections as referenced on the previous page under legal basis and specific legal authority.
SERVICE REQUIREMENTS:

Purpose of Title III of the Older Americans Act and Legal Authority

SECTION 1 - GENERAL POLICIES

PURPOSE OF 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 to:

   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.
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.
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
3. Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, Union
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 DOEA 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.
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.

F. At a minimum, such procedures shall include:
   1. Providing notice of an action to withhold funds;
   2. Providing documentation of the need for such action; and
   3. Conducting a public hearing concerning the action at the request of the AAA.

G. 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 H, below.

H. 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 G above, the Department may extend the period for not more than 90 days.

I. 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.
J. The procedures described in Section I above shall include:

1. Providing notice of an action or proceeding described in Section I;

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 on Aging (AoA).
DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 4: Older Americans Act

Service Requirements: Section 1 – General Policies

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.
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.
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
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 AoA.

E. If the AAA requests a hearing, DOEA shall withhold rescinding designation until the hearing decision is rendered.
**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 for AoA under 45 CFR 1321, if requested by the Department.
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.
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.

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 CIRTS 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 CIRTS 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.
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.
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 Operations Manual Instructions.
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.
INFORMATION AND ASSISTANCE:

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 for appropriate referral to the agency best able to respond to the indicated need. Each AAA shall ensure that an up-to-date directory 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 directory shall meet the criteria that guide the inclusion and exclusion of providers in the Aging and Disability Resource Center (ADRC) resource directory.

B. 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.

C. 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.
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.
Restrictions on Lobbying

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 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.
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).
TARGETING ECONOMIC OR SOCIAL NEEDS:

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
NON-DISCRIMINATION POLICIES:

All providers of OAA, Title III services 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 (45 CFR 84), Section 504 of the Rehabilitation Act of 1973, as amended.
AFFIRMATIVE ACTION:

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
RECRUITMENT OF OLDER PERSONS FOR EMPLOYMENT:

Each OAA, Title III service provider shall make every effort to actively recruit and employ qualified older persons.
**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.
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.


SECTION 2 - AREA AGENCIES ON AGING:

PURPOSE OF SECTION 2: 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.
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

Older Americans Act, Title III, Part A, Section 306(a)(b)(H)
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. 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.

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.
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.
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;

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

6. 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;
   
   e. Employee fringe benefits;
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Policy on AAA Staffing and Organization

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.
AREA AGENCY ON AGING AREA PLAN:

Area Plan Requirements:

A. Each AAA must develop an area plan as specified in the area plan instructions issued annually by DOEA.

B. Additional information about the area plan can be found in Chapter 1, Section 2, of this handbook.
AREA AGENCY ON AGING ADVISORY COUNCIL:

Advisory Council Requirements:

A. Each AAA must establish an advisory council with the composition of the council and its broad functions as follows:

1. **Council Functions:** The council shall carry out advisory functions which further the AAA’s mission of developing and coordinating community-based systems of services for all older persons in the PSA. The council shall advise the agency relative to:
   
   a. Developing and administering the area plan;
   
   b. Conducting public hearings;
   
   c. Representing the interests of older persons; and
   
   d. Reviewing and commenting on all community 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 individuals and representatives of community organizations who will enhance the leadership role of the AAA in developing community-based systems of services. The advisory council shall be made up of:

   a. Persons, including minority individuals, 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. Representatives of older persons;
   
   c. Representatives of health care provider organizations, including providers of veterans' health care (if appropriate);
   
   d. Representatives of supportive service provider organizations;
   
   e. Persons with leadership experience in the private and voluntary sectors;
   
   f. Local elected officials; and
   
   g. The public.
B. The advisory council must review and approve the AAA’s area plan as a prerequisite for the plan’s submission to DOEA.

C. 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.

D. The following additional restrictions apply to the AAA advisory council:

1. Membership selection should be closely representative of the demographics of the PSA. All counties in the PSA should 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 board of directors;
   
   c. Employees of service provider agencies under the area plan;
   
   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 advisory council conflicts with the preceding membership restrictions, it must prohibit identified individuals from voting on any issues and act to meet the requirement within 90 days.

4. Each AAA 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.
COMMUNITY INPUT ON AAA POLICY AND PROCEDURES:

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.
PUBLIC INFORMATION:

Public Information Requirements—Each Area Agency on Aging (AAA) shall:

A. Develop a public information program. The AAA should routinely provide information about its programs and activities to news media. The AAA should be a focal point for information about needs and activities of older persons throughout the PSA and should be knowledgeable of the current developments in the field of aging.

B. Make available to its provider’s 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.
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. 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:**

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.
Service Requirements: Section 2-Area Agencies on Aging

**CONTRACT PROVISION OF SERVICE:**

Contract Provision Requirements—Each AAA shall:

A. Implement the approved area plan through contracts with service provider agencies.

B. Establish written policies, procedures, criteria and standards for purchasing and procurement of goods and services on an open and competitive basis.

Note: Approval of AAA contracts and policies and procedures is the responsibility of the AAA board of directors.
**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 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.** 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 DOEAs 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 DOEAs grants accounting standards;
   
   e. A proposal including cost effective services in a defined geographic service area;
   
   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
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.

10. The service provider must complete all revisions noted by the AAA and respond within the negotiated time frame with a fully acceptable application.

D. The AAA is responsible for assuring that each application approved for OAA, Title III funding conforms to the applicable statutory and regulatory requirements.
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

Other training topics may include:

   1. DOEA Policy Notices and Transmittals;
   2. DOEA Programs and Services Handbook Overview;
   3. Aging Network Overview;
   4. CIRTS Data Entry and Reporting Requirements;
   5. Record-Keeping Requirements; and
   6. Confidentiality Requirements.

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.
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.
AAA COORDINATION WITH CORPORATION FOR NATIONAL AND COMMUNITY SERVICES (CNCS) PROGRAMS:

Each AAA must be aware of the Corporation for National and Community Services programs, their activities and level of participation in the PSA. These programs include Senior Corps (Foster Grandparents, Senior Companion and Retired Senior Volunteers), AmeriCorps, and Learn and Serve America.
AAA COORDINATION WITH TITLE V, OAA PROGRAM:

Each AAA must be aware of the 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.
COORDINATION WITH OTHER DOEA-FUNDED PROGRAMS:

Each 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.
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.
OUTREACH EFFORTS:

A statutory requirement, applicable to all AAAs, is to assure 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.
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 6 of this Handbook.
DISASTER PLANNING:

Each AAA shall designate a Disaster/Emergency Preparedness Coordinator. This person shall be responsible for ensuring compliance with the requirements set forth in Chapter 8 of this Handbook, Emergency Management and Preparedness.
Purpose and Legal Authority

SECTION 3 - SERVICE PROVIDERS

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
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 who provide meal related volunteer services when the participation of such individuals does not prevent the participation of older persons and their spouses.
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, and who have no one available to aid with meal preparation. Homebound means a person is unable to leave home without the assistance of another person;

2. The spouse of the recipient, regardless of age or condition; and

3. Disabled persons under age 60 years who reside with eligible clients, and are dependent on them 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:**

1. Elder abuse, neglect and exploitation services are delivered regardless of age.

2. Services provided to assist older individuals who reside in long-term care facilities in protecting their health, safety, welfare and rights.
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.
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.
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.
SERVICE PROVIDER APPLICATION (SPA):

A. 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.

B. 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.

C. The framework for the SPA is developed by the Department and includes the basic requirements, instructions and formats for requesting funds to provide DOEA-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.
REQUEST FOR PROPOSAL (RFP) AND INVITATION TO BID (ITB):

A. The AAAs must competitively bid contracts for DOEA-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.
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).
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:

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 SERVICE ARRAY AND TARGETING OBJECTIVES:

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.

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.
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.
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.

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.
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.
Service Requirements: Section 3—Service Providers

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.
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 take action 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 sufficient 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.

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:

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 on-the-job training;
4. Provide supervision;
5. Evaluate the volunteer's performance; and
6. 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.
**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).
C. **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.

D. **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.

E. **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.
**Documentation and Reporting of Unusual Incidents:**

Unusual Incident Reporting and Documentation Requirements—Each AAA and Service Provider shall:

A. Maintain files on unusual incidents (e.g., an accident, exposure to blood borne pathogens, injury, illness, altercation involving services or clients, and other reportable conditions as specified by the Department by contract);

B. Have written procedures to investigate, report, and record unusual incidents; and

C. Respond to unusual incidents in a manner prescribed by the Department and in accordance with all federal, state, and local laws and regulations.
SECTION 4—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. DOEAA 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).
D. Other services the area agencies may support with Title III B funds include the following:


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
SECTION 5 - NUTRITION PROGRAM POLICIES

PURPOSE OF SECTION 5: This section sets forth policies and procedures governing the operations of nutrition services under Title III C of the OAA.

Purpose of Nutrition Awards or Contracts: The AAA may award nutrition service funds received under Title III C 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 IIIIC 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 IIIIC Subpart 1, Section 331 42 U.S.C. 3030e

Older Americans Act, Title IIIIC, 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

Selection of Nutrition Program Service Providers

**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. Can efficiently and responsibility 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.

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.

3. A provider of nutrition services may provide restaurant-based meal service in the OAA Title III C-1 program. This service shall be provided in accordance with the following guidelines established to assist AAAs and nutrition service providers to expand C1 meal site locations in rural and isolated areas:

E. **Nutrition Provider’s Responsibilities:**

1. Obtain AAA approval for establishment of additional C-1 sites and determine appropriateness of using a local restaurant for a C-1 location.

2. Determine interest and capability of local restaurant.

3. Determine the number of restaurants 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:

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 restaurant 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. Misuse of restaurant vouchers;
k. Provision of nutrition education;
l. Nutrition Program’s monitoring of the restaurant using the Nutrition Program Compliance Review form;
m. Nutrition Program review of public health department review of restaurant;

5. Develop a survey for determining participant satisfaction concerning:

a. If the restaurant meal option is meeting the recipient’s needs;
b. The quality of the meals; and

c. The service provided by restaurant staff.

6. Evaluate restaurant 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. Assurance that restaurant 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. Assurance that the restaurant’s three most recent local health inspection reports have no significant citations and no recurring citations;
g. Assurance that the restaurant has not had any closures or Administrative Complaints from a regulatory agency regarding food safety/sanitation in the past 12 months; and
Service Requirements: Section 5—Nutrition Program Policies

Selection of Nutrition Program Service Providers

h. Capability of meeting the administrative and operational demands of the program as outlined below.

F. Restaurant Provider’s Responsibilities:

1. To become a C-1 meal site, a restaurant 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 in the restaurant 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. 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. The restaurant 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 at restaurant;
   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
h. Facilitate an initial inspection of the site by nutrition provider staff. This inspection will include the completion of the Nutrition Provider’s Compliance Review Form. Thereafter, the provider must permit Nutrition Program, AAA, and the Department staff to make onsite inspections at any date or time, with or without prior notification.

3. The Nutrition provider and restaurant provider’s contract files must include, but are not limited to the following items:

a. A written, executed agreement outlining the service provided;
b. Copy of the restaurant’s current food service license;
c. The three most recent local health inspection reports;
d. A copy of the current local fire department inspection report. All items that were cited by the fire department must be corrected prior to the start of the program;
e. The approved menus;
f. A copy of the Professional Food Manager’s certificate(s);
g. An insurance certificate stating current policy coverage and, if available, evidence of umbrella or excess liability policy;
h. Designation of sections of the proposal that are claimed to be proprietary along with rationale justifying exception of these sections from Freedom of Information Act release; and
i. Unit cost.

G. AAA Responsibilities:

1. The AAA must provide written notification to the Department’s Registered Dietitian at least 60 calendar days prior to a nutrition provider opening a restaurant-based meal service.

2. The AAA must provide the Department an accurate listing of all the Congregate Meal Sites and Food Service Vendors at least annually and within 48 hours of any changes.
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.

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. Training shall be designed to enhance staff performance as related to the specific job responsibilities of each staff member.

Each nutrition service provider shall set aside sufficient budgetary funds for training, including in-service training, and as applicable, Certified Food Protection Manager training (see next paragraph). 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.

**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 have successfully passed the test to become 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.

2. **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 food borne illness. Staff and volunteers must be trained prior to assuming food service assignments.

3. 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.

**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.

a. Registered Dietitian (RD) A Registered Dietitian is a food and nutrition expert who has met the following criteria to earn the RD credential:

i. Completed a minimum of a bachelor’s degree at a U.S. regionally-accredited university or college or equivalent and course work approved by the Commission on Accreditation for Dietetics Education (CADE) of the Academy of Nutrition and Dietetics.

ii. Completed a CADE-accredited or approved supervised practice program at a healthcare facility, community, agency, or a food service corporation, or combined with undergraduate or graduate studies.

iii. Passed a national examination administered by the Commission on Dietetic Registration (CDR).

iv. Completes continuing professional educational requirements to maintain registration.

The above requirements are documented and verified by The Academy of Nutrition and Dietetics’ Commission on Dietetic Registration. Every RD must provide a current copy of the Commission on Dietetic Registration (CDR card) issued by Academy of Nutrition and Dietetics to employer.
DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 4: Older Americans Act

Service Requirements: Section 5—Nutrition Program Policies

Planning for Nutrition Services

b. **Licensed Dietitian/Nutritionist (LD or LD/N)** Florida has regulatory laws for dietitians and nutrition practitioners. (Florida Statutes Chapter 468.509, FAC Chapter 64B). Licensed Dietitians are food and nutrition experts who have met the following criteria as outlined in the Florida Statutes 468.509 and FAC Chapter 64B and have earned LD or LD/N credential.

i. Completed a minimum of a bachelor’s or post baccalaureate degree with a major course of study in human nutrition, food and nutrition, dietetics, or food management, or an equivalent major course of study, from a school or program accredited, at the time of the applicant’s graduation, by the appropriate accrediting agency recognized by the Commission on Recognition of Post and Secondary Accreditation and the United States Department of Education.

ii. Completed a pre-professional experience component of not less than 900 hours or has education or experience determined to be equivalent by the board.

iii. Has an academic degree, from a foreign country, that has been validated by an accrediting agency approved by the United States Department of Education as equivalent to the baccalaureate or post-baccalaureate degree conferred by a regionally accredited college or university in the United States.

iv. Completed a major course of study in human nutrition, food and nutrition, dietetics or food management.

v. Passed the State examination for licensure.

vi. Completes continuing professional education requirements to maintain licensure.

The above requirements are documented and verified by State of Florida, Department of Health, Division of Medical Quality Assurance Dietitian/Nutritionist License. Every qualified dietitian must provide a current copy of a State of Florida, Department of Health, Division of Medical Quality Assurance Dietitian/Nutritionist License to employer.
For a change in the qualified dietitian’s position, a funding application packet shall be submitted to the AAA and contain the following:

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, Division of Medical Quality Assurance (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, Division of Medical Quality Assurance (Refer to F.A.C. Chapter 64B8)

A resume for the provider’s qualified dietitian, along with a copy of the individual’s current registration with the Commission on Dietetic Registration of the Academy of Nutrition and Dietetics and/or current Florida license with the Department of Health, Division of Medical Quality Assurance (Refer to F.A.C. Chapter 64B8) shall be included in the funding application packet and submitted to the AAA when there is a personnel change in this position.
3. Responsibilities and functions of the qualified dietitian shall be reduced to writing in the contract and 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 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;

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.

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 in accord with federal and state policies and shall take into consideration the nutrition budget. 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;

      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.
Service Requirements: Section 5—Nutrition Program Policies

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, and may not have had any closures (temporary or permanent) or Administrative Complaints related to food safety in the past 12 months. 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 24 hours of any sanitation inspection and provide a copy of the report.

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.

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. The AAA monitoring of the nutrition service provider shall ensure compliance with food safety, food sanitation and service standards outlined in the current NPCR. Meal site reviews must be conducted quarterly at each physical meal site location. The current NPCR is to be used when conducting quarterly meal site reviews, and must be conducted as follows:

i. Once per year by the nutrition consultant (licensed dietitian or licensed and registered dietitian,)

ii. Once per year by the nutrition program services provider’s administrative staff member, and

iii. Twice per year by the meal site manager or designee.

Although quarterly meal site reviewers must use the NPCR form, only applicable sections should be completed; and

d. Monitoring may include review of all aspects of kitchen management including, but not limited to:

i. All local and state level health department inspections,

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.
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 Florida licensed dietitian or licensed registered 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.

F. **Menu Posting:** Approved preselect menus shall be dated and posted in a conspicuous location at each congregate nutrition site for participants’ review. Posted menus should be in a font size 14 or larger for easy review. 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 14 or larger 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 and procedure must be available for site manager’s use. 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 ensures target nutrients are served in accordance with current nutritional standards, while also allowing menu component flexibility. This method is encouraged for programs that serve a unique ethnic or cultural group. The computer-assisted nutrient analysis method is preferred by DOE, because it permits menu development that more closely represents typical elderly eating patterns and can accommodate non-traditional menus.

   b. The component meal pattern menu development method is not preferred by DOE and is encouraged only for a nutrition provider with limited computer skills and/or to serve meal site recipients that customarily consume a “traditional” meal.
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](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:


   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](http://fac.dos.state.fl.us)
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.
### Macronutrients

<table>
<thead>
<tr>
<th></th>
<th>1 meal/day 33 1/3 % DRI/Al</th>
<th>2 meals/day 67% DRI/Al</th>
<th>3 meals/day 100% DRI/Al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kilocalories (1)</td>
<td>600</td>
<td>1200</td>
<td>1800</td>
</tr>
<tr>
<td>Protein grams (1)</td>
<td>30</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>~20% of total Kcal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;14 grams from entrée per meal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbohydrate grams (1)</td>
<td>75</td>
<td>150</td>
<td>225</td>
</tr>
<tr>
<td>~50% of total Kcal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fat grams (1)</td>
<td>20</td>
<td>40</td>
<td>60</td>
</tr>
<tr>
<td>20-35% of total Kcal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturated fat (1)</td>
<td>Limit intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10% total Kcal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Added sugars (1)</td>
<td>Limit intake</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;10% of total Kcal or 45 grams/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietary Fiber grams (2)</td>
<td>7</td>
<td>14</td>
<td>21</td>
</tr>
</tbody>
</table>

### Vitamins

<table>
<thead>
<tr>
<th></th>
<th>1 meal/day 33 1/3 % DRI/Al</th>
<th>2 meals/day 67% DRI/Al</th>
<th>3 meals/day 100% DRI/Al</th>
</tr>
</thead>
<tbody>
<tr>
<td>A *( mug/d) (2)</td>
<td>233</td>
<td>467</td>
<td>700</td>
</tr>
<tr>
<td>C ( mg/d) (2)</td>
<td>25</td>
<td>50</td>
<td>75</td>
</tr>
<tr>
<td>D ( mcg/d) (2)</td>
<td>*6.7</td>
<td>*13.3</td>
<td>*20</td>
</tr>
<tr>
<td>E ( mg/d) (2)</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Thiamine ( mg/d) (2)</td>
<td>0.37</td>
<td>0.73</td>
<td>1.1</td>
</tr>
<tr>
<td>Riboflavin ( mg/d) (2)</td>
<td>0.37</td>
<td>0.73</td>
<td>1.1</td>
</tr>
<tr>
<td>B6 ( mg/d) (2)</td>
<td>0.5</td>
<td>1.0</td>
<td>1.5</td>
</tr>
<tr>
<td>Folate ( mug/d) (2)</td>
<td>133</td>
<td>267</td>
<td>400</td>
</tr>
<tr>
<td>B12 ( mcg/d) (2)</td>
<td>0.8</td>
<td>1.6</td>
<td>2.4</td>
</tr>
</tbody>
</table>

### Minerals

<table>
<thead>
<tr>
<th></th>
<th>1 meal/day 33 1/3 % DRI/Al</th>
<th>2 meals/day 67% DRI/Al</th>
<th>3 meals/day 100% DRI/Al</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calcium (mg/d) (2)</td>
<td>400</td>
<td>800</td>
<td>1200</td>
</tr>
<tr>
<td>Copper (ug/d) (2)</td>
<td>300</td>
<td>600</td>
<td>900</td>
</tr>
<tr>
<td>Iron (mg/d) (2)</td>
<td>2.7</td>
<td>45.3</td>
<td>8</td>
</tr>
<tr>
<td>Magnesium (mg/d) (2)</td>
<td>106.7</td>
<td>213.3</td>
<td>320</td>
</tr>
<tr>
<td>Zinc (mg/d) (2)</td>
<td>2.7</td>
<td>5.3</td>
<td>8</td>
</tr>
<tr>
<td>Potassium (mg/d) (1))</td>
<td>1566.7022</td>
<td>133.3</td>
<td>4700</td>
</tr>
<tr>
<td>Sodium (mg/d) (1))</td>
<td>&lt;767</td>
<td>&lt;1533</td>
<td>&lt;2300</td>
</tr>
</tbody>
</table>

*RDA’s are in bold type and AI’s are in ordinary type followed by an asterisk (*).


2. Used highest DRI value for age > 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.
Component Meal Pattern Requirements for Menu Development: This method of menu development must comply with the following:


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.
Service Requirements: Section 5—Nutrition Program Policies

Menu Review and Approval

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

<table>
<thead>
<tr>
<th>Food Group</th>
<th>Servings/Meal</th>
<th>Daily Dietary Guideline Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grains</td>
<td>2 servings: (1 cup (cooked) pasta or rice, 2 cups cereal, 2 slices bread (1 ounce each)</td>
<td>6-ounce equivalent servings daily. Include 3-ounce equivalent of whole grain high fiber foods</td>
</tr>
<tr>
<td>Vegetable</td>
<td>1.7 servings: 3/4 cup cooked or 1-1/2 cups raw equivalent measure (may serve an additional fruit instead of a vegetable)</td>
<td>2 1/2 cups (5 servings daily). Serve a variety of vegetables, including those that are dark green, red, and orange. Beans/peas</td>
</tr>
<tr>
<td>Fruit</td>
<td>1 serving: 1/2 cup (4 ounces) or equivalent measure</td>
<td>1.5 cups (4 servings daily) Focus on whole fruits and include those that are deeply colored fruits such as oranges.</td>
</tr>
<tr>
<td>Dairy</td>
<td>1 serving: 1 cup (8 ounces) or equivalent measure</td>
<td>3, 1-cup equivalent servings daily. Select low-fat products</td>
</tr>
<tr>
<td>Protein Foods</td>
<td>1.7 serving: 2-ounce edible portion or equivalent measure</td>
<td>5 ounce-equivalent servings daily</td>
</tr>
<tr>
<td>Fat</td>
<td>1 serving: 1 teaspoon or equivalent measure is optional</td>
<td>Select foods lower in fat and saturated fat. Limit total fat to 30%, saturated 10% (20%)</td>
</tr>
<tr>
<td>Dessert</td>
<td>Optional</td>
<td>Select foods high in whole grains, low in fat and sugar</td>
</tr>
<tr>
<td>Optional Beverages: Water, coffee, tea, decaffeinated beverages, fruit juices.</td>
<td>8 ounces, minimum, per seasonal preferences</td>
<td></td>
</tr>
</tbody>
</table>

*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](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.

**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
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 (1 ounce); 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:

<table>
<thead>
<tr>
<th>Grains</th>
<th>Amount that counts as 1 ounce equivalent of grains</th>
<th>Common Portions and ounce equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bagels</td>
<td>WG*: whole wheat RG*: plain, egg</td>
<td>1 &quot;mini&quot; bagel</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 large bagel = 4 ounce equivalents</td>
</tr>
<tr>
<td>Biscuits</td>
<td>(baking powder/buttermilk – RG*)</td>
<td>1 small (2” diameter)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 large (3” diameter) = 2 ounce equivalents</td>
</tr>
<tr>
<td>Breads</td>
<td>WG*: 100% whole wheat RG*: white, wheat, French</td>
<td>1 regular slice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 small slice French</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 snack-size slices rye bread</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 regular slices = 2 ounce equivalents</td>
</tr>
<tr>
<td>Bulgur</td>
<td>Cracked wheat (WG*)</td>
<td>1/2 cup cooked</td>
</tr>
<tr>
<td>Cornbread</td>
<td>(RG*)</td>
<td>1 small piece (2½ “X 1 ¼” X 1 ¼”)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 medium piece (2 ½” X 2 ½” X 1 ¼&quot;) = 2 ounce equivalents</td>
</tr>
<tr>
<td>Crackers</td>
<td>WG*: whole wheat, rye, RG*: saltines, snack crackers</td>
<td>5 whole wheat crackers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 rye crisp breads</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 square or round crackers</td>
</tr>
<tr>
<td>English muffin</td>
<td>WG*: whole wheat RG*: plain, raisin</td>
<td>1/2 muffin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 muffin = 2 ounce equivalents</td>
</tr>
</tbody>
</table>
### Menu Review and Approval

<table>
<thead>
<tr>
<th>Grains</th>
<th>Amount that counts as 1 ounce equivalent of grains</th>
<th>Common Portions and ounce equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muffins</td>
<td>WG* whole wheat, RG* bran, corn, plain 1 small (2 ½ “diameter)</td>
<td>1 large (3 ½” diameter) = 3 ounce equivalents</td>
</tr>
<tr>
<td>Oatmeal</td>
<td>(WG) ½ cup cooked 1 packet instant 1 ounce (1/3 cup) dry (regular or Quick)</td>
<td></td>
</tr>
<tr>
<td>Pancakes</td>
<td>WG*: whole wheat, buckwheat, RG*: buttermilk, plain 1 pancake (4 ½ “diameter) 2 small pancakes (3” diameter)</td>
<td>3 pancakes (4 ½ “diameter) = 3 ounce equivalents</td>
</tr>
<tr>
<td>Ready-to-eat breakfast cereal</td>
<td>WG* toasted oat, whole wheat flakes, RG* corn flakes, puffed rice 1 cup flakes or rounds 1 ¼ cup puffed</td>
<td></td>
</tr>
<tr>
<td>Rice</td>
<td>WG*: brown, wild, RG*: enriched, white, polished ½ cup cooked 1 ounce dry</td>
<td>1 cup cooked = 2 ounce equivalents</td>
</tr>
<tr>
<td>Pasta-spaghetti, macaroni noodles</td>
<td>WG*: whole wheat, RG*: enriched, durum ½ cup cooked 1 ounce dry</td>
<td>1 cup cooked = 2 ounce equivalents</td>
</tr>
<tr>
<td>Tortillas</td>
<td>WG*: whole wheat, whole grain corn, RG*: flour, corn 1 small flour tortilla (6” diameter) 1 corn tortilla (6” diameter)</td>
<td>1 large tortilla (12” diameter) = 4 ounce equivalents</td>
</tr>
</tbody>
</table>

*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.
### B. **Vegetables:** A serving of vegetable, including dried beans, peas, lentils, lima beans, potato, plantains, sweet potato, and corn, is generally the following:

<table>
<thead>
<tr>
<th></th>
<th>Amount that counts as 1 cup of vegetables</th>
<th>Amount that counts as ½ cup of vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dark Green Vegetables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Broccoli</td>
<td>1 cup chopped or florets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 spears 5” long raw or cooked</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 cup cooked</td>
<td></td>
</tr>
<tr>
<td>Spinach</td>
<td>1 cup cooked</td>
<td>1 cup raw is equivalent to ½ cup of vegetables</td>
</tr>
<tr>
<td></td>
<td>2 cups raw is equivalent to 1 cup of vegetables</td>
<td></td>
</tr>
<tr>
<td>Raw leafy greens:</td>
<td>2 cups raw is equivalent to 1 cup of vegetables</td>
<td></td>
</tr>
<tr>
<td>spinach, romaine,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>watercress, dark green</td>
<td></td>
<td></td>
</tr>
<tr>
<td>leafy lettuce, endive,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>escarole</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Red and Orange Vegetables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carrots</td>
<td>1 cup, strips, slices, chopped, raw, or cooked</td>
<td>1 medium carrots</td>
</tr>
<tr>
<td></td>
<td>2 medium</td>
<td>About 6 baby carrots</td>
</tr>
<tr>
<td></td>
<td>1 cup baby carrots (about 12)</td>
<td></td>
</tr>
<tr>
<td>Tomatoes</td>
<td>1 large raw whole (3”)</td>
<td>1 small raw whole (2 ¼” diameter)</td>
</tr>
<tr>
<td></td>
<td>1 cup chopped, sliced, raw, canned, or cooked</td>
<td>1 medium canned</td>
</tr>
<tr>
<td>Tomato juice</td>
<td>1 cup</td>
<td>½ cup</td>
</tr>
<tr>
<td>Sweet potato</td>
<td>1 large baked (2 ¼” or more diameter)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1 cup sliced or mashed, cooked</td>
<td></td>
</tr>
<tr>
<td>Winter squash</td>
<td>1 cup cubed, cooked</td>
<td>½ acorn squash, baked = ¾ cup</td>
</tr>
<tr>
<td>(acorn, butternut,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hubbard)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beans and Peas</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dry beans and peas</td>
<td>1 cup whole or mashed, cooked</td>
<td></td>
</tr>
<tr>
<td>(such as black,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>garbanzo, kidney,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pinto, soy bean beans,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>black eyed peas,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or split peas</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Starchy Vegetables</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Other Vegetables

<table>
<thead>
<tr>
<th>Vegetable</th>
<th>Cup Weight</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cabbage, green</td>
<td>1 cup, chopped or shredded</td>
<td>Raw or cooked</td>
</tr>
<tr>
<td>Cauliflower</td>
<td>1 cup pieces or florets raw or cooked</td>
<td></td>
</tr>
<tr>
<td>Celery</td>
<td>1 cup, diced or sliced, raw or cooked</td>
<td>2 large stalks (11” to 12” long)</td>
</tr>
<tr>
<td>Cucumbers</td>
<td>1 cup raw, sliced, or chopped</td>
<td></td>
</tr>
<tr>
<td>Green or wax beans</td>
<td>1 cup cooked</td>
<td></td>
</tr>
<tr>
<td>Green peppers</td>
<td>1 cup chopped, raw, or cooked</td>
<td>1 small pepper</td>
</tr>
<tr>
<td></td>
<td>1 large pepper (3” diameter, 3 ¾” long)</td>
<td></td>
</tr>
<tr>
<td>Lettuce, iceberg or head</td>
<td>2 cups raw, shredded, or chopped = equivalent to 1 cup of vegetables</td>
<td>1 cup raw, shredded, or chopped Equivalent to ½ cup of vegetables</td>
</tr>
<tr>
<td>Onions</td>
<td>1 cup chopped, raw, or cooked</td>
<td></td>
</tr>
<tr>
<td>Summer squash or zucchini</td>
<td>1 cup cooked, sliced, or diced</td>
<td></td>
</tr>
</tbody>
</table>

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.
### Dry beans and peas
(such as black, garbanzo, kidney, pinto, soy beans, black eyed peas, or split peas)

<table>
<thead>
<tr>
<th>Amount that counts as 1 cup of vegetables.</th>
<th>Amount that counts as ½ cup of vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 cup whole or mashed, cooked</td>
<td></td>
</tr>
</tbody>
</table>

### Starchy Vegetables

<table>
<thead>
<tr>
<th>Corn, yellow or white</th>
<th>1 cup</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 large ear (8” to 9” long)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Green peas</th>
<th>1 cup</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>White potatoes</th>
<th>1 cup diced, mashed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 medium boiled or baked potato (2 ½” to 3” diameter)</td>
</tr>
<tr>
<td></td>
<td>French fried: 20 medium to long strips (2 ½” to 4” long)</td>
</tr>
<tr>
<td></td>
<td>(Contains added calories from solid fats.)</td>
</tr>
</tbody>
</table>

### Other Vegetables

<table>
<thead>
<tr>
<th>Cabbage, green</th>
<th>1 cup, chopped or shredded</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Raw or cooked</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cauliflower</th>
<th>1 cup pieces or florets raw or cooked</th>
</tr>
</thead>
</table>

| Celery | 1 cup, diced or sliced, raw or cooked |
|        | 2 large stalks (11” to 12” long) |
|        | 1 large stalk (11” to 12” long) |

<table>
<thead>
<tr>
<th>Cucumbers</th>
<th>1 cup raw, sliced, or chopped</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Green or wax beans</th>
<th>1 cup cooked</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Green peppers</th>
<th>1 cup chopped, raw, or cooked</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 large pepper (3” diameter, 3 ½” long)</td>
</tr>
<tr>
<td></td>
<td>1 small pepper</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lettuce, iceberg or head</th>
<th>2 cups raw, shredded, or chopped = equivalent to 1 cup of vegetables</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 cup raw, shredded, or chopped = equivalent to ½ cup of vegetables</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Onions</th>
<th>1 cup chopped, raw, or cooked</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Summer squash or zucchini</th>
<th>1 cup cooked, sliced, or diced</th>
</tr>
</thead>
</table>

Source: [http://www.choosemyplate.gov](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.
### Fruits:
A serving of fruit is generally the following:

<table>
<thead>
<tr>
<th>Fruit</th>
<th>Amount that counts as 1 cup of fruit</th>
<th>Other amounts (count as ½ cup of fruit unless noted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apple</td>
<td>½ large (3.25&quot; diameter) 1 small (2.5&quot; diameter) 1 cup sliced or chopped, raw or cooked</td>
<td>½ cup sliced or chopped, raw or cooked</td>
</tr>
<tr>
<td>Applesauce</td>
<td>1 cup</td>
<td>1 snack container (4 oz)</td>
</tr>
<tr>
<td>Banana</td>
<td>1 cup sliced 1 large (8&quot; to 9&quot; long)</td>
<td>1 small (less than 6&quot; long)</td>
</tr>
<tr>
<td>Cantaloupe</td>
<td>1 cup diced or melon balls</td>
<td>1 medium wedge (1/8 of a medium melon)</td>
</tr>
<tr>
<td>Grapes</td>
<td>1 cup whole or cut-up 32 seedless grapes</td>
<td>16 seedless grapes</td>
</tr>
<tr>
<td>Grapefruit</td>
<td>1 medium (4&quot; diameter) 1 cup sections</td>
<td>½ medium (4&quot; diameter)</td>
</tr>
<tr>
<td>Mixed fruit (fruit cocktail)</td>
<td>1 cup diced or sliced, raw or canned, drained</td>
<td>1 snack container (4 oz.) drained = 3/8 cup</td>
</tr>
<tr>
<td>Orange</td>
<td>1 large (3-1/16&quot; diameter) 1 cup sections</td>
<td>1 small (2-3/8&quot; diameter)</td>
</tr>
<tr>
<td>Orange, mandarin</td>
<td>1 cup canned, drained</td>
<td></td>
</tr>
<tr>
<td>Peach</td>
<td>1 large (2 ¼&quot; diameter) 1 cup sliced, diced, raw, cooked, or canned, drained 2 halves, canned</td>
<td>1 small (2&quot; diameter) 1 snack container (4 oz.) drained = 3/8 cup</td>
</tr>
<tr>
<td>Pear</td>
<td>1 medium pear (2.5 per lb.) 1 cup sliced, diced, raw, cooked, or canned, drained</td>
<td>1 snack container (4 oz.) drained = 3/8 cup</td>
</tr>
<tr>
<td>Pineapple</td>
<td>1 cup chunks, sliced or crushed, raw, cooked, or canned, drained</td>
<td>1 snack container (4 oz.) drained = 3/8 cup</td>
</tr>
<tr>
<td>Strawberries</td>
<td>About 8 large berries 1 cup whole, halved, or sliced, fresh or frozen</td>
<td>½ cup whole, halved, or sliced</td>
</tr>
<tr>
<td>Watermelon</td>
<td>1 small wedge (1&quot; thick) 1 cup diced or balls</td>
<td>6 melon balls</td>
</tr>
<tr>
<td>Dried fruit (raisins, prunes, apricots, etc.)</td>
<td>1 cup dried fruit is equivalent to 1 cup fruit. ½ cup raisins ½ cup prunes 1 cup dried apricots</td>
<td>½ cup dried fruit is equivalent to ½ cup fruit 1 small box raisins (1.5 oz.)</td>
</tr>
<tr>
<td>100% fruit juice (orange, apple, grape, grapefruit, etc.)</td>
<td>1 cup</td>
<td>½ cup</td>
</tr>
</tbody>
</table>

Source: [http://www.choosemyplate.gov](http://www.choosemyplate.gov)
Service Requirements: Section 5—Nutrition Program Policies

Menu Review and Approval

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 may be provided in place of milk and include (for the equivalent of one cup of milk).

<table>
<thead>
<tr>
<th>Dairy Alternates</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 cup yogurt</td>
</tr>
<tr>
<td>1 ½ ounce hard cheese (Cheddar, Monterey, Provolone, Colby, American Mozzarella, Swiss, Parmesan) or 2 ounces processed cheese (American)</td>
</tr>
<tr>
<td>8 ounces tofu (processed with calcium salt)</td>
</tr>
<tr>
<td>1 ½ cup ice milk/ice-cream</td>
</tr>
<tr>
<td>1 ½ cup cottage cheese 1% fat</td>
</tr>
<tr>
<td>1 ½ cup custard</td>
</tr>
</tbody>
</table>

Source: http://www.ChooseMyPlate.gov
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:

<table>
<thead>
<tr>
<th>Amount that counts as 1 ounce equivalent in the Protein Foods Group</th>
<th>Common portions and ounce equivalents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meats 1 ounce cooked lean beef 1 ounce cooked lean pork or ham</td>
<td>1 small steak (eye, round, or filet) = 3 1/2 to 4 ounce equivalents 1 small lean hamburger = 2 to 3 ounce equivalents</td>
</tr>
<tr>
<td>Poultry 1 ounce cooked chicken or turkey, without skin 1 sandwich slice of turkey (4 1/2” x 2 1/2” x 1/8”)</td>
<td>1 small chicken breast half = 3 ounce equivalents 1/2 cornish game hen = 4 ounce equivalents</td>
</tr>
<tr>
<td>Seafood 1 ounce cooked fish or shell fish</td>
<td>1 can tuna, drained = 3 to 4 ounce equivalents 1 salmon steak = 4 to 6 ounce equivalents</td>
</tr>
<tr>
<td>Eggs 1 egg</td>
<td>3 egg whites = 2 ounce equivalents 3 egg yolks = 1 ounce equivalents</td>
</tr>
<tr>
<td>Nuts and seeds 1/2 ounce of nuts (12 almonds, 24 pistachios, 7 walnut halves) 1/2 ounce of seeds (pumpkin, sunflower, or squash seeds, hulled, roasted) 1 Tablespoon of peanut butter or almond butter</td>
<td>1 ounce of nuts or seeds = 2 ounce equivalents</td>
</tr>
<tr>
<td>Beans and peas 1/4 cup of cooked beans (black, kidney, pinto, or white beans) 1/4 cup of cooked peas (chickpeas, cowpeas, lentils, or split peas) 1/4 cup of baked beans, refried beans 1/4 cup (about 2 ounces) of tofu 1 oz. tempeh, cooked 1/4 cup roasted soybeans 2 Tablespoons of hummus</td>
<td>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</td>
</tr>
</tbody>
</table>
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.
### Portion Control Guide—Protein Foods

<table>
<thead>
<tr>
<th>Food Item</th>
<th>Required Portion Size = 3 ounces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cottage cheese—2 ounces by weight = ¼ cup</td>
<td>6 ounces by weight = ¾ cup</td>
</tr>
<tr>
<td>Chicken</td>
<td>1 drumstick and 1 thigh or ½ breast = 3 ounces</td>
</tr>
<tr>
<td>Chili, soups</td>
<td>Must serve at least 1 ½ cup containing 3 ounces of meat or meat alternate to provide one meal</td>
</tr>
<tr>
<td>Cooked dried beans and peas</td>
<td>1 ½ cup</td>
</tr>
<tr>
<td>One egg = 1 ounce</td>
<td>3 eggs</td>
</tr>
<tr>
<td>Lasagna, Macaroni and Cheese, Beef or other Meat Stew, Meat Casseroles</td>
<td>1 ½ cup</td>
</tr>
<tr>
<td>Meat Loaf 1 slice 2” x 4” x 2” = 4 ounces</td>
<td>4 ounces (yield from a 20” x 12” x 2” pan = 33 servings)</td>
</tr>
<tr>
<td>Pizza 3 ¼ “x 7” = 3 ounces M/MA</td>
<td>10 servings per 18” x 26” pan or 5 + servings from 12” x 20” pan</td>
</tr>
<tr>
<td>Roast Meats</td>
<td>3 ounces</td>
</tr>
<tr>
<td>Sandwiches, sliced meats/cheese</td>
<td>3 ounces</td>
</tr>
<tr>
<td>Salad typefilings</td>
<td>3 ounces = ¾ cup filling</td>
</tr>
<tr>
<td>Spaghetti sauces with ground beef</td>
<td>1 cup</td>
</tr>
<tr>
<td>Tofu</td>
<td>4 ounces</td>
</tr>
</tbody>
</table>
F. Prepared Fish Products:

<table>
<thead>
<tr>
<th>Fish Product</th>
<th>Serving or Portion Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fish sticks, Frozen Fried Breaded, 60 percent fish</td>
<td>Six 1 ounce sticks = 3 ounces cooked fish</td>
</tr>
<tr>
<td>Fish sticks, Frozen Raw Breaded, 72 percent fish</td>
<td>Six 1 ounce sticks = 3 ounces cooked fish</td>
</tr>
<tr>
<td>Fish portions, Frozen, Fried Battered. There is no standard portion for this product. Specify 45 percent fish and require a certificate of inspection from the processor</td>
<td>9-ounce portion = 3 ounces cooked fish</td>
</tr>
<tr>
<td>Fish portions, Frozen, Fried Breaded</td>
<td>6-ounce portion = 3 ounces cooked fish</td>
</tr>
<tr>
<td>Fish portions, Frozen, Raw Breaded 75 percent fish</td>
<td>6-ounce portion = 3 ounces cooked fish</td>
</tr>
<tr>
<td>Fish portions, Frozen, Unbreaded</td>
<td>4-ounce portion = 3 ounces cooked fish</td>
</tr>
</tbody>
</table>

G. Additional Menu Development Considerations:

1. **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 ½ 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.

2. **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:
   a. 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.
   b. 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.
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.

4. Sodium: The commitment to reduce sodium in the meals stems from the fact that nutrition-related chronic diseases remain the primary cause of death among people aged 65 and older. Florida has a diverse population and the Nutrition Programs in the State provide culturally appropriate meals to many ethnicities. Programs that choose to provide culturally appropriate meals, but are concerned with the sodium content of the meals, may consider:

   a. Providing nutrition education on sodium.

   b. Continuing to work with the sodium content of meals, making small steps to reduce the levels of sodium over time.

      i. Consistently placing foods that are a good source of potassium on the menus to provide maximum benefits to the seniors. Potassium rich diet blunts the effect of salt on blood pressure.

      ii. Using low sodium version of high sodium foods when available and feasible within budget allowances.
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. Eliminate use of palm oil and coconut oil in food preparation.

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.

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, pies, should be limited to once a week.

K. **Beverages:** Fluid intake should be encouraged. Dehydration is a common problem in older adults. It is a good practice to have drinking water available. Nonnutritive beverages such as coffee and tea do not contribute with nutrient requirements but can help with hydration. It is recommended meal site managers stop serving nonnutritive beverages (such as coffee or tea) 30 minutes prior and during the meal time to encourage participants to increase intake of the nutritive beverages (i.e. milk, fruit juice) that are listed on the posted menu.

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](http://www.eatright.org).
M. **Dietary Supplements:** Dietary supplements encompass a wide range of products, including but not limited to vitamins, minerals, amino acids, herbs, products that require preparation such as powdered mixes or concentrated liquids and other botanicals. 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 physician.

2. **Therapeutic Diet:** A therapeutic diet is an individualized diet prescription written by a physician 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 physician, 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 licensed dietitian or licensed registered dietitian (i.e. 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.

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. The guidelines for shelf stable meals are:

1. Nutrient content of the meal must meet all requirements of the program and be approved by the AAA or nutrition program qualified dietitian.

2. Only top-grade, non-perishable foods in intact packages shall be included.

3. Cans are to be easy open, with pull tabs whenever possible.

4. 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.)

5. Fruit and vegetable juices are to be 100 percent pure juices.

6. Dried fruit must be packed in an airtight container.

7. When applicable, easy-to-read preparation instructions should be included.
P. 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 days, including 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.
Food Purchasing/Preparation Standard

**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.

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.
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 of the freshness date.

E. **Unacceptable Food Items:** In accordance with the Florida Food Code, unacceptable items include:

1. Food that has passed its expiration 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.

**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 of 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.
FOOD PREPARATION AND SAFETY STANDARDS:

A. **Meals Served at More than One Congregate Site:** When nutrition service is designed to provide meals for more than one congregate nutrition site and those sites serve similar cultural and/or ethnical participants, efforts should be made to have all meals prepared at one facility and then delivered to the various sites. This is considered the most economical method of delivery of meals to multiple sites. However, if meal site location requires a long transit time for delivery, or if meal site(s) serve a culturally and/or ethnically diverse population, then nutrition projects are encouraged to consider multiple vendors that can meet the unique needs of each site while limiting the meal delivery transit time.

B. **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.

The following paragraphs outline some specifics of guidelines but do not list all requirements. Interested parties should read the Food Hygiene Code at (http://www.doh.state.fl.us/environment/community/).

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.

C. **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.
D. **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.

**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. “Cleaning” is defined as removing visible dirt and stains; “Sanitizing” is defined as reducing the number of micro-organisms by using hot water at 171° F, or a chemical sanitizing solution. (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.msdsssearch.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 food borne 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;

2. Ham salad, chicken salad, egg salad, pasta salad, shrimp salad, lobster 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 ham salad, chicken salad, egg salad, shrimp 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.

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 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.

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.
N. Hazard Analysis Critical Control Point:

1. Hazard Analysis Critical Control Point (HACCP) is a food safety system that was developed by the Food and Drug Administration, Center for Food Safety and Applied Nutrition. It is a proactive, comprehensive, science-based food safety system that allows operators to continuously monitor their establishments and reduce the risk of food borne illness. HACCP is based on the idea that if biological, chemical or physical hazards are identified at specific points within a food’s flow through the operation, the hazards can be prevented, eliminated, or reduced to safe levels. A successful HACCP system uses a combination of hazard and risk analysis, proper food handling procedures, monitoring techniques, and record keeping to keep food safe. 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.

g. **Establish effective record keeping to document 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 food-borne pathogens.

**NOTE:** A HACCP principles guide for operators of food service is available at [http://www.fda.gov/Food/GuidanceRegulation/HACCP/ucm2006801.htm](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 food borne 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 Food Borne Illness Outbreak Procedure:

1. Nutrition programs should have a plan in place to respond to a suspected food borne illness outbreak.

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 physician? Obtain physician’s name if diagnosed.
   d. What food and/or drinks were consumed?
   e. What was the 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 food borne disease outbreak may have occurred when two or more persons experience a similar illness, usually gastrointestinal, after eating a common food.

4. If a food borne 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.
**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.
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:** Meals served to an elderly individual under the Medicaid Waiver, CCE-funded meals or other means tested program may not be included in the NSIP count.
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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NON-DISCRIMINATION BASED ON DISABILITY:

Access to benefits and services for clients with disabilities shall be ensured pursuant to the Americans with Disabilities Act (42 U.S.C. 12101).

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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;
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 in accordance with 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

      ii. Menus must identify serving utensils to be used for each food item.
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. Compliance with federal, state, and local food safety regulations. The food service vendor may not have had any closures (temporary or permanent) or Administrative Complaints regarding food safety within the past 12 months;

   b. 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;

   c. Requirement to provide documentation of the three most recent food preparation inspections conducted by the state regulatory authority;

   d. Requirement to provide a written plan of correction for any high priority or significant findings on sanitation inspections;

   e. Requirement to notify the Nutrition Provider immediately for any closures or Administrative Complaints in regards to food safety; and notify the Nutrition Provider within 24 hours of any sanitation inspections;

   f. Description of vendors’ delivery standards and sanitation that includes holding temperatures for transporting and serving food; and

   g. Right of the nutrition program, AAA, or Department staff to inspect the food preparation and storage areas.

4. **Food Service:** The following food service issues shall be addressed:

   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.

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 or if the food was spoiled or otherwise inedible or a provision for a 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 foods are used prior to the product expiration date.

f. 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).
Service Requirements: Section 5 – Nutrition Program Policies

Food Service Contract Provisions

**g. Administration:**

i. Schedule and method of payment to the food vendor;

ii. Sales tax exemption;

iii. Responsibility for product liability insurance and property damage;

iv. Bonding;

v. Requirement that the vendor’s financial records are open for audit purposes;

vi. AAA approval; and

vii. 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. *No eligible individual shall be denied a meal because of failure to contribute.*

B. **Contribution Schedules:** Nutrition providers may develop suggested contribution schedules. Suggested contribution schedules shall not include means testing or consideration of an individual’s ability to pay. Providers are not required to advertise the full cost of the meal.

C. **No eligible individual shall be denied a meal because of failure to contribute.**

D. **Privacy and Confidentiality:** Nutrition providers shall establish procedures to protect the privacy and confidentiality of each client relative to his/her contribution. One example is the use of envelopes in which clients place their contributions.

E. **Use of Contributions:** All nutrition contributions shall be used to increase the number of meals, facilitate access to nutrition services, and to provide nutrition counseling and nutrition education.

F. **Nutrition Assistance Program aka SNAP, (formerly Food Stamps):** Nutrition service providers may apply for authorization to accept Nutrition Assistance Program as contributions.

   1. Providers must be certified to accept Electronic Benefits Transfer (EBT) Card, which contains a client’s Food Assistance benefits. Authorization is obtained from the appropriate field office of the Food and Nutrition Service, Department of Agriculture.

   2. Providers must have an EBT machine or manual scanner to process Food Assistance Program benefits.

   3. Posters that inform clients that EBT benefits are accepted as a contribution must be displayed by nutrition service providers at congregate nutrition meal sites that accept them.
4. Meal sites may use the following link to have their site set up to accept EBT: [http://www.fns.usda.gov/SNAP/retailers/application-process.htm](http://www.fns.usda.gov/SNAP/retailers/application-process.htm)

G. 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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**LEFT OVER FOOD:**

**Procedures for Handling Left Over Food:**

A. Left-over food from a congregate meal site or from a home delivered meal route may not be transported back to the preparation site.

B. Left-over food shall be stored properly or discarded at the congregate nutrition meal site.

C. Left-over food may not be frozen to be served as client meals later.

D. Left-over 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.

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Service Requirements: Section 5 – Nutrition Program Policies

**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.

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Service Requirements: Section 5—Nutrition Program Policies

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 food borne 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 shall be planned and directed by a qualified dietitian, cooperative extension agents or trained meal site or wellness coordinators, under the direction of the qualified dietitian.

B. Nutrition education activities may be provided by a qualified dietitian, cooperative extension agents or trained meal site or wellness coordinators, under the direction of the qualified dietitian.

C. Qualified dietitians may want to review 64B8-44.007(21) Florida Administrative Code’s section on telehealth and its possible use for nutrition education delivery method to assess its compatibility with program.

D. Nutrition education is provided at each site and distributed to each home delivered meal client a minimum of once a month.

E. The provider’s qualified dietitian shall develop a written annual nutrition education plan that documents subject matter, presenters and materials to be used. The AAA, qualified dietitian may develop a single educational curriculum, which may be used by multiple sites.

F. Congregate sessions shall be a minimum of 15 minutes in length.

G. 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 shall include the date of distribution, copy of distributed material, and number of clients receiving the information.
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 physician 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 can be given the opportunity to contribute toward the cost of the nutrition counseling service. Programs should base a suggested donation amount on the full cost of providing the service. When costing the service, include administration, in-kind, supplies, travel, and documentation time.
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, except for clients enrolled in SMMC LTC 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
Service Requirements: Section 5—Nutrition Program Policies

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.

8. **Supportive Services:** To the maximum extent feasible, the site should have available sufficient space and time for the provision of needed supportive services.
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.

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.
**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, and 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.
**Service Requirements: Section 5—Nutrition Program Policies**

**Home Delivered Meals**

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”).

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 noon 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.
11. Each provider shall monitor their HDM meal routes. Providers shall monitor the meal temperatures of all hot and cold potentially hazardous food items. Monitoring shall occur at least monthly. Routes shall be monitored on a random and rotating basis. Whenever temperature noncompliance is 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.

Home-Delivered Frozen Meals: Elderly clients who receive frozen meals must be evaluated using DOE Form 217 before choosing this option. 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.

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.

E. 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.
Service Requirements: Section 5—Nutrition Program Policies

F. **Home-Delivered Cold Meals:** Elderly clients who receive cold or frozen meals must be carefully evaluated using DOE Form 217 before choosing this option. 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 cold or frozen meals expiration date shall be clearly labeled. Instructions for storage and cooking shall be provided in large print.

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 cold or 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 and before the expiration date.

G. **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 to, or have a friend or family member available, to operate kitchen equipment, which is required to later reheat prepared, delivered meals for consumption.
H. 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.
CLIENT EVALUATION FORM FOR COLD OR FROZEN HOME-DELIVERED MEALS

NAME: ____________________________________________________________

ADDRESS: _________________________________________________________

PHONE: ____________________________________________________________

IN 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:

____________________________________________________________________

ABILITY TO PERFORM SMALL MOTOR TASKS (ARTHRITIS?):

_________ GOOD    _________ FAIR    _________ POOR

If poor, please explain:

____________________________________________________________________

DOEA FORM 217, August 2010
MENTAL EVALUATION: (ALZHEIMER'S, CONFUSION, ETC.)

__________ GOOD __________ FAIR __________ POOR

If poor, please explain:


COOKING FACILITIES:

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 OF HANDLING FROZEN or COLD HOME - DELIVERED MEALS?


DOE Form 217, August 2010
Service Requirements: Section 6-Evidence-Based Disease Prevention & Health Promotion Services

Purpose and Legal Authority

SECTION 6 – EVIDENCE-BASED DISEASE PREVENTION AND HEALTH PROMOTION SERVICES

PURPOSE AND LEGAL AUTHORITY:

Purpose of Section 6:

The primary purpose of the Title IIID Evidence-based Disease Prevention and Health Promotion program is to provide services and activities, which 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 Administration on Aging, the program shall target elders aged 60 and over for education and implementation activities that support healthy lifestyles and promote healthy behaviors. Per the Administration on Aging, health education reduces the need for costlier medical interventions. Priority is given to serving elders living in medically underserved areas of the State or who are of greatest economic need. The program requires attention be given to low-income older individuals. These include low-income minority elders, older individuals with limited English proficiency, and older individuals residing in rural areas. Title III D is to 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
**SERVICES OFFERED:**

A. A Matter of Balance (MOB)

B. Active Living Every Day

C. Arthritis Foundation Exercise Program

D. Arthritis Self-Management (Self-Help) Program

E. Brief Intervention and Treatment for Elders (BRITE)

F. Chronic Disease Self-Management Program (CDSMP)

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. Disease Information

M. EnhanceFitness

N. Enhance Wellness

O. Fit & Strong!

P. Health Promotion

Q. Health Risk Assessment

R. Health Risk Screening

S. Health Eating Every Day
Service Requirements: Section 6 - Evidence-Based Disease Prevention & Health Promotion Services

V. Healthy Ideas
W. Healthy Moves for Aging Well
X. Home Injury Control
Y. HomeMeds
Z. 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. Arthritis Foundation Tai Chi Program (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.
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.).
SECTION 7 – VULNERABLE ELDER RIGHTS PROTECTION ACTIVITIES:

PURPOSE AND LEGAL AUTHORITY:

Purpose of Section 7: 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
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;
Service Requirements: Section 7—Vulnerable Elder Rights Protection Activities

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.
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
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:


   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;
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.
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. It is intended that voluntary citizen ombudsman councils be used, through and under the leadership of the State Long-Term Care Ombudsman, to operate a state ombudsman program. 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.

Purpose: The Program’s 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.

Ombudsmen may also assist residents residing in facilities offering extended congregate care.

Responsibilities: Responsibilities of the Long-Term Care Ombudsman Program are in 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 every long-term care facility for 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.

F. 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.
SECTION 8 - MULTIPURPOSE SENIOR CENTERS:

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 III B 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.
Service Requirements - Section 8: - Multipurpose Senior Centers

**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.
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;

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
Service Requirements: Section 8 – Multipurpose Senior Centers

A/R/C Projects

8. **Potential** for use of the MPSC for the following groups of recipients:

a. Title III, Older Americans Act;

b. Alzheimer’s Disease Initiative;

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.
Service Requirements: Section 8 – Multipurpose Senior Centers

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.
Service Requirements: Section 8 – Multipurpose Senior Centers

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;

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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Service Requirements: Section 8 – Multipurpose Senior Centers

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;
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

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.

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.
Service Requirements: Section 8 – Multipurpose Senior Centers

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:


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;
Service Requirements: Section 8 – Multipurpose Senior Centers
Special Consideration for Renovation or Construction Projects

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;

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.

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.
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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Service Requirements: Section 8 – Multipurpose Senior Centers

Obligation of OAA, Title III Funds for A/R/C Projects

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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Service Requirements: Section 8 – Multipurpose Senior Centers

Monitoring of A/R/C Projects

**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 3 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 3 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 8-7 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 DOE 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 paragraph 8-15, by prompt notification to DOE 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, AoA 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 Administration.

E. **Disposition:** DOEA will notify AoA Regional Office in Atlanta of the receipt of recaptured federal funds and request disposition instruction.
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.
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 AoA.

**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 AoA.

J. **Federal Assistant Secretary for Aging Approval of Waiver Request:** The regional office of AoA 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.
Service Requirements: Section 8 – Multipurpose Senior Centers

**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.

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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.
**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 DOE 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.
## SENIOR CENTER ANNUAL VERIFICATION FORM
### ACQUISITION/RENOVATION/CONSTRUCTION

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
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<td></td>
<td>(Street) (City) (Zip)</td>
</tr>
<tr>
<td>Telephone: ( )</td>
<td>Contact Person:</td>
</tr>
</tbody>
</table>

**Project Type** (Check one): 
- [ ] Acquisition  
- [ ] Renovation  
- [ ] Construction

**Date Verification Period Begins:** ____________ **Ends:** ____________  
Anniversary Date

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
Purpose and Legal Authority

Section 9 – National Family Caregiver Support Program:

**Purpose and Specific Legal Authority:**

**Purpose of Section 9:** 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

<table>
<thead>
<tr>
<th>Term:</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Child</strong></td>
<td>Individual not more than 18 years old or an individual with a disability.</td>
</tr>
<tr>
<td><strong>Family Caregiver</strong></td>
<td>Adult family member, or another individual, who is an informal provider of in-home and community care to an older individual.</td>
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<tr>
<td><strong>Frailty</strong></td>
<td>The older individual is determined to be functionally impaired because the individual:</td>
</tr>
<tr>
<td></td>
<td>A. Is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Grandparent or older individual who is a relative caregiver</strong></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>A. Lives with the child;</td>
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<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>C. Has a legal relationship to the child, legal custody or guardianship, or is raising the child informally?</td>
</tr>
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</table>

## 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:
CAREGIVER SUPPORT PROGRAMS/SERVICES

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)

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

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 clients enrolled in the OA3E (elder recipient 60 and older) or OA3EG (grandparent) caregiver programs. The elder recipient (60 and older) 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) and 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
6. Outreach
7. Referral/Assistance
8. Screening/Assessment
9. Sitter
10. Transportation
**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.
OLDER AMERICANS ACT (OAA) REGISTERED SERVICES:

Registered Services are the cluster of services for which AoA 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
GRIEVANCE PROCEDURES:


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Chapter 5

Administration of the Community Care for the Elderly (CCE) Program
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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.
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. 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.
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 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
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
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.
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.

B. Program Requirements: The CCE program requirements are listed on the following pages.
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 CCE services. Functional impairment shall be determined through a functional assessment administered to each applicant for 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 activities. The Screening Form (701S) is used to prioritize applicants for services who have not begun to receive services. Applicants can be prioritized by greatest need to be assessed and to receive needed services. A priority score and rank are produced. The Comprehensive Assessment (701B) is used at initiation of services, at reassessment and to assess and update significant change in the client’s situation. A risk score is produced from the 701B and a priority score and rank are produced from either form.

   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.
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 in Section D below.

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.
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.

Clients in the following groups are priority recipients for CCE services, listed in the order of the highest priority:

A. Assessment and Prioritization of Service Delivery for New Clients

Clients in the following subgroups are priority recipients for CCE case management and CCE 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 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.

   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 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): “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.

3. Aging Out individuals: Individuals receiving Community Care for Disabled Adults (CCDA) and Home Care for Disabled Adult (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 individuals not included in (1), (2), and (3) 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 first 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 Waiver Services:

1. The contractor shall require subcontractors to identify potential Medicaid eligible CCE clients through the assessment instrument and refer them to apply for Medicaid waiver services (hereafter referred to as “waiver services”).

2. Individuals identified as being potentially Medicaid waiver eligible are required to apply for waiver services in order to receive CCE services and can only receive CCE services while the Medicaid waiver eligibility determination is pending. If the individual is found ineligible for waiver services for any reason other than failure to provide required documentation, the individual may continue to receive CCE services.

3. Individuals who have been identified as being potentially Medicaid waiver eligible must be advised of their responsibility to apply for waiver services as a condition of receiving CCE services during the Medicaid waiver eligibility determination process.

4. 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.
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. 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

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.
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.
Program Requirements

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<tr>
<td>l.</td>
<td>Provide and monitor program policies and procedures for the PSAs.</td>
</tr>
<tr>
<td>m.</td>
<td>Review and make recommendations for improvement on program reports.</td>
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<tr>
<td>n.</td>
<td>Provide technical assistance to the AAAs in program planning and development and ongoing operations, as needed.</td>
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<tr>
<td>o.</td>
<td>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.</td>
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<tr>
<td>p.</td>
<td>Assist the AAAs and Lead Agencies in determining CCE services to be funded within the PSAs.</td>
</tr>
<tr>
<td>q.</td>
<td>Co-monitor with the AAAs, if feasible.</td>
</tr>
<tr>
<td>r.</td>
<td>Process payments to the contract agencies.</td>
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<tr>
<td>s.</td>
<td>Develop co-payment guidelines.</td>
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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.
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<tr>
<td>f.</td>
<td>Provide technical assistance to Lead Agencies and vendors to ensure provision of quality services.</td>
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<tr>
<td>g.</td>
<td>Require annual submission of CCE applications or updates, for funding of current Lead Agencies using minimum guidelines provided by DOEA.</td>
</tr>
<tr>
<td>h.</td>
<td>Notify applicants of acceptability of applications and any further action.</td>
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<tr>
<td>i.</td>
<td>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.</td>
</tr>
<tr>
<td>j.</td>
<td>Assess Lead Agency fiscal management capabilities.</td>
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<tr>
<td>k.</td>
<td>Monitor and evaluate Lead Agency case management capabilities.</td>
</tr>
<tr>
<td>l.</td>
<td>Assess the availability of a 10 percent match for Lead Agency budget.</td>
</tr>
<tr>
<td>m.</td>
<td>Establish agreements for Lead Agency and CCE services according to manuals, rules and agreement procedures of DOEA. Establish vendor agreements, when applicable.</td>
</tr>
<tr>
<td>n.</td>
<td>Monitor and evaluate contracts, subcontracts and vendor agreements for programmatic and fiscal compliance.</td>
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<tr>
<td>o.</td>
<td>Submit payments to contractors.</td>
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<tr>
<td>p.</td>
<td>Arrange in-service training for Lead Agencies at least annually.</td>
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<td>q.</td>
<td>Establish appeal procedures for handling disputes involving Lead Agency, CCE services and vendor agreements.</td>
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<tr>
<td>r.</td>
<td>Establish procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services.</td>
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Program Requirements | Responsibilities of Stakeholders
--- | ---
s. | 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.

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 in order to provide a continuum of care.
   c. Provide directly or establish subcontracts or vendor agreements, when applicable, for CCE services.
   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 to the fullest extent possible to provide services to clients and assist with other Lead Agency activities.
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<td>g. Compile accurate reports.</td>
<td>h. Monitor subcontracts and vendor agreements to ensure quality services and efficient use of funds. Make payments to subcontractors for CCE services.</td>
</tr>
<tr>
<td>i. Initiate and maintain coordination among agencies.</td>
<td>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.</td>
</tr>
<tr>
<td>k. Accept voluntary contributions, gifts and grants to carry out a community care service system.</td>
<td>l. Demonstrate innovative approaches to program management, staff training and service delivery that impact on cost avoidance, cost effectiveness and program efficiency.</td>
</tr>
<tr>
<td>m. Establish and follow procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services.</td>
<td>n. Conduct client satisfaction surveys to evaluate and improve service delivery.</td>
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Program Requirements

Line of Communication

**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:

Chapter 6

Administration of the Alzheimer’s Disease Initiative (ADI)
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**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) and their caregivers; and

2. **Cure:** To find through research the cause, treatment and ultimately a cure for AD.

C. **ADI Program Components:** The ADI is composed of the following program components:

1. Alzheimer’s Disease Advisory Committee;

2. Memory disorder clinics;

3. Model day cares;

4. Specialized Alzheimer’s Services Adult Day Care Centers;

5. Respite care; and

6. A brain bank.
LEGAL BASIS, HISTORY AND SPECIFIC LEGAL AUTHORITY:

Legal Basis and History:

A. **Florida Statutes:** In 1985, 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. Model day care programs; (Currently, there are 34 Specialized Alzheimer’s Services Adult Day Care Centers)
5. Four memory disorder clinics; and
6. Through subsequent amendments:
   a. A brain bank; and
   b. Additional memory disorder clinics. (Currently, there are 16 designated MDCs.)

B. **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.

C. **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 disorder, or be suspected of having Alzheimer’s disease or a related disorder.
2. **Caregivers:** Caregivers are also eligible to receive training, respite and related support services to assist them in caring for the ADI client.
3. **Eligibility for Multiple Services:** There is no prohibition against an ADI client receiving more than one type of ADI service during the same time period.

   a. **Multiple ADI Services:** The use of multiple ADI services for a client should be based upon the client’s assessed needs and upon the local resources available.

   b. **Example:** A client may receive services at an ADI model day care program three days a week and also receive respite care in the home two days a week.

4. Clients MAY NOT be dually enrolled in the ADI program and a Medicaid capitated long-term care program.

**Specific Legal Authority:**

Chapter 430.501-504, F.S.

Chapter 58D-1, F.A.C.

Chapter 429.918, F.S.
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: There are many other related disorders, which are included by reference every time the term Alzheimer’s disease is used in this document. Some of the more well-known of these related disorders 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.

   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.

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.
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 and model day care. Co-payment shall be assessed for all services below except Intake. Refer to Appendix A, “Service Descriptions and Standards,” for a description of each service.

1. Caregiver Training/Support;
2. Case Aide;
3. Case Management;
4. Counseling (Gerontological);
5. Counseling (Mental Health/Screening);
6. Education/Training;
7. Intake;
8. Model Day Care/Specialized Alzheimer’s Services Adult Day Care Center;
9. Respite (Facility-Based);
10. Respite (In-Home); and
11. Specialized Medical Equipment, Services and Supplies.
12. Transportation

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. Diagnosis, evaluation and referral services for ADI clients;
b. Service-related research and research on the cause, prevention and treatment of Alzheimer’s disease. MDCs shall initiate at least one contact with respite and model day care providers annually to review progress relative to research efforts and exchange ideas with the providers.

c. Training: Develop and provide training for lay and professional caregivers.

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 model day care providers, which will include health professionals and caregivers.

ii. AAAs, memory disorder clinics, respite and model day care programs must collaborate in the development of training to meet staff needs.

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. The sixteen (16) MDCs are based regionally at:

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<thead>
<tr>
<th>Name of Memory Disorder Clinic</th>
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<tr>
<td>a. The University of Miami</td>
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<td>b. The University of Florida</td>
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<td>c. The University of South Florida</td>
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<td>d. Mayo Clinic</td>
<td>Jacksonville</td>
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<td>e. West Florida Hospital</td>
<td>Pensacola</td>
</tr>
<tr>
<td>f. East Central Florida Memory Disorder Clinic</td>
<td>Melbourne</td>
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<tr>
<td>g. Orlando Regional Healthcare System, Inc.</td>
<td>Orlando</td>
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<tr>
<th></th>
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<td>Tallahassee</td>
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<tr>
<td>i.</td>
<td>St. Mary’s Medical Center</td>
<td>Palm Beach</td>
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<tr>
<td>j.</td>
<td>Lee Memorial Health System</td>
<td>Ft. Myers</td>
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<tr>
<td>k.</td>
<td>Sarasota Memorial Health Care System</td>
<td>Sarasota</td>
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<td>l.</td>
<td>Mount Sinai Medical Center</td>
<td>Miami Beach</td>
</tr>
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<td>m.</td>
<td>North Broward Regional Medical Center</td>
<td>Pompano Beach</td>
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<td>n.</td>
<td>Morton Plant Hospital</td>
<td>Clearwater</td>
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<td>o.</td>
<td>Florida Atlantic University</td>
<td>Boca Raton</td>
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<tr>
<td>p.</td>
<td>Florida Hospital</td>
<td>Orlando</td>
</tr>
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#### 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:

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<tr>
<td>a.</td>
<td>State-sponsored memory disorder clinics;</td>
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<td>b.</td>
<td>Model day care and respite care programs; and</td>
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<tr>
<td>c.</td>
<td>Local organizations providing services to clients with dementia and their families;</td>
</tr>
<tr>
<td>d.</td>
<td>Self-referral; and</td>
</tr>
<tr>
<td>e.</td>
<td><strong>Brain Bank Information:</strong> Information regarding the Brain Bank program and applications can be obtained from:</td>
</tr>
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The Wien Center for Alzheimer’s Disease and Memory Disorders  
Mount Sinai Medical Center
Services Provided Under the ADI Program

4300 Alton Road
Miami Beach, Florida 33140

Phone: 305-674-2018
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 first priority.

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**: In addition to the primary brain bank site in Miami, there is a coordinator at the regional brain bank site to assist in recruiting clients and act as liaison between the brain bank and the client’s family:

   Alzheimer's & Dementia Resource Center
   1506 Lake Highland Drive
   Orlando, FL 32803
   (407) 843-1910
4. **Model Day Care**: These are licensed specialized Alzheimer’s services adult day care centers, licensed in accordance with Section 429.918 F.S., that are considered models because they provide specialized Alzheimer’s services for AD clients. 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 in model day care centers 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;

iv. Providing relief for the ADI client’s primary caregiver.

5. **Alzheimer’s Disease Advisory Committee**: Pursuant to Chapter 430.501(2)(3), Florida Statutes, the Governor of the State of Florida appoints a ten (10) member Alzheimer’s Disease Advisory Committee to advise DOEA.

a. **Committee Composition**: The composition of the 10-member committee should include the following individuals:

i. At least four (4) who are licensed medical doctors in accordance with Chapters 458 or 459, Florida Statutes; or hold a Ph.D. degree and are currently involved in the research of Alzheimer’s disease;

ii. At least four (4) who are the primary caregivers of persons diagnosed with Alzheimer’s disease or related dementias; and

iii. Whenever possible, the ten-member committee shall include one (1) each of the following professionals: gerontologist,
Services Provided Under the ADI Program

- geriatric psychiatrist, geriatrician, neurologist, social worker, and registered nurse.

iv. Additional Selection Criteria: The Governor shall appoint committee members from a broad cross section of public, private and volunteer sectors.

v. DOEA Role: The Secretary of DOEA shall forward all nominations to the Governor.

vi. Secretary of DOEA: The Secretary of DOEA shall serve as an ex-officio member of the committee.

b. Member Terms: Members shall be appointed for four (4) year staggered terms.

c. Committee Chair: The committee shall select one of its members to serve as chair for a one (1) year term.

d. Committee Function: The function of the advisory committee is to advise DOEA in the performance of its duties under the ADI. As appropriate, and with the approval of DOEA, the advisory committee may establish subcommittees to carry out the functions of the committee.

e. Frequency of Committee Meetings: The committee shall meet at least quarterly or as frequently as necessary. DOEA will advise MDCs, model day care providers, respite care providers and local Alzheimer's Association chapters of ADI advisory committee meetings.

f. Committee Support: DOEA shall provide support staff to assist the committee in the performance of its duties. DOEA shall provide minutes and reports generated in the ADI Advisory Committee meetings to interested parties as requested. DOEA shall prepare and disseminate an annual report on the accomplishments of the ADI components to all providers.

g. Member Reimbursement: Members of the committee and subcommittees shall receive no salary, but are entitled to reimbursement for travel and per diem expenses, as provided in Section 112.061, F.S., while performing duties.
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 model 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. **Staff Liaison:** Provide staff assistance to the ADI Advisory Committee; and

   k. **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.

2. **Responsibilities:** The AAA has the following responsibilities:

   a. **Competitive Solicitation:** Conduct competitive solicitation for agencies to provide respite and model day care services, as applicable, in accordance with Chapter 287, Florida Statutes, and the AAA board approved procurement procedures;

   b. **Subcontracts:** Enter into subcontracts with agencies to provide ADI respite and model day care services, as applicable;

   c. **Provider Application:** Review and critique the ADI service provider application to ensure completeness, accuracy and that all revisions are noted;

   d. **Administration and Monitoring:** Administer and monitor ADI program policies and procedures;

   e. **Program Reports:** Ensure that all program reports are accurately completed and submitted in a timely manner;

   f. **Technical Assistance:** Provide technical assistance to the ADI subcontracts in program planning and development and ongoing operations as needed;

   g. **Staff Development and Training:** Provide for AAA staff development and training;

   h. **Contracting Responsibilities:** Assume contracting responsibilities, including review of the applicant’s subcontracts, if applicable;

   i. **Provider Fiscal Assessment:** Assess the fiscal management capabilities of the service providers;

   j. **Performance Review:** Review the performance of service providers in carrying out their service delivery responsibilities;

   k. **Processing:** Process requests for payment and reports on receipts and expenditures to DOEA;
l. **Technical Assistance:** Provide technical assistance to providers to ensure provision of quality services;

m. **CIRTS:** Ensure compliance with Departmental Client Information and Registration Tracking System (CIRTS) policies;

n. **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 model day care providers annually, where applicable. The AAA must collaborate and act as liaison in arranging this training;

o. **Co-payment:** Ensure implementation of co-payment guidelines; and

p. **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 model day care as specified in the approved service provider application and each client’s care plan.

   a. **Co-Payment:** Assess and collect co-payments; and

   b. **Client Satisfaction:** Conduct client satisfaction surveys to evaluate and improve service delivery.
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 the Silver Alert Support Committee, its agency members, and 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 general public.

   a. The training will explain the Silver Alert Protocols, the part played by law enforcement, the MDCs, the senior network and the general public. It will emphasize the basic goals of the plan which are:

      i. Public safety
      ii. Assistance to law enforcement in locating a missing senior
      iii. Education
      iv. Prevention
Coordination of Services

B. Coordination with Respite Service Providers: MDCs will collaborate with in-home and facility-based respite service providers at the direction of DOEA for the purpose of 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 model 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 model day care and respite care providers 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 model day care and respite care providers to review progress with research efforts and exchange ideas.

C. SERVICE PROVIDERS:

1. Referral Form: Respite care and model day care center providers will be provided with a referral form for use by clients and caregivers in gaining access to MDCs. The procedure will include the following:
   2. The provider will complete and send the referral form to the MDC agency on behalf of AD client/caregiver.
   3. The AD client’s caregiver will contact the MDC to arrange for an appointment time.
   4. The MDC will forward the completed assessment to the respite care or model day care provider for the client’s file.
**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 in order 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 first 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 most frail 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.
CO-PAYMENT ASSESSMENT:

Co-payment assessment information is included in Appendix B of this Handbook.
GRIEVANCE PROCEDURES:

Chapter 7

Administration of the Home Care for the Elderly (HCE) Program
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Purpose of the HCE Program

PURPOSE OF THE HCE PROGRAM:

Purpose of Chapter: 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.
LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

A. Legal Basis:

1. 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.

2. 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:

1. Sections 430.601–608, F.S. as created by Chapter 95-418, Laws of Florida

2. Chapter 58H-1, F.A.C.
SERVICES PROVIDED UNDER THE HCE PROGRAM:

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.

   b. Subsidy Chart: This information is provided by DOEA to provider agencies on a subsidy chart (refer to Attachment 3 of this chapter for a sample subsidy chart).

2. Types of Subsidy Payments: Two types of subsidy payments are available in the HCE Program.

   a. Basic Subsidy: This subsidy is paid in accordance with the schedule of payments developed by DOEA (Attachment 3).

      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.

   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.
Services Provided Under the HCE Program

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**: Services must not be available for the client through Medicare, Medicaid, Veterans Administration (VA) or other insurance.

iv. **Applicability**: The services or supplies authorized for special subsidy directly relate to the client’s health conditions.

v. These 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);
(G) Counseling (Mental Health/Screening);
(H) Home Delivered Meals;
(I) Home Health Aide Service;
(J) Homemaker;
Services Provided Under the HCE Program

(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.

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.

**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.
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, for 30 days or less, the basic subsidy check will be sent to the caregiver as though the client were in the home.
   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, the client will be terminated from 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.
**GENERAL ELIGIBILITY CRITERIA AND ELIGIBILITY PROCESS:**

**General Eligibility Criteria:** To be eligible for HCE the client must meet the following criteria:

A. **Age:** Be age 60 years or older.

B. **Income and Assets:** Have income and assets which do not exceed the Medicaid Institutional Care Program (ICP) limits for nursing home care eligibility. DOEA will provide ICP limit information annually.

C. **Risk of Institutional Placement:** Be at risk of nursing home placement based on the comprehensive assessment (DOEA Form 701B).

D. **Caregiver:** Be living in the home with an adult caregiver age 18 years or older who is:

   1. Willing and able to provide care and assist in arranging services for the client; and
   2. Qualified as an HCE caregiver based on the client’s choice and the case manager’s assessment.

E. **Additional Requirements:** Program Enrollment Criteria for HCE Caregivers are more fully explained in specific eligibility sections of this chapter and are listed in Attachment 6 of this chapter.
Eligibility Process:

A. **Required Forms:** The case manager must complete the following forms as part of the eligibility process:

1. Comprehensive Assessment (DOEA 701B)
2. Care Plan (DOEA Forms 203A and 203B)
3. Notice of Case Action (Attachment 5a)
4. Financial Worksheet (for clients not identified as automatically financially eligible—Attachment 1)

B. **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.
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.
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.

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 in order 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 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).
Program Requirements | Specific Eligibility Criteria

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): “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 first priority is given to applicants at the higher levels of frailty and risk of nursing home placement.
Program Requirements

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<thead>
<tr>
<th>Specific Eligibility Criteria</th>
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<tr>
<td>2. <strong>Financial Eligibility:</strong> 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.</td>
</tr>
<tr>
<td>a. <strong>Persons with Automatic Eligibility:</strong> 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.</td>
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<tr>
<td>i. <strong>Basic Subsidy Amount:</strong> The amount of basic subsidy this type of client receives is determined by the amount of the monthly income the case manager records on the assessment instrument.</td>
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<tr>
<td>(A) Attachment 3 will assist in determining the amount of basic subsidy based on the applicant's income.</td>
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<td>(B) The case manager will enter the basic subsidy amount into the Client Information and Registration Tracking System (CIRTS).</td>
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<tr>
<td>ii. <strong>Methods of Benefit Verification:</strong> 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:</td>
</tr>
<tr>
<td><strong>Supplemental Security Income (SSI):</strong></td>
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<tr>
<td>(A) A copy of the SSI award letter or form, dated within 30 days from the time of application;</td>
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<tr>
<td>(B) Florida Medicaid Management Information System (FMMIS).</td>
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<tr>
<td>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 <a href="http://ahca.myflorida.com">http://ahca.myflorida.com</a>.</td>
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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 similar to 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.

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.
does not exceed the Institutional Care Program standard. DOE 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.

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;
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.

- **(B) Follow-up:** The case manager would have to follow up to determine the actual amount approved by Social Security.

- **(C) Receipt of Benefits:** In the month that the client begins to receive SSI, the client’s basic subsidy amount shall be adjusted to reflect the client’s new income amount.

- **(D) NOTE:** Each HCE client should be instructed to inform the case manager of any changes in income or assets.

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<th>Program Requirements</th>
<th>Specific Eligibility Criteria</th>
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<td><strong>v.</strong> <strong>Applicant Determined Financially Eligible:</strong> Once it is determined that the applicant is financially eligible, the case manager should refer to the basic subsidy chart (Attachment 3) to determine the amount of monthly subsidy for which the client is eligible. The client’s income is figured on the Financial Worksheet (Attachment 1) and that figure is</td>
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matched to the subsidy available for that income range listed on the Attachment 3.

vi. **Client File:** The Financial Worksheet is placed in the client file. The basic subsidy amount is entered into CIRTS in accordance with procedures in this Handbook regarding CIRTS data entry.

**B. HCE Caregiver:**

1. **Caregiver Assessment:** During the home visit, the case manager shall conduct an assessment of 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).

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 is capable of providing 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.

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<th>Program Requirements</th>
<th>Specific Eligibility Criteria</th>
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<td>i.</td>
<td>A Level II Background Screening will need to be completed for all HCE caregivers who are non-relatives of the consumer.</td>
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<tr>
<td>c. Physical Presence</td>
<td>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.</td>
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</table>
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 general public as one of the following:

i. Adult family care home;

ii. Group home;

iii. Half-way house;

iv. Assisted living facility; or

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 conduct an assessment of 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:** Particular 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.

**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 4) 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.

b. An annual eligibility re-determination includes:

i. Completion of the eligibility process as outlined in this chapter;

ii. Providing updates to the CIRTS 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.
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) in order to identify the client’s:
   a. Problems and 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: In order 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.
2. **Cut Off Date:** The client and caregiver registration cut-off date is the 15th of the month in order to receive the basic subsidy. Anyone registered after the 15th shall have the first day of the subsequent month as an eligibility date.

**Examples:**

<table>
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<tr>
<th>Client</th>
<th>CIRTS Start Date</th>
<th>Basic Subsidy (and Special Subsidy, if authorized) Received For</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>08/14/14</td>
<td>August 2014</td>
</tr>
<tr>
<td>B</td>
<td>08/16/14</td>
<td>September 2014</td>
</tr>
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**F. 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.
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 DOE A 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 in order 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.

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 case narrative.
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 particular 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 make arrangements with a competent adult person to supervise and observe the status of the client.

   b. **Alternate Caregiver:**

   i. When absences from the home are on a daily basis or of a routine nature, i.e. 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.

   ii. The caregiver may pay the alternate caregiver for provision of services; however, respite services are not appropriate in a routine employment situation under the HCE program even for clients who are also CCE or ADI eligible.
3. **Arrangements for Supervision**: The caregiver should make arrangements 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.

4. **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.
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.
Program Requirements | Role of the HCE Caregiver
--- | ---

(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.


SERVICE COORDINATION WITH OTHER DOEA 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. Consumers MAY NOT be dually enrolled in the HCE program and a Medicaid capitated long-term care program.

   In some circumstances, the case manager may authorize eligibility for services such as personal care and homemaker.

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.

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.
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.
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. Prepare and revise the AAA area plan update;
   
   c. Plan with Lead Agencies to determine service needs;
   
   d. Provide technical assistance to Lead Agencies and vendors to ensure the provision of quality HCE services;
   
   e. Require an annual submission of HCE application or updates for funding of current Lead Agencies and vendors;
   
   f. Assess and monitor the Lead Agency’s fiscal and programmatic management capabilities;
   
   g. Establish agreements for services in accordance with DOEA rules and agreement procedures;
   
   h. Review and evaluate contractor agreements, subcontractor agreements, and vendor agreements for programmatic and fiscal compliance;
   
   i. Remit payments to subcontractors;
   
   j. Arrange in-service training for case management agencies and vendors annually;
   
   k. Ensure that case management agencies follow established grievance procedures regarding denial, reduction or termination of HCE services to clients; and
   
   l. Ensure compliance with CIRTS regulations.
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 to the fullest extent 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 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.
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:

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: These refer to only the APPLICANT’S/CLIENT’S income and assets

<table>
<thead>
<tr>
<th>INCOME INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ask the applicant/client: “Do you receive income from any of the following sources, and if so, in what amounts?”</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>#</th>
<th>Income Source</th>
<th>Yes (✓)</th>
<th>No (✗)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Social Security (SSA)*</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>2.</td>
<td>Veteran’s Administration (VA)</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>3.</td>
<td>Disability Payments including Worker’s Compensation (Not SSA, SSI or VA)</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>4.</td>
<td>Retirement Pensions (Railroad, Union, Government)</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>5.</td>
<td>Interest and Dividends</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>6.</td>
<td>Annuity Income including Civil Service</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>7.</td>
<td>Rental property</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>8.</td>
<td>Estate/Trust Fund Income</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>9.</td>
<td>Alimony/child support</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>10.</td>
<td>Contributions from another person</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
<tr>
<td>11.</td>
<td>Other income</td>
<td></td>
<td>✓</td>
<td>$</td>
</tr>
</tbody>
</table>

**TOTAL APPLICANT/ CLIENT INCOME** $

* Gross SSA income needs to be counted. The SSA check is the net amount after the Medicare premiums are deducted.

<table>
<thead>
<tr>
<th>COMMENTS/ NOTES/ CALCULATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### ASSET INFORMATION

Ask the applicant/client: “Do you have any of the following assets, and if so, what are their values?

<table>
<thead>
<tr>
<th>#</th>
<th>Asset</th>
<th>Yes (✓)</th>
<th>No (✓)</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>More than one automobile (include amount only if car is less than 7 years old or more than 25 years old)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>2.</td>
<td>Life Insurance Policies that have a <strong>total face value of over $2,500.</strong></td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>3.</td>
<td>Cash on hand</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>4.</td>
<td>Checking Account(s)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>5.</td>
<td>Savings Account(s)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>6.</td>
<td>Certificate(s) of Deposit</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>7.</td>
<td>Individual Retirement Account(s)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>8.</td>
<td>Revocable Burial Contract</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>9.</td>
<td>Trust(s)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>10.</td>
<td>Stocks/Bonds/Mutual Funds</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>11.</td>
<td>Real Property (<strong>not homestead</strong>)</td>
<td></td>
<td></td>
<td>$</td>
</tr>
<tr>
<td>12.</td>
<td>Christmas Club savings</td>
<td></td>
<td></td>
<td>$</td>
</tr>
</tbody>
</table>

* 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:**
## FINANCIAL ELIGIBILITY DETERMINATION

<table>
<thead>
<tr>
<th></th>
<th>Income</th>
<th>Yes (✓)</th>
<th>No (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>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). <strong>Does the applicant/client meet the income eligibility requirement?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Assets</th>
<th>Yes (✓)</th>
<th>No (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>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. <strong>Does the applicant/client meet the asset eligibility requirement?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Financial Eligibility</th>
<th>Yes (✓)</th>
<th>No (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>If the applicant/client meets both eligibility requirements cited in 1 and 2 above, then he/she is financially eligible for the HCE program. <strong>Does the applicant/client meet both requirements?</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

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:** ________________
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:

<table>
<thead>
<tr>
<th>#</th>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Automobile</td>
<td>The individual’s automobile, which includes any mode of transportation regardless of use or value.</td>
</tr>
<tr>
<td>2.</td>
<td>Burial (Funds set aside for)</td>
<td>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.</td>
</tr>
<tr>
<td>3.</td>
<td>Burial Spaces Inclusions:</td>
<td>A burial space for each individual and immediate family which includes the following individuals:</td>
</tr>
<tr>
<td></td>
<td>A. Spouse;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Minor or adult children;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. Step children;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>D. Adopted children;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>E. Brothers and sisters;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>F. Parents;</td>
<td></td>
</tr>
</tbody>
</table>
G. Adopted parents; and

H. Spouse of any of the above.

**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 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 with the exception of 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 considered to be 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.

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 as long as 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:**

<table>
<thead>
<tr>
<th>#</th>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Additional Automobiles</td>
<td>One or more additional automobiles other than the one excluded.</td>
</tr>
<tr>
<td>2.</td>
<td>Cash on Hand</td>
<td>Any cash in the individual’s possession that is not income for the month is considered as an asset.</td>
</tr>
<tr>
<td>3.</td>
<td>Certificates of Deposit (CD) and Individual Retirement Accounts (IRA)</td>
<td>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.</td>
</tr>
</tbody>
</table>
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 applicant’s.

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.

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 particular 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 Fund 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>
<thead>
<tr>
<th>Type</th>
<th>Verification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stocks, bonds, mutual funds</td>
<td>Stock broker</td>
</tr>
<tr>
<td>U.S. Savings Bond</td>
<td>Bank</td>
</tr>
</tbody>
</table>

9. Trusts

Trusts are money or property held by a trustee for the benefit of the individual who is the beneficiary. This type of asset is the only one that is also considered income in the same month.

A. The principal balance of the trust is not usually available to the beneficiary, thus is not considered an asset.

B. **Exception:** If the individual for his 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.
### HCE BASIC SUBSIDY CHART

<table>
<thead>
<tr>
<th>Recipient’s Monthly Income</th>
<th>Basic Subsidy Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>$  0-24.99</td>
<td>$370</td>
</tr>
<tr>
<td>$  25-49.99</td>
<td>$337</td>
</tr>
<tr>
<td>$  50-74.99</td>
<td>$304</td>
</tr>
<tr>
<td>$  75-99.99</td>
<td>$272</td>
</tr>
<tr>
<td>$100-124.99</td>
<td>$239</td>
</tr>
<tr>
<td>$125-149.99</td>
<td>$207</td>
</tr>
<tr>
<td>$150-174.99</td>
<td>$174</td>
</tr>
<tr>
<td>$175-199.99</td>
<td>$148</td>
</tr>
<tr>
<td>$200-224.99</td>
<td>$122</td>
</tr>
<tr>
<td>$225-up to the ICP Income Ceiling</td>
<td>$106</td>
</tr>
</tbody>
</table>
OPTIONAL HCE SAFETY AND ACCESSIBILITY WORKSHEET:

<table>
<thead>
<tr>
<th>AREA OF CONCERN</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of Home, Floors—Overall Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposed wiring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creaking or uneven floors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ceilings with water marks</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doors open with difficulty</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Windows cannot be opened</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outside structure appears to be leaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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: ________________________________

<table>
<thead>
<tr>
<th>AREA OF CONCERN</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access—Overall Risk</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client lives above the 1st floor of the building</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client lives above the 1st floor of the building with no elevator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client has limited/deteriorating mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client lives in 2-story home with bedrooms upstairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client cannot climb stairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client uses a wheelchair for mobility</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Entrance to the home has steps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doorways are too narrow, rooms too small to safely maneuver</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Question and Response:

1. If the client uses a wheelchair for mobility, ask how he/she is able to maneuver within and in and out of the home?
Response: ________________________________

                                           ________________________________
                                           ________________________________
                                           ________________________________
### Attachment 4: Optional HCE Safety and Accessibility Worksheet

#### AREA OF CONCERN

<table>
<thead>
<tr>
<th>Electrical System—Overall Risk</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrical cords are frayed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extension cords are overused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Electric plugs are partially hanging out of the wall</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The wiring in the home is poor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Fire Safety—Overall Risk</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wall-to-wall clutter</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client and/or caregiver smoke</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No smoke alarms or alarms do not work (no batteries)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of non-vented space heater</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fireplace used without a screen guard</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

**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 the batteries lately?
   **Response:**

5. Do you set a timer when using the oven or toaster oven?
   **Response:**
### Attachment 4: Optional HCE Safety and Accessibility Worksheet

#### AREA OF CONCERN

<table>
<thead>
<tr>
<th></th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sanitation—Overall Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unpleasant odor in the house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>House is unclean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathrooms are unclean and odorous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Furniture/carpet are soiled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of pest or pest’s droppings in the house</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of dead pest odor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of pet odor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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:**

3. **Do you use sprays or tablets for control?**
   **Response:**

#### AREA OF CONCERN

<table>
<thead>
<tr>
<th></th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hot Water/Water—Overall Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of excessive amounts of dirty dishes from lack of water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client is unkempt, unclean and has body odor</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s clothing is unclean</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Questions and Responses:**

1. **Do you have running water?**
   **Response:**

2. **Do you have hot water?**
   **Response:**

**Additional Comments:**

---

July 2017
### Heating/Air Conditioning—Overall Risk

<table>
<thead>
<tr>
<th>Area of Concern</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature in the house is too warm or cold</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room is stuffy even with air conditioner on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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:  

### Shopping Accessibility—Overall Risk

<table>
<thead>
<tr>
<th>Area of Concern</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of little or no food in cabinets/pantry/refrigerator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evidence of prescriptions not filled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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:  

---

**July 2017**
## Attachment 4: Optional HCE Safety and Accessibility Worksheet

<table>
<thead>
<tr>
<th>AREA OF CONCERN</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation Accessibility—Overall Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client is unable to get to local transportation pickup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client does not drive or have anyone who can drive him/her</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregiver does not drive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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: 

<table>
<thead>
<tr>
<th>AREA OF CONCERN</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telephone Accessibility—Overall Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No telephone is visible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No phone number is listed on the referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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: 

---

DEPARTMENT OF ELDER AFFAIRS PROGRAMS AND SERVICES HANDBOOK
Chapter 7: Administration of the Home Care for the Elderly Program

July 2017 7-50
### AREA OF CONCERN

<table>
<thead>
<tr>
<th>Emergency Evacuation Capability—Overall Risk</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>The doors and windows are boarded up, nailed shut, covered with burglar bars or otherwise will not open</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The client is unable to walk, transfer to a wheelchair, open doors or manage stairs, making evacuation attempts impossible</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit access is obstructive (clutter, furniture, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client’s bedroom does not have two means of unobstructed exit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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 the case of an emergency?**
   **Response:**

### Additional Comments:

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 changes in your physical or financial conditions.

SECTION 2b: INELIGIBILITY  
You are not eligible to receive HCE services for the following reason(s):  
___ 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 a 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: ____________
**SECTION 1:**

<table>
<thead>
<tr>
<th>APPLICANT’S NAME:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td></td>
</tr>
<tr>
<td>TELEPHONE #:</td>
<td></td>
</tr>
<tr>
<td>CAREGIVER’S NAME:</td>
<td></td>
</tr>
</tbody>
</table>

This form is to notify you of the decision regarding review of your case action:

**SECTION 2:**

Based on all of the information involved in this reconsideration, the Lead Agency:

- A. Confirms the decision.
- B. Does not confirm the decision.

Comments: _____________________________

**SECTION 3:**

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: ______________
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:** Making arrangements 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 of 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;
   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 8

Emergency Management and Preparedness
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<td>8-78</td>
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<td>Attachment 8: DOEA Form 590, Discharge Planning Tool for Rapid</td>
<td>8-108</td>
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<td></td>
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<tr>
<td>J.</td>
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<td>Elder Helpline: Standards for Professional Information and Referral</td>
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<td>M.</td>
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</tr>
</tbody>
</table>
Purpose and Goals of Emergency Preparedness

PURPOSE AND GOALS OF EMERGENCY PREPAREDNESS:

The purpose and goals of a comprehensive Emergency Management and Disaster Preparedness Program are as follows:

Purpose:

A. To develop and implement essential and reliable communication, coordination and delivery of services for elders across government agencies, the aging network and care provider systems at the private, non-profit and public levels.

B. To facilitate emergency preparedness and disaster planning at federal, state and local levels. The Department of Elder Affairs (DOEA), other agencies whose charters require services to elders and, in particular, the Florida Division of Emergency Management, should assist local governments to facilitate emergency preparedness and disaster planning for older persons.

C. To ensure that government is sensitive to the unique needs and resources of elders. Some elders will have increased physical, mental and emotional needs during emergencies, requiring assistance to initiate protective actions. Those in institutions and with limited mobility may require extensive transportation efforts and assistance. Still other actively involved elders can serve as useful resources supporting the emergency response as they bring years of expertise to bear on the situations.

Goals:

A. Encourage the integration of a coordinated federal, state and local emergency response plan for elders in the state’s Comprehensive Emergency Plan (CEMP) in the event of public health emergencies, catastrophic events or disasters. To foster an environment that promotes well-being for Florida’s elders and enables them to remain in their homes and communities.

B. Provide education, demographic information, training and technical assistance on disaster planning and emergency response for elders to increase public awareness, create a culture of preparedness and provide expertise to local, state and federal officials.
C. Support efforts to improve access and transportation to special needs shelters, including improvements to the special needs registry, and ensure the appropriateness of services available at special needs shelters.

D. Support efforts to improve and standardize special needs shelter procedures for discharge planning and transition assistance for elders in the event of a public health emergency, catastrophic event or disaster.

E. Develop a comprehensive planning template and sample plan for communities to use in preparing to address unique needs of elders to mitigate the effects of public health emergencies, catastrophic events and disasters.

F. Seek support to identify resources available to locate and contact elders in the general population who are not currently receiving assistance or services from the aging network, but who may require assistance during a public health emergency, catastrophic event, power outage or disaster.

G. Work with local emergency response agencies and county emergency operations centers to maximize their ability to plan for and meet the needs of elders in the event of public health emergencies, catastrophic events or disasters.

H. Develop a coordinated team effort, including all of the expertise and capabilities of the aging network, to ensure the safety and ongoing care of the elderly prior to, during and following a disaster; and

I. Support the efforts of Area Agencies on Aging (AAAs), service agencies, and community-based service providers, including home health care providers, to maintain their ability to deliver services to older persons and communities in order to minimize any disruption of critical services.
SPECIFIC AUTHORITY:

A. **Section 20.41, Florida Statutes:** The Department of Elder Affairs is designated as the state unit on aging as defined in the federal Older Americans Act of 1965, as amended, and shall exercise all responsibilities pursuant to that act. In accordance with the federal Older Americans Act of 1965, as amended, the Department shall designate and contract with AAAs in each of the Department’s Planning and Service Areas (PSAs). Area Agencies on Aging shall ensure a coordinated and integrated provision of long-term care services to the elderly and shall ensure the provision of prevention and early intervention services. The Department shall have overall responsibility for information system planning. The Department shall ensure, through the development of equipment, software, data and connectivity standards, the ability to share and integrate information collected and reported by the AAAs in support of their contracted obligations to the state.

B. **Chapters 252 and 381, Florida Statutes:** Chapter 252 (Emergency Management) and Chapter 381 (Public Health), Florida Statutes

C. **Administration on Aging:** *Emergency Assistance Guide 2006* promulgated by the United States Health and Human Resources, Administration on Aging (AoA). The entire contents of the Administration on Aging: *Emergency Assistance Guide 2006* may be found at the following website: http://www.aoa.gov/AoARoot/Preparedness/Resources_Network/2006_Assist_Guide.aspx

Additional helpful information for the Aging Services Network and Other Professions may be found at: http://www.aoa.gov/AoARoot/Preparedness/Resources_Network/index.aspx


E. **P.L. 109-365, Older Americans Act Amendments of 2006** amends Title III, Section 306. AREA PLANS, (17), of the Older Americans Act of 1965. The amendment requires area plans to “include information detailing how the AAA will coordinate activities, and develop long-range emergency preparedness plans, with local and State emergency response agencies, relief organizations, local and State governments, and any other institutions that have responsibility for disaster relief service delivery.”
INTRODUCTION:

The State of Florida is vulnerable to a wide range of emergencies, including natural, technological, and man-made disasters, all of which threaten the life, health and safety of its people; damage and destroy property; disrupt services, everyday business and recreational activities; and impede economic growth and development. This vulnerability is exacerbated by the tremendous growth in the state's population, especially the growth in the number of persons residing in coastal areas, in the elderly population, in the number of seasonal vacationers, and in the number of persons with special needs. This growth has greatly complicated the state’s ability to coordinate its emergency management resources and activities.

The Office of Emergency Operations and Disaster Preparedness of the Florida Department of Elder Affairs focuses its efforts to reduce the vulnerability of the people and property of this state; to prepare for efficient evacuation and shelter of threatened or affected persons; to provide for the rapid and orderly provision of relief to persons and for the restoration of services and property; and to provide for the coordination of activities relating to emergency preparedness, response, recovery and mitigation among and between agencies and officials of this state, with similar agencies and officials of other states, with local and federal governments, with interstate organizations, and with the private sector.

Seasoned emergency officials recognize that a successful response starts well before a storm makes landfall – with families, communities and counties planning and preparing for a potential emergency. Florida Chapter Law 2006-71 provides historic state funding for emergency preparedness, response, recovery and mitigation capabilities. This legislation significantly enhances Florida’s ability to prepare for hurricanes, respond quickly in the aftermath of a storm, recover from the damage and impacts to the economy, and mitigate future threats to public safety and infrastructure. Further, this legislation provides the authority for the Secretary of Elder Affairs to convene Multiagency Special Needs Shelter Discharge Planning Response Teams, at any time that he or she deems appropriate and necessary, or as requested by Emergency Support Function (ESF) 8 at the State Emergency Operations Center (EOC), to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters. The teams are activated to provide resource and logistical support to local jurisdictions to assist with discharge planning and transition of special needs shelter clients to appropriate services and resources within the community.
The State’s policy for responding to disasters is to support local emergency response efforts. In the case of a major or catastrophic disaster, however, the needs of residents and communities will likely be greater than local resources. In these situations, the state must be capable of providing effective, coordinated and timely support to communities and the public.

A. **Disaster and Emergency Categories:** Disasters and emergencies are categorized as four types of incidents:

1. **Natural:** hurricanes, tornadoes, extreme thunderstorms, earthquakes, floods, wildfires, extreme heat and other such events;

2. **Man-Made:** large fires, hazardous material spills, major transportation accidents, explosions, nuclear power, terrorist events, use of weapons of mass destruction, mass migration, special events and civil unrest;

3. **Technological:** utility and information technology failures; and

4. **Biological:** pandemic influenza and public health events.

B. **Emergency Management “Life-cycles:”** Emergency management is based upon what is referred to as the “life-cycle” of the disaster situation. The four phases of disaster event response are:

1. Mitigation is a sustained action or ongoing effort that reduces or eliminates the risk of disaster occurrence including long-term risk to people and property from natural hazards and their effects.

   a. **Mitigation activities include:**

      i. Avoiding construction in high-risk areas such as floodplains;

      ii. Engineering buildings to withstand wind and earthquakes;

      iii. Changes in land use management;

      iv. Changes in safety and rules and regulations; and

      v. Changes in building codes/specifications.
b. **Culture of preparedness:** Educating and communicating to businesses, communities and individuals about safety precautions that can be taken to prevent avoidable disasters and improving emergency detection is also an important component of mitigation that contributes to creating a culture of preparedness.

2. **Preparedness** is activity taken for an emergency before it occurs that facilitates the disaster response to save lives, minimize damage, lessen the impact of an emergency and facilitate recovery. It is important to not just plan, but to prepare as well. Government agencies at all levels have an obligation to prepare themselves and the public for emergencies. The key to effective emergency management is being ready to provide a rapid emergency response.

a. **Preparedness activities include:**

i. Development of shelter and evacuation plans;

ii. Establishment of warning and communication systems;

iii. Training of emergency response personnel;

iv. Conducting of tests and exercises and determining logistics;

v. Educating the public about what they can do; and

vi. Evacuating designated persons pre-event and sheltering them until the threat passes.

b. **Personal preparedness:** Area Agencies on Aging, community groups, service providers, businesses, civic and volunteer groups, are also strategic partners in this effort to create a culture of preparedness among the state’s elders by educating the elderly population about the necessity of taking personal responsibility to have an emergency plan ready in advance of emergency events which includes:

i. Evacuation and sheltering plans;

ii. Transportation;

iii. Food, water and ice;
iv. Medications and prescriptions;

v. Fuel;

vi. Emergency contact information;

vii. Important documents, including living wills;

viii. Housing;

ix. Plan for pets; and

x. Checks, credit cards, debit cards and/or cash.

c. **Business preparedness:** Businesses, including AAAs, should have Disaster/Emergency Preparedness plans to ensure continuity of operations and the ability to continue to provide services.

3. **Response** is activities that occur immediately before, during or directly after an emergency or disaster.

a. **Response activities include:**

i. Activation of the emergency operations plan;

ii. Activation of warning systems;

iii. Staffing the emergency operations centers;

iv. Implementation of shelter or evacuation plans; and

v. Provision of emergency medical services.

b. **First responders** are responsible for:

i. Alerting and notifying both the public and partner agencies;

ii. Providing protection for citizens and property;

iii. Search and rescue;
iv. Emergency medical services;

v. The welfare of the public; and

vi. Restoration of critical services.

4. **Recovery** is assistance provided to return a community to normal or near-normal conditions, resulting in the restoration of a functioning community.

a. **Recovery activities include:**

   i. Damage assessments;

   ii. Repair;

   iii. Reconstruction;

   iv. Outreach;

   v. Temporary housing;

   vi. Loans or grants;

   vii. Disaster unemployment insurance;

   viii. Providing financial assistance;

   ix. Counseling programs; and

   x. Ongoing care.

b. **Short-term recovery** returns vital life-support systems, including societal underpinnings (fire protection, EMS, law enforcement, power, water and sewer), to minimum operating standards.

c. **Long-term recovery** may continue for a number of years after a disaster and seeks to return life to normal or improved levels.
HOMELAND SECURITY AND FEDERAL EMERGENCY PREPAREDNESS AND 
DISASTER PLANNING:

A. Homeland Security: The United States Department of Homeland Security (DHS) is a Cabinet department of the Federal Government of the United States with responsibility of protecting the territory of the United States from terrorist attacks and responding to natural disasters. The department was created from 22 existing federal agencies, including the Federal Emergency Management Agency (FEMA), in response to the terrorist attacks of September 11, 2001. The department was established on November 25, 2002 by the Homeland Security Act of 2002.

The Department of Homeland Security/Emergency Preparedness and Response (EP&R)/FEMA, in close coordination with the DHS Office of the Secretary, will maintain the National Response Plan. The Plan will be updated to incorporate new Presidential directives, legislative changes, and procedural changes based on lessons learned from exercises and actual events.

1. Preparation Roles and Responsibilities: State and local governments are closest to those affected by natural disasters, and have always been the lead in response and recovery. The federal government acts in a supporting role, providing assistance, logistical support and certain supplies.

2. Local government is responsible for providing for the safety and security of citizens in advance of a hurricane. That means they are in charge of developing emergency plans, determining evacuation routes, providing public transportation for those who can’t self-evacuate, and setting up and stocking local shelters with relief supplies.

3. State government is responsible for mobilizing the National Guard, pre-positioning certain assets and supplies, and setting up the state’s emergency management functions. They are also in charge of requesting federal support though the formal disaster declaration process.

4. Federal government is responsible for meeting those requests from the state, before, during and after the disaster. This includes:

   a. Providing logistical support for search and rescue;

   b. Providing food, water and ice;

   c. Establishing disaster centers and processing federal disaster claims; and
d. Participating in short and long-term public works projects, such as debris removal and infrastructure rebuilding.

B. National Response Framework: The National Response Framework (NRF) presents the guiding principles that enable all response partners to prepare for and provide a unified national response to disasters and emergencies. It establishes a comprehensive, national, all-hazards approach to domestic incident response. The National Response Plan was replaced by the National Response Framework effective March 22, 2008.

The National Response Framework defines the principles, roles and structures that organize how we respond as a nation. The National Response Framework:

1. Describes how communities, tribes, states, the federal government, private-sectors, and nongovernmental partners work together to coordinate national response;

2. Describes specific authorities and best practices for managing incidents;

3. Builds upon the National Incident Management System (NIMS), which provides a consistent template for managing incidents.

Information on the National Response Framework including Documents, Annexes, References and Briefings/Trainings can be accessed from the “NRF Resource Center”. For information on the National Response Plan, go to http://www.fema.gov/emergency/nrf/.

1. Engaged Partnership: Leaders at all levels must communicate and actively support engaged partnerships by developing shared goals and aligning capabilities so that no one is overwhelmed in times of crisis.

2. Tiered Response: Incidents must be managed at the lowest possible jurisdictional level and supported by additional capabilities when needed.

3. Scalable, Flexible and Adaptable Operational Capabilities: As incidents change in size, scope and complexity, the response must adapt to meet requirements.

4. Unity of Effort Through Unified Command: Effective unified command is indispensable to response activities and requires a clear understanding of the roles and responsibilities of each participating organization.
5. **Readiness To Act:** Effective response requires readiness to act balanced with an understanding of risk. From individuals, households, and communities to local, tribal, State, and Federal governments, national response depends on the instinct and ability to act.

C. **National Incident Management System (NIMS):** The National Incident Management System (NIMS) provides a systematic, proactive approach to guide departments and agencies at all levels of government, nongovernmental organizations, and the private sector to work seamlessly to prevent, protect against, respond to, recover from, and mitigate the effects of incidents, regardless of cause, size, location, or complexity, in order to reduce the loss of life and property and harm to the environment.

NIMS works hand in hand with the National Response Framework (NRF). NIMS provide the template for the management of incidents, while the NRF provides the structure and mechanisms for national-level policy for incident management.

As initially laid out in Homeland Security Presidential Directive (HSPD)–5, Management of Domestic Incidents, which established NIMS, adoption and implementation of the NIMS by State, tribal, and local organizations is one of the conditions for receiving Federal preparedness assistance (through grants, contracts, and other activities).

Preparedness funding is used strictly for those activities that would prepare an agency or jurisdiction to respond to an incident. However, these funds are contingent upon NIMS compliance. Eligibility to receive public assistance funding following a disaster is not based on NIMS compliance. Funds received as a result of a Presidential Disaster Declaration are awarded to assist a community in returning to a pre-disaster state.

1. **NIMS Benefits:**

   a. Enhance organizational and technological interoperability and cooperation;

   b. Provide a scalable and flexible framework with universal applicability;

   c. Promote all-hazards preparedness;

   d. Enable a wide variety of organizations to participate effectively in emergency management/incident response; and
e. Institutionalize professional emergency management/incident response practices.

2. **NIMS Compliance:** States should continue to follow all guidance contained in the *5-Year NIMS Training Plan*, released in February 2008, to include implementation of *ICS-400: Advanced ICS* training. Implementing the NIMS objectives (reference Attachment 1) signifies that the State is working toward comprehensive NIMS implementation. States should address progress relating to NIMS Implementation within its NIMS Compliance Assistance Support Tool (NIMSCAST) to be eligible for Federal preparedness assistance.

3. **NIMS Training:** The NIMS Integration Center coordinates the development of a National Standard Curriculum for NIMS, which is built around available federal training opportunities and course offerings that support NIMS implementation. The curriculum serves to clarify training that is necessary for NIMS-compliance and streamline the training approval process for courses recognized by the curriculum. NIMS and Incident Command System (ICS) training of employees with a direct role in emergency and incident management and response is necessary for NIMS compliance. The NIMS Integration Center strongly recommends that volunteers with a direct role in emergency and incident management and response take NIMS and ICS training. The amount of training depends on the person’s position level in response operations. For NIMS training information, see Attachment 1: NIMS Training Guidelines. Additional information regarding NIMS training can be found at: [http://www.fema.gov/emergency/nims/](http://www.fema.gov/emergency/nims/).

D. **Federal Disaster Assistance – FEMA and the Stafford Act:**

1. **Federal Emergency Management Agency (FEMA):** FEMA manages federal response and recovery efforts following any national incident. FEMA also initiates mitigation activities, works with state and local emergency managers, and manages the National Flood Insurance Program. FEMA became part of the U.S. Department of Homeland Security on March 1, 2003.

2. **Robert T. Stafford Disaster Relief and Emergency Assistance Act:** PL 100-707, signed into law November 23, 1988, amended the Disaster Relief Act of 1974, PL 93-288. This Act constitutes the statutory authority for most Federal disaster response activities especially as they pertain to FEMA and FEMA programs.
When a disaster overwhelms the capabilities of the state, the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act are implemented. The Governor, as mandated by the Act, must submit a request for a Presidential Disaster Declaration so that federal resources can be released. Federal disaster assistance falls into three general categories:

a. **Individual Assistance**: Aid to individuals, families, and business owners through FEMA. Eligibility requirements will be released at the time of the disaster. In addition to FEMA, non-profit relief organizations and other governmental agencies may also be providing assistance to those impacted.

b. **Public Assistance**: Aid to public, and certain private non-profit entities, for specified emergency services and the repair or replacement of disaster-damaged public facilities. Agencies involved in the response to or recovery from a disaster are eligible for reimbursement of the costs caused by the disaster. In order to obtain this assistance, it is necessary for agencies to have a written record and to keep track of expenditures, hours worked, etc. Agencies should work with emergency management officials to determine what types of expenditures should be tracked and how to best track them.

c. **Mitigation Assistance**: Aid to improve infrastructure conditions that will lessen the impact of a similar disaster in the future.

d. **Tele-registration Information**: Assistance is available for affected individuals and businesses after a Presidential disaster declaration. The first step for individuals or business that require assistance is to call the FEMA’s National Tele-registration Center:

1 (800) 621-3362 or 1 (800) 462-7585 (TTY).

Once an application is processed, further assistance will be coordinated through a Disaster Recovery Center, which may be established in each of the declared counties or regionally. Representatives of federal, state, local, and volunteer organizations are made available to help disaster victims who are applying for assistance.
**STATE OF FLORIDA:**

Chapter 252, Florida Statutes, (State Emergency Management Act) mandates the development of Florida’s Comprehensive Emergency Management Plan (The Plan). The Plan was updated in 2012. The Plan establishes a framework through which the State of Florida prepares for, responds to, recovers from, and mitigates the impacts of a wide variety of disasters that could adversely affect the health, safety and/or general welfare of the residents of the State. The Plan provides guidance to State and local officials on procedures, organization, and responsibilities, as well as provides for an integrated and coordinated local, State and federal response.

A. **Operations Plan:** The Plan is an operations-based plan that addresses:

1. Evacuation;
2. Sheltering;
3. Post-disaster response and recovery;
4. Deployment of resources;
5. Communications, and
6. Warning systems.

B. **Annual Exercises:** The Plan calls for annual exercises to determine the ability of State and local governments to respond to emergencies.

C. **State Agency and Volunteer Organizations:** The Plan also defines the responsibilities of State agencies and volunteer organizations.

D. **Plan Components:** The Plan describes the basic strategies, assumptions, operational goals and objectives, and mechanisms through which the State will mobilize resources and conduct activities to guide and support local emergency management efforts through preparedness, response, recovery, and mitigation.

E. **Emergency Support Functions:** To facilitate effective operations, the Plan adopts a functional approach that groups the types of assistance to be provided into 18 Emergency Support Functions.
1. Each Emergency Support Function is headed by a lead or primary agency or organization, which has been selected based on its authorities, resources, and capabilities in that functional area.

2. The primary agency appoints an Emergency Coordinating Officer to manage that function in the State EOC.

3. The Emergency Coordinating Officers and staff of the Division of Emergency Management form the State Emergency Response Team.

4. The State Emergency Response Team serves as the primary operational mechanism through which State assistance to local governments is managed.

5. State assistance will be provided to impacted counties under the authority of the State Coordinating Officer, on behalf of the Governor, as head of the State Emergency Response Team.

F. **Purpose:** The Plan establishes a framework for an effective system of comprehensive emergency management, the purpose of which is to:

1. Reduce the vulnerability of people and communities of this State to loss of life, injury, or damage and loss of property resulting from natural, technological, criminal, or hostile acts;

2. Prepare for prompt and efficient response and recovery activities to protect lives and property affected by emergencies;

3. Respond to emergencies using all State and local systems, plans and resources as necessary;

4. Recover from emergencies by providing for the rapid and orderly implementation of restoration and rehabilitation programs for persons and property affected by emergencies, and

5. Assist in anticipation, recognition, appraisal, prevention, and the mitigation of emergencies that may be caused or aggravated by inadequate planning for, and regulation of, public and private facilities and land use.
FLORIDA DEPARTMENT OF ELDER AFFAIRS:

The mission of the Department of Elder Affairs (DOEA), Office of Emergency Operations and Disaster Preparedness is to ensure the safety and security of Florida’s elders by establishing reliable communication, coordination, and delivery of services across governmental agencies, the aging network, and care provider systems at the private, non-profit, and public levels.

A. Emergency Response Plan: The Department of Elder Affairs shall devise a written Disaster/Emergency Response Plan that outlines the response process when a disaster/emergency is reported. The plan shall include a Comprehensive Emergency Management Plan (CEMP) and Continuity of Operations Plan (COOP). (For plan details, see Attachment 2: Comprehensive Emergency Management Plan and Attachment 3: Continuity of Operations Plan.)

1. The Response Plan Must:
   a. Be practical and simple;
   b. Be comprehensive, covering the entire range of disasters to which all or any portion of the state may be vulnerable; and
   c. Outline a comprehensive and effective program to ensure continuity of essential functions under all circumstances.

2. Elements: The following elements must be considered in the development of the written plan:
   a. Capabilities/Limitations: DOEA’s capabilities and limitations in response to a disaster.
   b. Agency Interactions: Interactions with other agencies. A listing of agencies with which DOEA will coordinate response and recovery activities should be maintained.
   c. Plans/Responsibilities: The plans and responsibilities of the AoA and the AAAs, and how they relate to the plans and responsibilities of DOEA.
   d. Overall State Disaster/Emergency Planning: The degree of overall disaster/emergency planning in the state for elders.
e. **Relief Agency Roles:** The roles of the various relief agencies in the state and state-level leadership for local elements of government and their service and assistance agencies.

f. **Relief Authority:** The organizations primarily responsible for relief authority and assistance in each community, both private and government. A clear and simple chain of command for each organization, so that lines of coordination and control are clear, is needed.

g. **Relief Boundaries:** The appropriateness of dividing jurisdictions or the entire state into workable segments. Where possible, these should follow traditional Program Service Areas (PSA) boundaries.

h. **Local, State, and Federal Disaster Response:** Consider how DOEA's disaster response relates to and works with local, state, and national disaster response teams;

i. **Types of Disasters:** The types of disasters/emergencies that are most and least likely to occur in the state. Attention should be given to the relative probability of occurrence; the probable lead time involved; the potential magnitude; any factors which make one or another area more or less likely to be involved; and the kinds of effects which may be produced in specific geographical areas (effects on people, systems, facilities, resources and institutions).

j. **Information Dissemination:** Plans for sharing and disseminating information with other organizations, which will be collecting data and doing needs assessment.

k. **State Agency:** The necessity for DOEA to assume a significant degree of responsibility in disasters that are local in nature but are significant to a degree that a community is unable to cope or provide adequate resources and services for elders.

**B. Emergency Coordinating Officer:** The Department shall designate an Emergency Coordinating Officer and an Alternate Emergency Coordinating Officer (Chapter 252.365(1), (2), (3), Florida Statutes). (Attachment 4: Role of Department of Elder Affairs Emergency Coordinating Officer) The Emergency Coordinating Officer is responsible for:
1. **Emergency Response Plan:** Formulating the written Disaster/Emergency Response Plan which includes a Comprehensive Emergency Management Plan (CEMP) and a Continuity of Operations Plan (COOP) including a Pandemic Annex;

2. **Coordinating:** Coordinating with the Division of Emergency Management on emergency preparedness issues, preparing and maintaining emergency preparedness and post disaster response and recovery plans for the Department;

3. **Maintaining Rosters:** Maintaining an updated roster of emergency contacts for the Department of Elder Affairs, key agencies with which DOEA will coordinate response and recovery activities, the Division of Emergency Management, the State EOC, and designated emergency operations officials of the AAAs;

4. **Training:** Coordinating appropriate training for Department personnel;

5. **Liaison:** Establishing and maintaining liaison with other elements of state government including the State EOC, the FEMA, Homeland Security, AoA and local representatives of the aging network; staffing the State EOC to direct and coordinate the response and recovery efforts for elders needing assistance following an emergency event; and serving as the primary liaison with the AAAs, Comprehensive Assessment for Long-Term Care Services (CARES) Offices, the Long-Term Care Ombudsmen, and the DOEA program offices. Elders may be aging in place and living independently in the community, or residing in long-term care facilities or nursing homes.

6. **Communications:** Communicating, as needed, with various entities such as:
   
a. The executive branch of state government;
   
b. Other units of state government including the State EOC;
   
c. Homeland Security and FEMA personnel;
   
d. Department of Health and Human Services, Administration on Aging, the Centers for Disease Control and the Centers for Medicare and Medicaid Services personnel;
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e. Area Agencies on Aging;

f. Lead agencies and service providers;

g. Representatives of local and county government units;

h. Representatives of non-profit, faith-based, and volunteer agencies and organizations;

i. Community groups and organizations; and

j. The general public.

7. **Emergency Response Plan Technical Assistance**: Providing technical assistance to the AAAs in the development of their written Disaster/Emergency Response Plans, to include a Comprehensive Emergency Management Plan (CEMP) and Continuity of Operations Plan (COOP) by:

a. Providing guidelines and templates for each plan, and

b. Receive and review the Area Agency on Aging plans on an annual basis for plans required to be submitted each May 1st.

8. **Education**: Promoting disaster preparedness and education among DOEA personnel, elders, and the aging network.

C. **Coordination Functions**: Under the leadership of the Emergency Coordinating Officer, the DOEA shall review the State Comprehensive Emergency Management Plan, and take necessary actions to encourage the integration of a coordinated federal, state, and local emergency response plan for elders. DOEA and the Emergency Coordinating Officer shall:

1. **Leadership Role**: Assume a leadership role in disseminating information concerning the DOEA Continuity of Operations Plan and the Disaster/Emergency Response Plan; ensuring other units of state government, the AAAs, and ACL understand what is planned.
2. **State Disaster/Emergency Plan Inclusion:** Ensure the DOE’s inclusion in the State Disaster/Emergency assistance planning.

3. **Disaster/Emergency Assistance:** Ensure that agencies involved in Disaster/Emergency assistance understand what services and information DOE can provide, and ensure DOE and the AAAs understand what services and information other agencies can provide.

4. **Working Relationships:** Establish working relationships with federal, state, and local emergency officials, members of the aging network, and key stakeholders responsible for providing services and disaster/emergency assistance to elders.

5. **Educational Process:** Initiate an educational process, which makes emergency responders and organizations aware of the unique needs of older persons.

D. **Location and Identification of Elders:** DOE and the AAAs must be able to estimate the number of elders who may be affected by a disaster/emergency in a given area. Strategies must be developed to locate elders who reside in residential community or those living in care facilities.

1. **AAA Elder Identification Efforts:** Area Agencies on Aging are responsible for identifying elders, not just the clients they serve but elders located in the general population, who may be at risk due to disruption of services (e.g., lack of food, power, water, sewer, medicine, fire protection, emergency medical service, law enforcement, and/or continuity of care). Based on AAA figures or other sources, each AAA must develop a set of maps for the area served by the AAA to include:

   a. **Residential Sites:** Key sites where older persons reside including residential communities, senior housing/condominiums, and/or neighborhoods having clusters of senior housing;

   b. **Congregate Sites:** Locations of senior centers, congregate meal sites, and other sites where seniors congregate; and

   c. **Assistance Sites:** General location of sites providing services or assistance for older individuals.
2. **DOEA:** DOEA shall develop a set of maps which generally display the following information:

   a. **Older Population Density:** State and county maps showing population densities of older persons by age; and

   b. **Elder Service Needs:** State and county maps showing densities of older persons by program/service needs.

3. **Elder Location Maps:** AAA maps should be overlaid onto DOEA maps to provide detailed information about the location of elders and general location of sites providing services or assistance within a given geographic location.

   A geographic map (GIS) with a demographic overlay would show the most vulnerable populations when disaster/emergency possibilities and geography are related, such as floods and hurricanes.

E. **Information Flow:**

1. **Non-Emergencies:** During non-emergency situations, the DOEA Emergency Coordinating Officer serves as the primary liaison for initiating or receiving messages related to disaster/emergency preparedness and response and is responsible for ensuring the flow of information and directives among the AAAs, ACL, and emergency officials.

2. **Emergencies:** In anticipation of and during emergency situations, DOEA shall perform the following tasks:

   a. **Information Flow:** Devise and monitor procedures to ensure the orderly flow of information in anticipation of and during emergency conditions to establish and maintain vertical and horizontal communications with appropriate agencies and personnel;

   b. **Emergency Memorandums:** Notify the potentially affected AAAs on Aging on actions to be taken in the event of disasters/emergencies;
i. **Preparation to Implement Emergency Relief Measures:** This memorandum is sent from the Secretary of Elder Affairs to the AAAs notifying them to be prepared to implement emergency relief measures. (Attachment 5: Department of Elder Affairs Emergency Memorandum: Preparation to Implement Emergency Relief Measures)

ii. **Implementation of Emergency Relief Measures:** This emergency memorandum is sent from the Secretary of Elder Affairs to the AAAs notifying them to implement emergency relief measures. (Attachment 6: Department of Elder Affairs Emergency Memorandum: Implementation of Emergency Relief Measures)

c. **Conferences:** Conduct regular conferences, face-to-face or by phone, with affected AAAs and key on-site elements of the Aging Network;

d. **Daily Information:** Obtain daily information from each affected AAA via conference calls (DOEA Conference call number is 1-888-670-3525, conference code 6726185686; however, other conference lines may be used and information will be shared with all necessary parties prior to the calls.), faxes or standardized reports:

**Pre-event:** Establish the AAA’s state of readiness, identify unmet needs, determine actions to be initiated and monitor compliance; and

**Post-event:** Determine the impact of the event on the Area Agency on Aging, the AAA’s staff, and the elderly within the service area, identify unmet needs, determine actions to be initiated and monitor compliance.

e. **Other information (suggested):**

i. Source of report and contact information in the event more information or clarification is needed

ii. Waiver needs
iii. Critical issues

iv. Action needed

v. Number of elderly served by the AAA before the disaster

vi. Counties or area affected

vii. Number of elderly in the affected area

viii. Institutional facilities needing assistance with evacuation, including number of residents

ix. How much of the Aging Network is operational?

x. What are the immediate needs today?

xi. Types and Number of clients with special needs (dementia, non-ambulatory, mental health, substance abuse, evacuation with pets, etc.)

xii. Number of injuries (*please note source of information*)

xiii. Number of fatalities (*please note source of information*)

xiv. Number of clients evacuated or displaced (*please note source of information*)

xv. Assistance with evacuations needed or requested?

xvi. Number of homes / property affected (structural damage, mold, etc.)

xvii. Total number of clients affected

xviii. Translation services needed

xix. Number & location(s) of senior centers damaged

xx. Number of vans/buses/vehicles damaged

xxi. Number & location(s) of meal production facilities damaged
Emergency Preparedness Responsibilities and Requirement

xxii. Other Aging Network property or facilities damaged

xxiii. Aging Network services (or supplies) provided to disaster victims

xxiv. Quantity of such services (or supplies) provided to disaster victims (e.g., Number of meals)

xxv. Aging Network services interrupted because of disaster

xxvi. Services/supplies that are needed but not available or not being provided

xxvii. Is support needed from other States or the federal government?

xxviii. Identify supporting agencies (e.g., Red Cross, healthcare providers, VOAD)

xxix. Services/supplies provided from other agencies

xxx. Unmet needs?

xxx. Providers/contractors functioning at decreased capacity

xxxii. Providers/contractors closed and/or unable to function

xxxiii. Report daily on any changes in the following as needed:

(A) Special populations

(B) Homebound individuals

(C) Home delivered meals

(D) Transportation

(E) Congregate meal sites

(F) Medical needs (medications, supplies, etc.)
xxxiv. What critical needs do you need assistance with?

xxxv. What actions could the State or Federal agencies take to provide assistance?

xxxvi. Describe coordination with local emergency management officials, FEMA, etc.

xxxvii. Overall Status Summary of the impact of the incident to elders

xxxviii. Number of special needs shelters and census (breakdown of elders, disabled, children if possible)

xxxix. Number of general population shelters and census of elders

xl. Total Number of shelters and total census (estimate).

xli. Screening or needs assessments being done at shelters?

xlii. List unmet service needs in shelters

xliii. Aging Network staff assigned to any shelters?

xxxiv. Need for ADA compliant special needs shelters?

xxxv. Power outages / electricity available?

xxxvi. Roads open?

xxxvii. Phone and internet access available?

xxxviii. Is staff available for deployment?

xxxix. Does staff need additional support?

f. **Reporting Decisions**: Keep others informed, particularly of pending decisions, and, as made, alerting AAAs and other resources;
g. **Advocacy:** Conduct and report on DOEA state level advocacy efforts for impacted elders and the aging network;

h. **Debriefing:** Devise a system of regular debriefings from affected AAAs, DOEA field staff and other relevant sources; and

i. **EM Constellation:** Monitor the State Emergency Operations Center’s (SEOC) EM Constellation to track missions, ensure the fulfillment of the missions and escalate the missions, as appropriate, view reports and info messages, and keep informed of new developments and vital statistics during emergency activation. If necessary, EM Constellation will work with counties to ensure requests for assistance and/or supplies are entered as missions in support of requests by the aging network.

F. **Special Needs Shelter Discharge Planning:** DOEA is responsible for assisting counties, that have been severely impacted by a natural or manmade disaster and exhausted all local resources, in discharge planning for special needs shelter clients. (Attachment 7: Standard Operating Procedures for Multiagency Special Needs Shelter Discharge Planning Response Teams, Attachment 8: DOEA Form 590, Discharge Planning Tool for Rapid Needs Evaluation; and Attachment 9: Procedures for Discharge Planning Tool for Rapid Needs Evaluation) The form can also be used at Essential Services Centers, Disaster Recovery Centers and for community outreach. The form is a valuable tool in quickly assessing the needs of an individual and identify resources that will assist them transition successfully back to their pre-event residence, or if the special needs client needs assistance in obtaining services to develop an alternate relocation plan.

1. **Response Team Deployment:** Response teams are activated to provide resource and logistical support to local jurisdictions to assist with discharge planning and transition of clients to appropriate services and resources within the community. DOEA shall deploy multiagency special needs shelter discharge planning response teams to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters:

   a. At any time that the Secretary of the Department of Elder Affairs deems appropriate and necessary.

   b. Assistance may be also be requested by Emergency Support Function (ESF) 8 at the State Emergency Operations Center, to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters.
2. **Response Team Composition**: The Secretary of Elder Affairs shall convene, at any time deemed appropriate and necessary, a multi-agency special needs shelter discharge planning team to assist local areas that are severely impacted by a natural or manmade disaster that requires the use of special needs shelters. (381.0303 (1)(e) Florida Statutes.

The Multi-Agency Special Needs Shelter Discharge Planning Response Team will be comprised of representatives from each designated state agency’s local, regional or district locations due to their knowledge of local resources and services available to assist Special Needs Shelter clients.

Response Teams shall include at least one representative from each of the following state agencies, although the Secretary of Elder Affairs may determine that the nature or circumstances surrounding the disaster do not warrant participation from a particular agency’s staff:

a. Department of Elder Affairs;

b. Department of Health;

c. Department of Children and Family Services;

d. Department of Veterans’ Affairs;

e. Division of Emergency Management;

f. Agency for Health Care Administration; and

g. Agency for Persons with Disabilities.

3. **Response Team Lead**: The Department of Elder Affairs will designate an Elder Affairs representative to serve as the Multiagency Special Needs Shelter Discharge Planning Response Team lead. This position may be filled by staff from the following:

a. Comprehensive Assessment and Review for Long Term Care Services (CARES),

b. Long Term Care Ombudsman (Ombudsman), or

c. Area Agency on Aging (AAA).
G. **Recovery:** The Department of Elder Affairs, as part of Emergency Support Function 6 – Mass Care, is requested during recovery efforts to provide staffing for and the Disaster Recovery Centers (DRCs).

The Disaster Recovery Centers are placed in readily accessible facilities or mobile offices where applicants may go for information about FEMA or other federal disaster assistance programs, in addition to state programs and local services.

When the State Recovery Desk announces the locations for the DRCs, they will request that a variety of state agencies and non-profits organizations provide staffing. A mission will be entered into EM constellation. The Department of Elder Affairs provides staffing as requested that can include one or all of the following:

1. Area Agencies on Aging (AAA)

2. Comprehensive Assessment and Review for Long-Term Care Services (CARES)

3. Long-Term Care Ombudsman Program (LTCOP)

The number of staff required for the DRCs will vary depending on the event and the impact. Each agency and non-profit organization is required to provide staffing for at least five (5) days (which must include two weekend days). The Department in coordination with the AAAs will provide staffing, but evaluate the need for staffing on a day-to-day basis. Staff assigned to each DRC is required to provide statistics on the number of elders seen and assisted at the close of each business day to their supervisor and the DOE A ECO or Alternate ECO.
Emergency Preparedness Responsibilities and Requirement

When staffing is requested from the Area Agency on Aging, CARES and LTCOP for an Essential Services Center or a Disaster Recovery Center, the points of contact will be sent information by email that will assist staff at the center. Additional information and literature appropriate to the type of aging services available in the area should be provided by the Area Agency on Aging and the Aging Network Partners.

The designated Department DRC Coordinator will coordinate staffing between the Area Agency on Aging, CARES and LTCOP. The AAAs will be asked to provide the primary staffing requirements due to their knowledge, availability and expertise regarding aging services in the impacted community. The AAAs are encouraged to utilize the staff of their local service providers in addition to their own staff. CARES and LTCOP staff will be utilized to supplement the staffing requirements.

If the Department is not seeing sufficient requests for assistance to warrant continued staffing of the DRC, a request for approval to pull staffing back will be made by the Department’s ECO to the ESF6 Recovery Liaison and the Recovery Desk. Upon receiving approval to pull back staffing at the DRC, staff assigned on the last day will provide the FEMA and State DRC/ESC Managers with information on the services available and contact information for the AAA and the Department of Elder Affairs. Notification of the staff being withdrawn will be provided to the ESF6 Recovery Liaison and the Recovery Desk by the Department’s ECO and/or Alt ECO.

The Department may also provide Community Outreach in coordination with the Area Agency on Aging, other state agencies, and non-profit organizations to reach and address the unmet needs of those elders who were unable to evacuate or chose to shelter in place.

Special Needs Shelters are operated by the Department of Health. The Department of Elder Affairs monitors the census of all special needs shelters in conjunction with Emergency Support Function 8 – Health and Medical.

The Department of Elder Affairs assigns and coordinates staffing to support discharge planning for special needs shelters within and outside the disaster area, as requested by the counties. Requests for Discharge Planning assistance are made by:
1. County EOC ESF8 Representatives should create a mission request in EM Constellation to request Discharge Planning assistance, once all local resources have been exhausted, and the following information is needed in the mission description.

   a. County Name
   b. What type of services are needed (elderly, disabled, children)
   c. When is the staff needed to report for duty
   d. Where are they needed (address and POC)
   e. How long are they needed
   f. How many clients are needing services
   g. How many staff members are requested

Requests received for discharge planning often involves elders. However, they can encompass individuals that are not usually served by the Department of Elder Affairs. Every effort will be made to contact appropriate state agency partners to assist with the unmet needs of clients if outside the scope of the services provided by the aging network.

**IMPORTANT** – In keeping with NIMS protocols, the Department should only respond when there is a mission in EM Constellation or prior approval given by the DOEA Emergency Coordinating Officer to avoid duplication of effort and to track the status and details of the mission.

**H. Diminishment of Needs and De-Escalation:** As the response phase is nearly completed and the recovery phase begins, DOEA shall lead the return of the elements of the Aging Network to normalcy. DOEA shall:

1. **Conduct Operational Debriefings – Hotwash:** Once the event has passed, the emergency coordinating officer must review actions taken during the disaster/emergency to determine what was and was not effective (hotwash). It is important to include aging network personnel who participated in the response to ensure that various perspectives are known. The purpose of the review of the details of an event from a factual perspective is to:
a. Learn what actually happened for the historical record or planning process;

b. Improve future results in similar missions; and

c. Increase the readiness of those being debriefed for further action.

2. **Assist with Disaster Related Grants:** The Department may assist impacted agencies in preparing paperwork to apply for Administration on Aging, FEMA and other disaster related grants. The Department acts as a funnel for AoA funds to the affected AAAs and local service providers.

3. **Restore Attention to Program Basics:** The continuing conduct of service programs for the large number of persons who were not directly affected by the disaster/emergency will serve as a steadying influence on the AAAs and local service providers. As the effects of the disaster/emergency are dealt with, geographic or program areas should return to routine services.
Emergency Preparedness Responsibilities and Requirements

AREA AGENCIES ON AGING:

Area Agencies on Aging (AAAs) are designated by the Florida Department of Elder Affairs and play a pivotal role in assessing community needs and developing programs that respond to those needs. These agencies also act as advocates for improved services for older persons and their families. During a disaster or emergency, the AAA must respond to meet the immediate needs of those affected.

A. Emergency Preparedness:

1. Emergency Response Plan: In order to maintain a state of readiness, the Area Agency on Aging shall develop a written Disaster/Emergency Response Plan that outlines the response process when a disaster/emergency is reported. The plan shall include a Comprehensive Emergency Management Plan (CEMP) and Continuity of Operations Plan (COOP) including a Pandemic Annex. (For plan details, see Attachment 2: Comprehensive Emergency Management Plan and Attachment 3: Continuity of Operations Plan.)

a. The Response Plan must have the following components:

i. Simplicity: Be practical and simple;

ii. Comprehensive: Be comprehensive and relevant to the variety of disasters that potentially could hit the geographic area serviced by the Area Agency on Aging; and

iii. Ensure Program Continuity: Outline a comprehensive and effective program to ensure continuity of essential functions under all circumstances.

b. Elements: The following elements must be considered in the development of the written plan:

i. Types of Incidents: Consider the types of disasters/emergencies prevalent in the AAA service area;

ii. Capabilities/Limitations: Consider the AAA’s capabilities and limitations;
iii. **Clients:** Consider the possibility that, due to the nature and extent of the disaster/emergency, the AAA might be called upon to provide services and assistance to elders who are not clients of the AAA or lead agencies;

iv. **Responsibilities of AoA/DOEA:** Consider the plans and responsibilities of ACA and DOEA;

v. **Relief Agencies:** Consider the roles of various relief agencies in the service area;

vi. **Relief Authority:** Consider the organizations primarily responsible for relief authority;

vii. **Local, State, and Federal Disaster Response:** Consider how the AAA’s disaster response relates to and works with local, state and federal disaster response teams;

viii. **Redundant Plans:** Consider the possibility that, due to the nature and extent of the disaster/emergency, service and product suppliers (such as those providing homemaker and personal care services, transportation, food, water and ice) might be overwhelmed and unable to provide services and/or products and have redundant/backup plans to obtain needed services and/or products;

ix. **Elder Evacuees:** Include a plan for providing services on an emergency basis for elder evacuees and relocations from other service areas or states;

x. **Communications:** Provide guidelines to ensure that adequate staffing will be available to continue daily operations and ensure that communications are maintained with DOE; and

xi. **Information and Referral (Elder Helpline):** Provide guidelines to ensure that the Elder Helplines of all affected AAAs will provide information and referral service during (when possible), and following a disaster/emergency event (See Attachment 10: Alliance for Information & Referral Services (AIRS) Elder Helpline: Standards for Professional Information and Referral – Modified).
The Elder Helpline, 1-800-96-ELDER (1-800-963-5337), provides information and referral services to the community during, when appropriate, and following a disaster or other emergency. Each AAA as part of their contract maintains the operation of the Elder Helpline for their Planning and Service Area (PSA). This service shall include assessing the needs of the elders, evaluating appropriate resources, indicating organizations capable of meeting those needs, helping elders for whom services are unavailable by locating alternative resources and actively participating in linking elders to needed services or volunteer opportunities. The AAAs are responsible for establishing reciprocal agreements within the aging network for the transfer of services in the event of COOP activation. If catastrophic conditions warrant, the Department of Elder Affairs has established a toll-free helpline to assist with emergency overflow calls. The designated phone number is 1-877-363-2825 (requires activation and staffing).

c. Submit AAA Plan to DOEA: The AAAs shall submit their Disaster/Emergency Response Plan to the Emergency Coordinating Officer of the Department of Elder Affairs annually, on or before May 1st, for review.

2. Emergency Coordinating Officer: The AAA shall designate an Emergency Coordinating Officer and an Alternate Emergency Coordinating Officer. The Emergency Coordinating Officer is responsible for:

a. Emergency Response Plan: Formulating the written Disaster/Emergency Response Plan which includes a Comprehensive Emergency Management Plan (CEMP), a Continuity of Operations Plan (COOP) and a Pandemic Annex; A Comprehensive Emergency Management Plan (CEMP) establishes a framework for an effective system of comprehensive emergency management. The Plan describes the basic strategies, assumptions, operational goals and objectives, and mechanisms through which a jurisdiction will mobilize resources and conduct activities to guide and support emergency management efforts through preparedness, response, recovery and mitigation. To facilitate effective operations, the Plan uses a functional approach in order to maximize the use of resources in a disaster situation.
A Continuity of Operations (COOP) Plan establishes policy and guidance to ensure the execution of an agency or organization’s mission essential functions in the event that the agency or organization is threatened or incapacitated, and the relocation of selected personnel and functions is required.

Each AAA needs to develop a Pandemic Annex to their Continuity of Operations Plan. A pandemic event will result in widespread illness and associated absenteeism from the workplace. This annex should include plans on how the AAA would continue mission-essential operations. The agency should develop a list of “mission-essential functions” performed by agency staff. Mission-essential functions are those duties and tasks that are of immediate importance to the agency’s mission and the health and welfare of elder Floridians in the event of disaster or other crisis. Mission-essential functions include all duties and tasks directly associated with the delivery of life-sustaining services and/or the continued operations of critical agency infrastructure. Emergency staffing and backfill of existing positions will be of primary concern in order to provide essential services to the public.

b. **Coordinating:** Coordinating with local emergency management officials on emergency preparedness issues;

i. Establish working relationships prior to disaster/emergency events with local emergency officials (county emergency operations staff, county sheriff, county health department special needs shelter unit managers, local fire and police departments, and other key team members on the community response teams);

ii. Participate in local emergency disaster planning;

iii. Ensure local emergency officials understand the role of the AAA and the AAA Emergency Coordinating Officer in emergency/disaster response;

iv. Provide local emergency officials with an inventory of community resources for the elderly; and

v. Educate local emergency officials regarding the unique needs of the elderly, including special dietary requirements.
c. **Maintaining AAA Emergency Contact Lists:** Maintaining an updated list of emergency contacts for AAA staff to include:

   i. **Telephone numbers:** work, home, cell and/or satellite phones;
      
   ii. **E-mail addresses:** work and home; and

   iii. **Emergency contact:** name and telephone number(s).

   d. **Maintaining Emergency Contact Lists:** Maintaining an updated list of emergency contacts for the Department of Elder Affairs, local emergency management agencies, AAA Lead Agencies, service providers, and key suppliers;

   e. **Maintaining Emergency Response Rosters:** Maintaining an updated list of AAA staff who can be called upon, in the event of a disaster, to provide assistance at Disaster Recovery Centers, Regional Operational Centers, or with discharge planning at Special Needs Shelters;

      i. Staff shall be identified as those having administrative/support skills or services/program skills;

      ii. Rosters should be provided to the DOEA Emergency Coordinating Officer;

      iii. Maintain hard copy printouts of client lists in the event of extensive power loss or loss of computer access; and

   g. **Training:** Coordinating appropriate emergency/disaster preparedness and response training for AAA personnel;

   h. **Liaison:** Establishing and maintaining liaison with other elements of local emergency management, local representatives of the aging network and the Emergency Coordinating Officer of DOEA;
Emergency Preparedness Responsibilities and Requirements

i. **Communicating with DOEA:** Participating in regular conferences, face-to-face or by phone, with DOEA during emergency events and providing current information regarding the impact of the event on the AAA, AAA staff, and the ability of the AAA to provide services to elders within the service area and identification of unmet needs;

j. **Education:** Promoting disaster preparedness and education among AAA personnel, elders, and the aging network; and,

k. **Exercises:** Participation in tabletop exercises conducted at the state and local levels.

3. **AAA “Fit” in All Local, State and Federal Emergency Plans:**

a. **Emergency Chain of Command:** All states, including Florida, have developed a systematic, written response to disasters. This response indicates a chain of command in the event of a disaster/emergency, including which local, state and federal agency will take the lead in determining the scope of the disaster/emergency and requesting assistance from the federal government, when applicable.

b. **State Government Responsibility:** It is the responsibility of state government to assist local government in implementing emergency management programs in order to protect life and property from the effects of hazardous events. This plan is based on the concept that the initial response to an emergency will be by local government agencies and the public and private entities, such as an Area Agency on Aging, that have been designated a role in a disaster.

c. **Local Government Responsibility:** It is the responsibility of local government to implement emergency management programs in order to protect life and property from the effects of hazardous events. The initial response to an emergency will be by local government agencies and local public and private entities, such as an Area Agency on Aging, that have been designated a role in a disaster.

d. **Vertical and Horizontal Communication:** As a result of this process, most of the AAA’s disaster/emergency preparation consists of establishing and maintaining vertical and horizontal communications with all who will work with the AAA when a disaster/emergency strikes.
e. **Expectations of AAA:** To determine who will perform which services in the case of a disaster/emergency, the AAA needs to understand what will happen and what will be expected of the AAA.

i. **AAA Role:** The AAA will be a player in a community-wide response team.

ii. **Community Response Team:** As a member of the response team, the AAA must develop a clear picture of all members of this community-wide response team.

4. **Pre-planning Community Coordination:**

a. **Emergency Response System:** The AAA shall identify the current Disaster/Emergency response system within its service area and determine the AAA’s role within the system.

b. **Aging Network Representation in Disaster/Emergency Response System:** The AAA should work with municipal and county emergency management to ensure that the aging network is represented within the municipal and county emergency operations centers.

c. **Community Resources:** The AAA should provide an inventory of community resources and services for the elderly.

d. **Special Needs Education:** The AAA should educate the community and emergency organizations to the unique needs of the elderly and the AAA resources.

e. **Community Organization Response Team:** The AAA should forge alliances with community organizations that might assist in responding to disasters/emergencies affecting elders within the service area. Among the organizations that may be a part of the response team are the following:

i. American Red Cross;

ii. Salvation Army;

iii. Civil Defense;
iv. Faith-based organizations;

v. Volunteer and non-profit organizations;

vi. Department of Economic Opportunity;

vii. Business community;

viii. Neighborhood groups, homeowner and condominium associations;

ix. Neighborhood watch groups; and

x. Volunteer organizations.

f. **Local Response Team:** Local players in a response team:

i. Local government (mayor, police, county authorities including county emergency operations staff);

ii. County sheriff;

iii. County Health Department – especially staff assigned to Special Needs Shelters and Department of Health Regional Special Needs Shelter Consultants;

iv. Local fire and police departments;

v. Nursing homes and assisted living facilities; and

vi. Media (Is the warning system in place appropriate for cultural diversity, multi-lingual, and for persons with visual and hearing impairments?).

g. **Resources:** Community resources to call upon to assist in the identification and location of elders requiring emergency assistance:

i. Four wheel drive, boat and ham radio owners;

ii. Mail carriers;
iii. Grocery stores or pharmacies that deliver;

iv. Volunteer and community-based organizations and faith-based groups that visit homebound elders;

v. Desk clerks of single occupancy hotels;

vi. Anyone trained in Disaster/Emergency response who knows the community;

vii. Meals on Wheels, Personal Care and Homemaker service providers; and

viii. Senior center staff.

**h. Identification of Elder Persons:** Area Agencies on Aging are responsible for identifying older persons, not just the clients they serve, but also elders located in the general population, who may be at risk due to disruption of services (e.g., lack of food, power, water, sewer, medicine, fire protection, emergency medical service, law enforcement, and/or continuity of care). Immediately after a disaster/emergency, the AAA shall identify the number of elderly affected by the disaster/emergency. Information that will facilitate identification should be obtained in advance and incorporated into the Disaster/Emergency Response Plan. The following elements may assist in this endeavor:

i. The latest Census information on the number of seniors by county;

ii. Maps that pinpoint concentrations of elderly people, including elders in the general population, assisted living facilities, nursing homes and retirement communities;

iii. A geographic map (GIS) with a demographic overlay would show the most vulnerable when disaster/emergency possibilities and geography are related, such as floods and hurricanes;

iv. Maps of concentrations of one-person senior households;
Emergency Preparedness Responsibilities and Requirements

v. Maps of concentrations of low income, minority and ethnic groups. (Is an interpreter available if English is not their first language?);

vi. Locations of apartment dwellers whose needs might go unanswered because of their solitude; and

vii. Specific data about the socio-economic characteristics of seniors. Often lower socio-economic individuals lack insurance and need more assistance than more economically secure persons.

i. **AAA Maps**: Based on the information obtained about the locations of elders within the service area, the AAA should develop maps indicating these locations and provide the maps to DOEA to be incorporated into DOEA’s elder population density maps. Information should also be shared with local emergency officials to assist with planning efforts addressing the needs of vulnerable populations (elders, disabled and children). In addition to the location of elders within the service area, AAA maps should include the location of:

   i. Senior centers;

   ii. Congregate meal sites; and

   iii. Other locations that provide services and assistance to seniors.

j. **Lead Agencies and Service Providers**: The AAA should ensure that Lead Agencies and Service Providers within the service area of the AAA have:

   i. Written Disaster/Emergency Response Plans;

   ii. Emergency contact lists for staff;

   iii. Call down lists of clients; and

   iv. Printed hard copy lists of clients in the event of prolonged power outages or loss of computer access
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k. **Contracted Service Providers:** The AAA should have Memorandums of Understanding in all contracts with service providers to ensure continuity of services in the event of a disaster/emergency.

5. **Area Agency on Aging Functioning:**

a. **Chain of Command:** In the event of a disaster/emergency, the AAA Executive Director and/or staff could well be affected. Personal homes, personal safety, and relatives and friends may need attention before it will be possible to assist in the response and resume the functions of the Area Agency on Aging. A specific chain of command should be in place designating the person(s) who will assume responsibilities during the critical response phase of disaster/emergency. Throughout the preparation stage, these individuals must be involved in the planning and preparation activities.

b. **Response Activity Tools:** At the time of disaster/emergency, the AAA Executive Director and/or designated staff will need in his/her possession tools to begin the response activity. These items should be assembled in a secure enclosure, such as a suitcase, and kept in a secured and accessible location. A list of what may be needed is found in Attachment 11: Response Activity Tools.

B. **Emergency Response:**

Response is the phase of a disaster/emergency in which the AAA will work to meet the immediate needs of those affected by the disaster/emergency. The response phase is the initial reaction to ensure that everyone’s safety, sanitation and security is intact. Until that is complete, the recovery phase cannot begin. When a disaster/emergency occurs, a good plan will allow the maximization of resources for the greatest assistance to elders.

Contacts that were made and relationships developed during the preparation phase with the people and resources planning to respond to a disaster/emergency will prove beneficial during the response phase. (See Attachment 12: Disaster/Emergency Checklist for details of response activities.)
The following are the elements of the disaster/emergency response:

1. **Alert Staff:**
   
   a. **Institute Planned Call Tree:**
      
      i. Telephone communication may not be possible; contingency plans for this should be in place. For instance, will staff all meet at the office? Where will staff meet if the office is destroyed? When should staff call to report their status? (Please provide updated information for the DOEA website to show the status of the AAA.)

      ii. Depending on the scope of the disaster/emergency, staff may be victims. This should be the first question asked to staff: “How are you and members of your family?” “Are you safe and secure?” “What can we do to assist you so you can return to work to assist elders?”

   b. **Assign Duties:**
      
      i. Assign duties for the operations of the AAA from prepared list. Have backup staff in place to provide relief to assigned staff. Ensure adequate rest and rotation of staff.

      ii. Include plans to staff (as needed and/or requested) special needs shelters, general population shelters, essential services centers (ESC), disaster recovery centers (DRC) (including community outreach activities, if needed), senior centers, and county emergency operations centers.

   c. **Advanced Warning:** When advanced warning is possible:
      
      i. Tasks cited a. and b. above should begin in anticipation of the disaster.

      ii. Staff transportation will be the first requirement. Ensure all vehicles have full gas tanks.

      iii. Staff communications will be important. Ensure that all cell phones, satellite phones, and/or blackberries are charged.
iv. Staff must have proper identification to ensure they are recognized as authorized emergency support staff. Have AAA and, if available, emergency support staff credentials and identification. These should be coordinated with local emergency management officials.

d. **Contact Key Providers:**

i. Ensure all providers have disaster/emergency contingency plans.

ii. Ensure that requirements for performance in a disaster/emergency situation are included in all contracts or as a Memorandum of Understanding. Emphasize the critical need for record keeping.

2. **Organization: Begin Recordkeeping.** This is critical. These records will be needed to track expenditures and utilization of resources, receive reimbursement from the appropriate federal or state sources later. Records should include, at a minimum, the following information:

a. Mission number, if available;

b. Staff time, including overtime;

c. Any supplies;

d. Number of contacts made with seniors;

e. Type and unit of service provided;

f. Resources and inventory used;

g. Intake forms for all seniors;

h. Any contracted services;

i. Personal expenses; and

j. Phone log (be specific).
3. **Assessment:**

   a. **Information:** Within 24 hours of the disaster/emergency, collect sufficient information to determine the needed type, scope and location of AAA disaster/emergency assistance activities. Communicate this information to DOEA and to local emergency management officials.

   b. **Resource Allocation:** Information will help determine allocation of AAA resources, eliminate duplications and increase effectiveness to meet the disaster/emergency need.

   c. **Types of Information:** Collect information on:

      i. Numbers of affected elders including clients and those not typically receiving services but who, under normal circumstances, are able to live independently;

      ii. The kinds of services and supplies needed;

      iii. Available resources;

      iv. Availability of housing – both temporary and long-term;

      v. Need for nutrition, mental health or medical services; and

      iv. Scarcity and disruption of transportation.

   d. **Assess Geographic Scope of Disaster:**

      i. Assess the amount of damage inflicted on impacted seniors; include demographic information (frail, low-income) and their short and long-term needs.

      ii. Assume this initial assessment will be incomplete and imprecise.

      iii. Look for service gaps and identify where additional services and resources are needed.
iv. Report to DOEA during daily conference calls and identify priority needs. Follow with an emailed report, if email services are available.

4. Action Which May Need to be Initiated:
   a. **Evaluation**: Evaluate the operability of AAA offices and relocate, if needed. Notify DOEA of any AAA relocation.
   
b. **Contacts**: Maintain contact with DOEA and county emergency operations for consultation and guidance regarding assistance, resources and newly developing needs. All requests for assistance should be coordinated with local emergency management officials.

If local resources have been exhausted, notify DOEA to ensure the unmet need is addressed at the state level. Request county officials to enter a mission number in EM Constellation so that specific information (what is needed, how much is needed, when it is needed, etc.) can be documented.

c. **Community Resources**: Inform those people identified as community resources, such as faith-based groups and volunteers, that the AAA is available to assist isolated elderly.

d. **Information Sources**: Maintain sources to obtain accurate information and dispel rumors and panic.

5. **Provide Emergency Services**: Once the elders affected by the disaster/emergency and their needs are identified, the AAA should arrange for provision of needed services which may include:
   a. Food, water and ice;
   b. Medications and health care;
   c. Personal needs and items (clothing, toiletries);
   d. Assistance in locating pets;
   e. Assistance in communicating with family and friends;
   f. Homemaker and personal care services;
Emergency Preparedness Responsibilities and Requirements

Area Agency on Aging

6. Intake Forms:

a. Central File: All intake forms must be maintained in a central file for follow-up.

b. Follow-Up: All seniors contacted by the AAA must have follow-up.

c. Follow-Up Purpose: Follow-up is required because:

   i. Additional needs will develop.

   ii. Additional resources will become available.

   g. Debris removal;

   h. Mental health counseling; and

   j. Assistance in completing applications for disaster relief and assistance.
iii. Services delivered and not delivered must be tracked.

iv. This information will be critical for the AAA in prioritizing requests for assistance for elders affected by the disaster/emergency.

C. **Emergency Recovery:** The goal of recovery is sustained care offered over a longer period of time and is intended to assist people in resuming their normal, daily lives. There is no way to return people to their life, as it existed before the disaster/emergency. Too often, the mementos, landmarks, and tragically even the people that once defined their lives are no longer there. The goal is to move forward.

The Department of Elder Affairs, as part of Emergency Support Function 6 – Mass Care, is requested during recovery efforts to provide staffing for the Disaster Recovery Centers.

When the State Recovery Desk announces the locations for the DRCs, they will request that a variety of state agencies and non-profit organizations provide staffing. A mission will be entered into EM Constellation. The Department of Elder Affairs provides staffing as requested that can include one or all of the following:

1. Area Agencies on Aging (AAA)
2. Comprehensive Assessment and Review for Long-Term Care Services (CARES)
3. Long-Term Care Ombudsman Program (LTCOP)

The number of staff required for the DRCs will vary depending on the event and the impact. Each agency and non-profit organization is required to provide staffing for at least three days. The Department in coordination with the AAAs will provide staffing, but evaluate the need for staffing on a day-to-day basis. Staff assigned to each DRC is required to provide statistics on the number of elders seen and assisted at the close of each business day to their supervisor and the DOEA ECO or Alternate ECO.
When staffing is requested from the Area Agency on Aging, CARES and LTCOP for a Disaster Recovery Center, the points of contact will be sent a packet of information by email that will assist staff. The packet will be appropriate to the center being established. Additional information and literature appropriate to the type of aging services available in the area should be provided by the Area Agency on Aging and the Aging Network Partners.

The designated Department DRC Coordinator will coordinate staffing between the Area Agency on Aging, CARES and LTCOP. The AAAs will be asked to provide the primary staffing requirements due to their knowledge, availability and expertise regarding aging services in the impacted community. The AAAs are encouraged to utilize the staff of their local service providers in addition to their own staff. CARES and LTCOP staff will be utilized to supplement the staffing requirements.

One of the assigned duties of the AAAs is to include plans to staff (as needed and/or requested), Disaster Recovery Centers (DRC), senior centers, and serves as a liaison to the county emergency operations centers. Depending on the magnitude of the event, staffing may also be warranted at special needs shelters and general population shelters to assist with Discharge Planning. It is the responsibility of the AAA ECO to identify staff that is required for the DRCs in their area. Once a staffing roster is established, the roster should be sent promptly to the designated Department DRC Coordinator so gaps in the staffing roster can be filled. The ECO or Alternate ECO notifies the State Recovery Desk of the staffing and roster and posts rosters in the appropriate mission in EM Constellation.

If the Department is not seeing sufficient requests for assistance to warrant continued staffing of the DRC, a request to pull staffing back will be made to the ESF 6 Recovery Liaison and the Recovery Desk by the Department ECO. Once approval to pull staffing back has been received, staff assigned on the last day will provide the FEMA and State DRC/ESC Managers with information on the services available and contact information for the AAA and the Department of Elder Affairs. Notification of the staff being withdrawn will be provided to the ESF 6 Recovery Liaison and the Recovery Desk.

The Department may also provide Community Outreach in coordination with the Area Agency on Aging to reach those elders who were unable to evacuate or chose to shelter in place. This may require door-to-door visitation.
Special Needs Shelters are operated by the Department of Health. The Department of Elder Affairs monitors the census of all special needs shelters in conjunction with Emergency Support Function 8 – Health and Medical.

The Department of Elder Affairs assigns and coordinates staffing to support operations and discharge planning for special needs shelters within and outside the disaster area, once all local resources have been exhausted, as requested by the counties. Requests for Discharge Planning assistance are made by the county by:

1. County EOC ESF8 Representatives should create a mission request in EM Constellation to request Discharge Planning assistance and the following information is needed in the mission description:
   a. County name.
   b. What types of services are needed (elderly, disabled, children)?
   c. When is the staff needed to report for duty?
   d. Where are they needed (address and POC)?
   e. How long are they needed?
   f. How many clients need services?
   g. How many staff members are requested?

Requests received for discharge planning often involves elders. However, they can encompass individuals that are not usually served by the Department of Elder Affairs. Every effort will be made to contact appropriate state agency partners to assist with the unmet needs of clients, if outside the scope of the services provided by the aging network.

**IMPORTANT** – In keeping with NIMS protocols, the Department should only respond when there is a mission in EM Constellation or prior approval given by the DOEA Emergency Coordinating Officer to avoid duplication of effort and to track the status and details of the mission.
Note: Elders are unique and their reactions will be unique. For some, their life experiences have made it clear that change, even a disaster/emergency, will be survived. For others, the disaster/emergency may seem to have destroyed all evidence that their life had value.

1. Changes that Occur in the Recovery Phase:
   a. Complexity: Emergency needs are met; long-term solutions are more complex.
   b. Additional Resources: More resources become available.
   c. Long-Range Goals: Long-range planning and coordination become paramount.

2. Resources:
   a. Identification of Needs: The AAA will have staff, direct service providers, volunteers, subcontractors, etc., who work day to day with the affected elders and can identify their long-term needs.
   b. Resources: DOEA will assist the AAA in obtaining additional resources (if available and the AAA has effectively communicated and appropriately documented the extent of the need).
      i. The AAA shall keep sufficient service and fiscal records to meet any reporting requirements.
      ii. The AAA fiscal manager or independent auditor should work with the AAA to ensure reporting systems and expenditures comply with established rules and regulations.

3. Client Exploitation: AAA staff, direct service providers, volunteers and subcontractors should be aware of the possibility of elders being exploited following disasters and, if suspected, should take appropriate actions. Exploitation of the disabled and the elderly due to a disaster is defined as any activity that takes advantage of a disaster circumstance in order to improperly and/or illegally utilize funds, assets or property of that person via fraud, forgery, coercion, or deception, etc. (See Attachment 13: Indicators of Exploitation).
NIMS TRAINING GUIDELINES:

<table>
<thead>
<tr>
<th>FY10-11</th>
<th>Complete IS-700; IS-800; ICS-100; ICS-200 – Awareness Training</th>
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<tbody>
<tr>
<td></td>
<td>Complete ICS-300; ICS-400 – Advanced Training</td>
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<tr>
<td></td>
<td>Complete Emergency Management Framework Course – Awareness Training</td>
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<td></td>
<td>Complete ICS Position-Specific Training – Practicum</td>
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A. Acronyms:

1. **NIMS** – National Incident Management System
2. **ICS** – Incident Command Structure

B. Required Training: Entry Level Staff:

1. FEMA IS-700: NIMS, An Introduction
2. ICS-100: Introduction to ICS or equivalent

C. Personnel: Federal/State/Local/Tribal/Private Sector & Non-governmental personnel to include entry level first responders and disaster workers

1. Emergency Medical Service personnel
2. Firefighters
3. Hospital staff
4. Law Enforcement personnel
5. Public Health personnel
6. Public Works/Utility personnel
7. Skilled Support personnel
8. Other emergency management response, support and volunteer personnel at all levels
D. Required Training: First Line, Single Resource, Field Supervisors

1. FEMA IS-700: NIMS, An Introduction
2. ICS-100: Introduction to ICS or equivalent
3. ICS-200: ICS for Single Resources and Initial Action Incidents

E. Personnel: Federal/State/Local/Tribal/Private Sector & Non-governmental personnel to include:

1. First line supervisors
2. Single resource leaders
3. Field supervisors
4. Other emergency management/response personnel that require a higher level of ICS/NIMS Training
NIMS TRAINING GUIDELINES:

A. Middle Management:

1. Required Training
   a. FEMA IS-700: NIMS, An Introduction
   b. FEMA IS-800: National Response Framework, An Introduction
   c. ICS-100: Introduction to ICS or equivalent
   d. ICS-200: ICS for Single Resources and Initial Action Incidents
   e. ICS-300: Intermediate ICS or equivalent (FY07 Requirement)

2. Personnel: Federal/State/Local/Tribal/Private Sector & Non-governmental personnel to include:
   a. Strike team leaders
   b. Task force leaders
   c. Unit leaders
   d. Division/group supervisors
   e. Branch directors
   f. Emergency operations center and multi-agency coordination system staff

B. Command and General Staff

1. Required Training:
   a. FEMA IS-700: NIMS, An Introduction
   b. FEMA IS-800: National Response Framework, An Introduction
   c. ICS-100: Introduction to ICS or equivalent
Attachment 1: NIMS Training Guidelines

2. Personnel:
   a. Federal/State/Local/Tribal/Private Sector & Non-governmental personnel to include:
   b. Select department heads with multi-agency coordination system responsibilities
   c. Area commanders
   d. Emergency Managers and Emergency Coordinating Officers
   e. Emergency operations center and multi-agency coordination system managers

   d. ICS-200: ICS for Single Resources and Initial Action Incidents
   e. ICS-300: Intermediate ICS or equivalent (FY07 Requirement)
   f. ICS-400: Advanced ICS or equivalent (FY07 Requirement)
**COMPREHENSIVE EMERGENCY MANAGEMENT PLAN (CEMP):**

A comprehensive emergency management program encompasses all hazards and all phases of related planning including mitigation, preparedness, response and recovery. This includes business continuity, emergency and disaster planning, as well as all of the related specialty areas such as hazard identification and mitigation, emergency response, disaster recovery, business resumption, crisis management and continuity of operations to name a few.

Comprehensive Emergency Management Programs provide a complete approach for dealing with disruptions in both the public and the private sector.

Comprehensive Emergency Management deals with day-to-day disruptions as well as managing response to, and recovery from, major disasters. A comprehensive program will enable both governments and businesses to deal with any emergency, thus protecting the entire community.

A Comprehensive Emergency Management Plan (CEMP) establishes a framework for an effective system of comprehensive emergency management. The Plan describes the basic strategies, assumptions, operational goals and objectives, and mechanisms through which a jurisdiction will mobilize resources and conduct activities to guide and support emergency management efforts through preparedness, response, recovery, and mitigation. To facilitate effective operations, the Plan adopts a functional approach that groups the types of assistance to be provided into Emergency Functions.

**A. Definition of Comprehensive Emergency Management:** Comprehensive Emergency Management is generally defined to be a broad process aimed at the reduction of loss of life and property and the protection of people and assets from all types of hazards through a risk-based program of mitigation, preparedness, response and recovery. When properly implemented, CEMP includes many of the related activities included in specialty areas such as business continuity and disaster recovery.

1. **Comprehensive Emergency Management:** An integrated approach to the management of emergency programs and activities for all four emergency phases (mitigation, preparedness, response, and recovery), for all types of emergencies and disasters (natural, man-made, and attack), and for all levels of government and the private sector.
2. **Comprehensive Emergency Management Plan (CEMP):** Contains policies, authorities, concept of operations, legal constraints, responsibilities, and emergency functions to be performed. Agency response plans, responder standard operating procedures, and specific incident action plans are developed from this strategic document.

3. **Comprehensive Emergency Management Program (CEM Program):** Provides the framework for development, coordination, control and direction of all Comprehensive Emergency Management planning, preparedness, readiness assurance, response and recovery actions

B. **Business Continuity Management:** Business Continuity Management is a comprehensive process to ensure the continuation and improvement of business regardless of the nature of the event. It is meant to have a very broad meaning and is often used as an all-encompassing term to describe an integrated and enterprise-wide process.

1. Plans should include the following elements at a minimum (in alphabetical order):
   a. Accident prevention
   b. Business impact analysis
   c. Business recovery
   d. Business resumption planning
   e. Command centers
   f. Computer security
   g. Contingency planning
   h. Crisis communication
   i. Crisis management
   j. Disaster recovery
   k. Emergency management and response
   l. Event management
Attachment 2: Comprehensive Emergency Management Plan (CEMP)

m. Exercises and training
n. Information security
o. Mitigation planning
p. Project management and quality control
q. Risk control
r. Risk financing and insurance
s. Risk management
t. Safety and security
u. Software management

2. The plan must be maintained and updated as business processes change.

3. Continuity plans must be tested. Tabletop drills and functional exercises are generally used to ensure that the plans will work.
CONTINUITY OF OPERATIONS PLANS (COOP):

The Department of Elder Affairs and the AAAs must have written disaster/emergency plans, which include a Continuity of Operations Plan (COOP). This plan must protect life and property, including vital records, while supporting clients with essential services until normal operations can resume.

A. Overview of Continuity of Operations Plan:

1. Continuity of Operations Plans must provide for:
   a. Succession to office and emergency delegation of authority;
   b. Safekeeping of essential resources, facilities and records;
   c. Establishment of emergency operating capabilities; and
   d. Ensure that individual departments and agencies can continue performing their essential functions under a broad range of circumstances.

2. Continuity of Operations Plans must:
   a. Be effective with and without warning;
   b. Take an all-hazard approach;
   c. Include alternate facilities;
   d. Have essential functions operational within 12 hours of activation; and
   e. Be able to sustain operations for 30 days.

3. Objectives of COOP planning:
   a. Ensure continued performance of agency identified essential functions and operations during a COOP event;
   b. Reduce loss of life;
   c. Minimize damage and losses to critical processes and information;
Attachment 3: Continuity of Operation Plans (COOP)

d. Ensure successful succession to office in the event that a disruption renders the agency leadership unavailable to perform their responsibilities;

e. Reduce or mitigate disruptions to operations – anticipate what might occur and plan to deal with it;

f. Ensure that agencies have alternate facilities from which to perform their essential functions during a COOP event;

g. Protect essential facilities, equipment, vital records and other assets;

h. Achieve a timely and orderly recovery from a COOP situation;

i. Achieve an efficient reconstitution from an emergency and resume full service to both internal and external clients; and

j. Maintain a test, training and exercise program to support the implementation and validation of COOP plans.

B. Elements of a Viable COOP Plan:

1. **Essential functions:** Essential functions are an agency’s business functions that must continue with no or minimal disruptions.

a. Essential functions are those functions that enable an organization to:

   i. Provide vital services;

   ii. Exercise civil authority;

   iii. Maintain the safety of the general public; and

   iv. Sustain the industrial or economic base during an emergency.

b. Essential functions must continue even when an agency cannot support its broader mission.
c. When identifying essential functions, agencies must:
   i. Determine what must be continued in all circumstances, and
   ii. Consider those functions that cannot suffer an interruption for more than 12 hours.

d. Agencies must be capable of sustaining these essential functions for up to 30 days.

e. Essential functions may support another department, agency or organization.

f. Essential functions should be prioritized based on the criticality of the function and against the likely COOP triggers and scenarios.

2. **Vital Records**: Vital records are information items (electronic and hardcopy documents, references and records) that are considered to be vital to the operation of an organization and are needed to support essential functions during a COOP situation. This includes client records and files.

   a. Categories of vital records include:
      i. Emergency operation records;
      ii. Client records and files; and
      iii. Legal and financial records.

   b. An effective vital records program provides for the identification, protection and ready availability of vital records, databases and hardcopy documents necessary to support essential functions under the full spectrum of emergencies.

3. **Orders of succession**: Provisions for the assumption of senior agency officials’ duties during an emergency, in the event that any of those officials are unavailable to execute their legal duties, to support day-to-day operations.

   a. Orders of succession procedures include the conditions under which succession will take place, the method of notification, and any organizational limitation on the authorities.
b. Orders of succession are included with the agency’s vital records.

4. Delegations of Authority: Specify and document who is authorized to act on behalf of the department or agency head and other key officials for specific purposes.
   
a. Delegations of authority are required to ensure:
      
i. Continued operations of departments and agencies and their essential functions, and
      
ii. Rapid response to any emergency situation requiring COOP plan implementation.

b. A delegation of authority states explicitly:
   
i. The authority that is being delegated, including any exceptions;
   
ii. The limits of that authority;
   
iii. To whom the authority is being delegated (by title, not name);
   
iv. The circumstances under which delegated authorities would become effective and when they would terminate; and
   
v. The successor’s authority to re-delegate those functions and activities.

5. Alternate facilities: A department’s or an agency’s primary facility suffers damage, and an alternate facility is required for COOP operations. At least two alternate facilities should be identified in case the first selection is unavailable during the emergency.

6. Interoperable Communications: Communications that provide the capability to perform essential functions, in conjunction with other agencies, until normal operations can be resumed. Interoperable communications must be:
   
a. Redundant;
   
b. Available within 12 hours of activation; and
c. Sustainable for up to 30 days.

7. **Human Capital:** The transformation of how we employ, deploy, develop and evaluate the workforce. Focuses on results, not processes. Places the right people in the right jobs to most effectively perform the work of the organization—including cross training.

8. **Test, Training and Exercises:** Measures to ensure that an agency’s COOP program is capable of supporting the continued execution of its essential functions through the duration of a COOP situation.

9. **Devolution:** The capability to transfer statutory authority and responsibility for essential functions from an agency’s primary operating staff and facilities to other employees and facilities and to sustain that operational capability for an extended period.

   a. Addresses catastrophic or other disasters that render an organization’s leadership and staff unavailable or incapable of performing its essential functions from either its primary or alternate facility(ies).

   b. Should provide procedures, guidance and an organizational structure for the receiving organization to ensure that the organization’s essential functions are continued.

10. **Reconstitution:** The process by which surviving and/or replacement agency personnel resume normal agency operations from the original or replacement primary operating facility. A plan to return to normal operations after agency heads or their successors determine that reconstitution operation can begin.

C. **Continuity of Operations (COOP) Template:**

1. **Executive Summary:** The executive summary should briefly outline the organization and content of the COOP Plan and describe what it is, whom it affects, and the circumstances under which it should be executed. Further, it should discuss the key elements of COOP planning and explain the organization’s implementation strategies.
2. **Introduction:** The introduction to the COOP Plan should explain the importance of COOP planning to the organization. It may also discuss the background for planning, referencing recent events that have led to the increased emphasis on the importance of a COOP capability for the organization.

3. **Purpose:** The purpose section should explain why the organization is developing a COOP Plan. It should briefly discuss applicable Federal guidance and explain the overall purpose of COOP planning, which is to ensure the continuity of mission essential functions. Because of today’s changing threat environment, this section should state that the COOP Plan is designed to address the all-hazard threat.

4. **Applicability and Scope:** This section describes the applicability of the plan to the organization as a whole, headquarters as well as subordinate activities, co-located and geographically disperse, and to specific personnel groups of the organization. It should also include the scope of the plan. Ideally, plans should address the full spectrum of potential threats, crises and emergencies (natural as well as man-made).

5. **Essential Functions:** The essential functions section should include a list of the organization’s prioritized essential functions. Essential functions are those organizational functions and activities that must be continued under any and all circumstances. Organizations should:
   a. **Identify** all functions, then determine which must be continued under all circumstances;
   b. **Prioritize** these essential functions;
   c. **Establish** staffing and resource requirements; and
   d. **Integrate** supporting activity.

6. **Authorities and References:** This section should reference an annex that outlines all supporting authorities and references that have assisted in the development of this COOP Plan.
7. **Concept of Operations:** This section should explain how the organization will implement its COOP Plan, and specifically, how it plans to address each critical COOP element. This section should be separated into three phases.

   a. **Phase I: Activation and Relocation (hours 0-12):** The Phase I section should explain COOP Plan activation procedures and relocation procedures from the primary facility to the alternate facility. This section should also address procedures and guidance for non-relocating personnel.

      i. **Decision Process:** The section should explain the logical steps associated with implementing a COOP Plan, the circumstances under which a plan may be activated (both with and without warning), and should identify who has the authority to activate the COOP Plan. This process can be described here or depicted in a graphical representation.

      ii. **Alert, Notification and Implementation Process:** This section should explain the events following a decision to activate the COOP Plan. This includes employee alert and notification procedures and the COOP Plan implementation process.

      iii. **Orders of Succession:** This section should identify orders of succession to key positions within the organization. Orders should be of sufficient depth to ensure the organization’s ability to manage and direct its essential functions and operations. The conditions under which succession will take place, the method of notification, and any temporal, geographical or organizational limitations of authority should also be identified.
iv. **Delegations of Authority:** This section should identify, by position, the authorities for making policy determinations and decisions at headquarters, field levels and other organizational locations, as appropriate. Generally, pre-determined delegations of authority will take effect when normal channels of directions are disrupted and terminate when these channels have resumed. Delegations of authority should document the legal authority for making key decisions, identify the programs and administrative authorities needed for effective operations, and establish capabilities to restore authorities upon termination of the event.

v. **Devolution:** The devolution section should address how an organization will identify and conduct its essential functions in the aftermath of a worst-case scenario, one in which the leadership is incapacitated. The organization should be prepared to transfer all of their essential functions and responsibilities to personnel at a different office of location.

b. **Phase II: Onsite Operations (12 hours to 30 days):** The Phase II sections should identify initial arrival procedures, as well as operational procedures for the continuation of essential functions.

   i. **Mission Critical Systems:** The section should address the organization’s mission critical systems necessary to perform essential functions and activities. Organizations must define these systems and address the method of transferring/replicating them at an alternate site.

   ii. **Vital Files, Records and Databases:** This section should address the organization’s vital files, records and databases, to include classified or sensitive data, which are necessary to perform essential functions and activities and to reconstitute normal operations after the emergency ceases. Organizational elements should pre-position and update on a regular basis those duplicate records, databases or back-up electronic media necessary for operations.
c. **Phase III: Reconstitution (recovery, mitigation and termination):** The Phase III sections should explain the procedures for returning to normal operations—a time phased approach may be most appropriate. This section may include procedures for returning to the primary facility, if available, or procedures for acquiring a new facility. Notification procedures for all employees returning to work must also be addressed. The conduct of an After-Action Report (AAR), to determine the effectiveness of COOP plans and procedures should be considered.

8. **COOP Planning Responsibilities:** This section should include additional delineation of COOP responsibilities of each key staff position, to include individual Relocation Group (RG) members, those identified in the order of succession and delegation of authority, and others, as appropriate.

9. **Logistics:**

a. **Alternate Location:** The alternate location sections should explain the significance of identifying an alternate facility, the requirements for determining an alternate facility, and the advantages and disadvantages of each location. Senior managers should take into consideration the operational risk associated with each facility. Performance of a risk assessment is vital in determining which alternate location will best satisfy an organization’s requirements. Alternate facilities should provide:

i. Sufficient space and equipment;

ii. Capability to perform essential functions within 12 hours, up to 30 days;

iii. Reliable logistical support, services and infrastructure systems;

iv. Consideration for health, safety and emotional well-being of personnel;

v. Interoperable communications; and

vi. Computer equipment and software.
b. **Interoperable Communications:** The interoperable communications section should identify available and redundant critical communication systems that are located at the alternate facility. These systems should provide the ability to communicate within the organization and outside the organization. Interoperable communications should provide:

i. Capability commensurate with an agency’s essential functions;

ii. Ability to communicate with essential personnel;

iii. Ability to communicate with other agencies, organizations and clients.

iv. Access to data and systems;

v. Communications systems for use in situations with and without warning;

vi. Ability to support COOP operational requirements;

vii. Ability to operate at the alternate facility within 12 hours, and for up to 30 days; and

viii. Interoperability with existing field infrastructures.

10. **Tests, Training and Exercises:** This section should address the organization’s Test, Training and Exercise Plan. Tests, Training and Exercises familiarize staff members with their roles and responsibilities during an emergency, ensure that systems and equipment are maintained in a constant state of readiness, and validate certain aspects of the COOP Plan. COOP Test, Training and Exercise Plan should provide:

a. Individual and team training of agency personnel;

b. Internal agency testing and exercising of COOP plans and procedures;

c. Testing of alert and notification procedures;

d. Refresher orientation for COOP personnel; and
11. **Multi-Year Strategy and Program Management Plan:** This section should discuss how the organization plans to develop their Multi-Year Strategy and Program Management Plan (MYSPMP). The MYSPMP should address short and long-term COOP goals, objectives, timelines, budgetary requirements, planning and preparedness considerations, and planning milestones or tracking systems to monitor accomplishments. It should be developed as a separate document.

12. **COOP Plan Maintenance:** This section should address how the organization plans to ensure that the COOP Plan contains the most current information. Federal guidance states that organizations should review the entire COOP Plan at least annually. Key evacuation routes, roster and telephone information, as well as maps and room/building designations of alternate locations should be updated as changes occur.

13. **Annexes:**

   a. **Annex A: Authorities and References:** This annex should cite a list of authorities and references that mandate the development of this COOP Plan, and provide guidance towards acquiring the requisite information contained in the COOP Plan.

   b. **Annex B: Operational Checklists:** This section should contain operational checklists for use during a COOP event. A checklist is a simple tool that ensures all required tasks are accomplished so that the organization can continue operations at an alternate location. Checklists may be designed to list the responsibilities of a specific position or the steps required to complete a specific task. Sample operation checklists may include:

      i. Emergency Calling Directory;
      
      ii. Key Personnel Roster and Essential Functions Checklist;
      
      iii. Senior Emergency Response Team Roster;
      
      iv. Emergency Relocation Team Checklist
      
      v. Alternate Site Acquisition Checklist;
      
      vi. Emergency Operating Records and IT Checklist; and

c. **Annex C: Alternate Location/Facility Information**: This annex should include general information about the alternate location/facility. Examples include the address, point of contact, and available resources at the alternate location.

d. **Annex D: Maps and Evacuation Routes**: This annex should provide maps, driving directions, and available modes of transportation from the primary facility to the alternate location. Evacuation routes from the primary facility should also be included.

e. **Annex E: Definitions and Acronyms**: This annex should contain a list of key words, phrases and acronyms used throughout the COOP Plan and within the COOP community. Each key word, phrase and acronym should be clearly defined.

f. **Pandemic Annex**: Each AAA needs to develop a Pandemic Annex to their Continuity of Operations Plan. A pandemic event will result in widespread illness and associated absenteeism from the workplace. Rates of absenteeism will, however, depend on the severity of the pandemic. Health officials are predicting that in a severe pandemic, absenteeism attributable to illness, the need to care for ill family members and fear of infection may reach upwards of 40 percent during peak weeks of a community outbreak and could last up to three months. This annex should include plans on how the AAA would continue mission-essential operations. The agency should develop a list of “mission-essential functions” performed by agency staff. Mission-essential functions are those duties and tasks that are of immediate importance to the agency’s mission and the health and welfare of elder Floridians in the event of disaster or other crisis. Mission-essential functions include all duties and tasks directly associated with the delivery of life-sustaining services and/or the continued operations of critical agency infrastructure. Emergency staffing and backfill of existing positions will be of primary concern in order to provide essential services to the public.
ROLE OF DEPARTMENT OF ELDER AFFAIRS EMERGENCY COORDINATING OFFICER:

The Department of Elder Affairs Emergency Coordinating Officer provides statewide leadership, direction, guidance, support and coordination in the areas of disaster mitigation, preparedness, response and recovery for Florida’s elders.

A. Responsibilities of DOEA Emergency Coordinating Officer:

1. Developing the continuity of operations (COOP) and comprehensive emergency management (CEMP) plans for the Department of Elder Affairs, and providing technical assistance to AAAs with the development of their plans;

2. Work with the DOEA Communications Office to update the annual Disaster Preparedness Guide for Elders in English and Spanish;

3. Providing education, demographic information, training and technical assistance on disaster planning and emergency response for elders to increase public awareness and create a culture of preparedness;

4. Providing expertise to local, state and federal officials on the unique needs of elders and appropriateness of services and emergency response efforts;

5. Creating a culture of preparedness among the state’s elders by educating the elderly population about the necessity of taking personal responsibility to have an emergency plan ready in advance of emergency events which includes: evacuation and sheltering plans, transportation, food, water, ice, medications, fuel, emergency contact information and other important documents including prescriptions and living wills;

6. Supporting the efforts to improve access and transportation to special needs shelters, including enhancements to the special needs registry, and ensuring the availability of appropriate services at special needs shelters;

7. Standardizing procedures for discharge planning and transition assistance for special needs shelter clients in each county to ensure continuity of care and services including: assessment of medical, transportation, housing, financial, mental health and nutritional needs, and identification of available services or resources to meet client needs;
8. Leading the Statewide Interagency Special Needs Shelter Response Teams with assistance of designated staff from Department of Elder Affairs, Department of Health, Department of Children and Families, Department of Veterans’ Affairs, Division of Emergency, Agency for Health Care Administration, Agency for Persons with Disabilities, and other appropriate agencies and entities to assist local county emergency management agencies with the continued operation or closure of special needs shelters, as well as with the discharge of special needs clients to alternate facilities, if necessary;

9. Staffing the State Emergency Operations Center to direct and coordinate the response and recovery efforts for elders needing assistance following an emergency event. Serves as the primary liaison with the AAAs, CARES Office, Ombudsman and DOEA program offices. Elders may be aging in place and living independently in the community, or residing in long-term care facilities or nursing homes; and

10. Serves as the primary liaison to communicate information and directives related to emergency issues to and from the AAAs and AoA.

B. The Mission of the Office of Emergency Operations and Disaster Preparedness is to ensure the safety and security of Florida’s elders by establishing reliable communication, coordination and delivery of services across governmental agencies, the aging network, and care provider systems at the private, non-profit and public levels.
EMERGENCY MEMORANDUM

TO: Area Agency on Aging Directors and Aging Network Disaster Coordinators
FROM: Secretary _____________
SUBJECT: Preparation to Implement Emergency Relief Measures
DATE: ____________

Please be prepared to implement your disaster plans and take precautionary measures in relation to ____________, if you have not already done so. As the Area Agency on Aging you shall instruct lead agencies in the counties under your jurisdiction to contact the appropriate Local County Emergency Management Office to determine the evacuation status in their county. The next advisory is scheduled for ___________ and you will be provided with additional information.

1. Report to the Department of Elder Affairs Emergency Coordinating Officer or Alternate, the status of the counties at the earliest possible time.

2. Instruct Local Service Providers to be ready to implement a call-down of at-risk and special needs clients.

3. Both you and the Local Service Providers monitor local weather reports and activity and keep DOEA abreast of storm activity in your area.

4. Both you and Local Service Providers need to prepare hard copy reports and client lists to ensure your ability to contact clients to determine their status and identify any unmet needs. Electronic records may not be available after impact due to loss of power, damage to equipment or facilities, or inability to access databases or files.

5. Review Continuity of Operations Plans to address steps to be taken before, during and after an event to maintain operations and functionality of Elder Helplines and Information Referral services.

This information is primarily for the following PSAs (circled or in bold)

1 2 3 4 5 6 7 8 9 10 11

Note: Other PSAs, please monitor in case the forecast changes.
EMERGENCY MEMORANDUM

TO: Area Agency on Aging Directors and Aging Network Disaster Coordinators

FROM: Secretary ____________________

SUBJECT: Implementation of Emergency Relief Measures

DATE: ______________________________

The contracts in place with Area Agencies on Aging and Local Service Providers state in the event of a declared disaster or state of emergency by the President of the United States or the Governor of Florida, the Secretary of the Department of Elder Affairs has the authority to direct Area Agencies on Aging and, in turn, Local Service Providers to implement their Emergency Relief measures. Due to the current situation with _______, a declaration from the Governor has been issued, Executive Order ________, therefore, I am officially instructing the Area Agencies on Aging to:

- Contact and coordinate levels of activation with County Offices of Emergency Management and place call-downs to all Local Service Providers. Instruct them that implementation of emergency relief measures have been ordered by the Department of Elder Affairs.

Relief measures outlined in the Department of Elder Affairs guidelines for Local Service Providers include the following:

1. Pre- and Post-event call down of at-risk clients;
2. Evaluate the ability of the Area Agency on Aging and Local Service Providers to continue service delivery and report status to the Department of Elder Affairs Emergency Coordinating Officer (ECO) or Alternate;
3. After-hour staff coverage of Elder Helplines;
4. Delivery of services to all elderly in need after the storm, if necessary and possible;
5. Dispatch designated Emergency Service Directors from the Local Service Provider and Area Agency on Aging to shelters within and outside the disaster area to help elderly evacuees;
6. Distribution of meals before or after the event, if possible; and
7. Assignment of staff to Local Emergency Operations Centers within the disaster area and field assistance offices set up by the state and federal emergency agencies per agreements with local County Emergency Management officials.
The above measures are required minimums in Local Service Provider disaster plans. Any other measures above and beyond should also be taken as necessary. The AAAs are to assist as necessary with the Local Service Providers’ implementation of emergency measures.

This information is primarily for the following PSAs (circled/bold)

1  2  3  4  5  6  7  8  9  10  11

Note: Other PSAs should also monitor.
Florida Department of Elder Affairs

Office of Disaster Preparedness and Emergency Operations

Special Needs Shelter Discharge Planning Response Teams

MULTIAGENCY RESPONSE TEAMS
Standard Operating Procedure

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INTRODUCTION:

Natural and man-made emergencies and disasters impact homes, businesses and public infrastructure, often quickly overwhelming the response capabilities of local agencies. During such events, individuals who require assistance with activities of daily living may choose to evacuate to Special Need Shelters. A special needs shelter is a temporary emergency facility capable of providing care to residents whose medical condition is such that it exceeds the capabilities of the Red Cross General Population Shelter, but is not severe enough to require hospitalization.

The Secretary of the Florida Department of Elder Affairs (DOEA) is required to convene Multiagency Special Needs Shelter Discharge Planning Response Teams, at any time that he or she deems appropriate and necessary, or as requested by ESF 8 at the State Emergency Operations Center, to assist local areas that are severely impacted by a natural or manmade disaster and have exhausted all local resources, that requires the use of special needs shelters. The teams are activated to provide resource and logistical support to local jurisdictions to assist with discharge planning and transition of clients to appropriate services and resources within the community.

Availability of emergency workers during disaster response and recovery operations is a factor that must be considered by all emergency response organizations. All such organizations must take all necessary initiatives to ensure availability of their work force. This includes taking active steps to facilitate the safety and welfare of workers’ families.

It is the Department of Elder Affairs’ mission to provide essential social and health services to the elderly, promote social, physical, economic and emotional well-being to encourage maximum independence and improve the quality of life for seniors and their caregivers.
SPECIAL NEEDS SHELTER CLIENTS:

A. Definition and Criteria:

1. Client Definition:
   
   a. A person with special needs is defined as a person who during periods of evacuation, either mandatory or voluntary, will require assistance that exceeds the basic level of care provided at the general population shelter but will not require the level of skilled medical care provided at institutional facilities.

   b. One who would need assistance during evacuations and sheltering because of physical or mental handicaps (Chapter 252.355, F.S.).

2. Criteria for Special Needs Shelter client may include, but are not limited to:
   
   a. A person with a stable medical condition that requires periodic observation, assessment and maintenance (i.e. glucose readings, vital signs, ostomy care, urinary catheter);

   b. A person requiring periodic wound care assistance (i.e. dressing changes);

   c. A person with limitations that requires assistance with activities of daily living;

   d. A person requiring and needing assistance with oral, subcutaneous or intramuscular injectable, or topical medication;

   e. A person requiring minimal assistance with ambulation, position change and transfer (i.e. able to move more than 100 feet with or without an assistive device);

   f. A person requiring oxygen that can be manually supplied;

   g. A person medically dependent on uninterrupted electricity for therapies including but not limited to oxygen, nebulizer and feeding tubes. Ventilator dependent persons and persons with multiple special needs requiring a higher level of care, may need to be referred to a skilled medical facility;
h. A person with mental or cognitive limitations requiring assistance who is accompanied by an appropriate fulltime caregiver for the duration of their stay in the shelter;

i. A person requiring fulltime care who is accompanied by an appropriate fulltime caregiver for the duration of their stay in the shelter;

j. A person whose weight does not exceed the safety weight restrictions of provided cots; or

k. A person who can be safely transferred and does not require specialty lifting or transferring equipment. A person requiring a stretcher to be transported may need to be referred to a higher skilled medical facility.

3. Every reasonable effort should be made to avoid admitting clients with known infectious conditions or those who require isolation, i.e. Methycillin Resistant Staph Aureous (MRSA) or persons who require respiratory isolation, such as infectious TB.

4. Counties with special needs shelters with resources that can safely accept a person exceeding the above criteria may choose to do so.
B. Client Eligibility for Multiagency Special Needs Shelter (SpNS) Discharge Planning Response Team Assistance

1. Each special needs shelter client who has been identified by the special needs shelter staff and/or the Multiagency Special Needs Shelter Discharge Planning Team as not having a viable post-event discharge plan is eligible for discharge planning assistance from the special needs shelter staff and/or the Multiagency SpNS Discharge Planning Team.

2. Criteria for eligibility include the following:

   a. Pre-event residence is not habitable.

   b. Societal under-pinnings (fire protection, emergency medical service [EMS], law enforcement, power, water and sewer) are not available at pre-event residence.

   c. Continuity of care cannot be assured at pre-event residence.

   d. New medical conditions have presented or developed during the client’s stay at the special needs shelter. As an example, the client may experience the onset of confusion or incontinence, both of which may be temporary, but should be addressed and taken into consideration before discharging the client to their pre-event residence without appropriate additional care or services.

3. It is the responsibility of assisted living facilities, nursing homes and adult family care homes to have emergency plans in place and provide for the relocation and continuity of care for their residents. Should assisted living facility, nursing home or adult family care home residents seek shelter in special needs shelters, the individual will be admitted to the special needs shelter; however, the assisted living facility, nursing home or adult family care home staff will be contacted by the shelter staff and/or Discharge Planning team and requested to come to the special needs shelter to assume responsibility for the resident. In most cases, it is inappropriate for individuals residing pre-event in assisted living facilities, nursing homes or adult family care homes to be accommodated in special needs shelters due to the level of care required and limitation of services available.
SPECIAL NEEDS SHELTERS:

A. Special Needs Shelters are refuges of last resort intended to maintain the current health, safety and well-being of the medically-dependent individuals who are not acutely ill, to the extent possible;

B. Meet a multitude of human needs, both physical and psychological, under adverse conditions; and

C. Are generally intended to operate for a limited time of one to four days.

D. The purpose of a Special Needs Shelter is to provide, to the extent possible under emergency conditions, an environment in which the current level of health of the clients with special needs can be sustained within the capabilities of available resources.

1. Persons eligible for the Special Needs Shelter may have physical or mental conditions that require limited medical/nursing oversight that cannot be accommodated or provided for in a general population shelter.

2. Medical eligibility for the Special Needs Shelter is based on a “leveling system” that considers the acuity of the condition and the skills required to provide care.

3. The Special Needs Shelter is not a hospital, a nursing home/restorative care center or a hotel.
SCOPE:

This procedure is limited to the responsibilities of the Multiagency Special Needs Shelter Discharge Planning Teams. In addition, each agency shall maintain a roster of available and deployed employees including location and contact information.
PURPOSE:

The purpose of this standard operating procedure (SOP) is to provide guidelines for activation and deployment of the Multiagency Special Needs Shelter Discharge Planning Teams to implement the procedures within its scope of responsibility. This procedure also ensures a consistent mode of operations with other agencies and entities involved in Discharge Planning and Transition Services at Special Needs Shelters.
ASSUMPTIONS:

A. A disaster may occur with little or no warning and may escalate rapidly, depleting the resources of any single local response organization or jurisdiction to handle. Additional shelters may be needed post-event due to:

1. Duration of the event and/or post event conditions (extreme heat, lack of Access to food and medical services/medicine), or

2. Lack of availability of societal underpinnings (fire protection, EMS, law enforcement, power, water and sewer), or

3. Disruption of services to ensure the continuity of care.

B. Under an Executive Order signed by the Governor, additional provisions may be relevant to Discharge Planning at Special Need Shelters or response efforts in an affected area.

C. Prior to emergency activation, a working relationship should be developed between the county emergency operations center and the county health department.

D. The Secretary of the Department of Elder Affairs is encouraged to proactively work with other state agencies prior to any natural disasters for which warnings are provided to ensure that Multiagency Special Needs Shelter Discharge Planning Teams are ready to assemble and deploy rapidly upon a determination by state emergency management officials that a disaster area requires additional assistance or is deemed appropriate and necessary by the Secretary of the Department of Elder Affairs.

E. Local emergency management officials will exhaust all efforts and resources and demonstrate due diligence in the discharge of special needs shelters clients before requesting the assistance of a Multiagency Special Needs Shelter Discharge Planning Team through Emergency Support Function 8 (ESF 8, Health and Medical Services) of the State Emergency Operations Center.
F. A Multiagency Special Needs Shelter Discharge Planning Team shall include at least one representative from each of the following state agencies:

1. Department of Elder Affairs
2. Department of Health
3. Department of Children and Families
4. Department of Veterans’ Affairs
5. Division of Emergency Management
6. Agency for Health Care Administration
7. Agency for Persons with Disabilities

G. The Secretary of the Department of Elder Affairs may call upon any state agency or office to provide staff to assist a Multiagency Special Needs Shelter Discharge Planning Team.

H. Each state agency represented on the Multiagency Special Needs Shelter Discharge Planning Team should designate a primary contact for purposes of coordination and communication. The recommended point of contact is the agency’s Emergency Coordinating Officer. This designated agency contact will be known as the **Agency Primary Contact**.

I. The Multiagency SpNS Discharge Planning Team should be comprised of representatives from each agency’s local, regional or district locations due to their knowledge of local resources and services available to assist Special Needs Shelter clients. The safety of the employee is paramount and no employee should be deployed or activated until local emergency management officials have announced that roadways are safe to travel and that conditions are safe and secure for responders. Additional consideration should be given to ensure that the responding employee’s family and residence are secured prior to deployment to the special needs shelter. In some cases, the decision may be made to deploy staff from Tallahassee or another identified centralized location, if the local agency resources are unable to deploy, as requested.
J. The Department of Elder Affairs will designate an Elder Affairs representative (Comprehensive Assessment and Review for Long-Term Care Services [CARES], Long-Term Care Ombudsman [Ombudsman] or Area Agency on Aging [AAA]) to serve as the Multiagency SpNS Discharge Planning Team lead. This position will be known as the **Discharge Planning Team Lead in each county**. If emergency circumstances prevent a CARES, Ombudsman or Area Agency on Aging Response Team member from serving as the Discharge Planning Team Lead in a county, the Department of Elder Affairs may designate a Team member representing another agency to serve as the Discharge Planning Team Lead for the county.

K. The Secretary of Elder Affairs may determine that the nature or circumstances surrounding the disaster do not warrant participation from a particular agency’s staff.
AUTHORITIES AND REFERENCES:

A. Chapter 252, Florida Statutes

B. Section 381.0303, Florida Statutes

C. Chapter 2006-71, Laws of Florida
ROLE OF THE EMERGENCY COORDINATING OFFICER, FLORIDA DEPARTMENT OF ELDER AFFAIRS:

A. Mission: At the direction of the Secretary of the Florida Department of Elder Affairs, the Emergency Coordinating Officer is responsible for implementation of the Multiagency SpNS Discharge Planning Team and achieving operational objectives.

B. Responsibilities:

1. Implements the operational objectives of the Multiagency Special Needs Shelter Discharge Planning Team

2. Ensures staffing levels and numbers of employees designated to serve on the Multiagency SpNS Discharge Planning Team are appropriate based on the magnitude of the event.

3. Keeps the Secretary of Elder Affairs informed of response activities.

4. Coordinates with designated members of each represented agency regarding the efficient flow of verbal information to and from impacted county emergency operation centers (EOCs).

5. Manages the deployment of Multiagency SpNS Discharge Planning Team(s), which includes maintaining a roster of names, contact numbers, locations and expected deployment dates based on information provided by each agency.

6. Promotes the training and preparation activities for all activations of the Multiagency SpNS Discharge Planning Team.

7. Tasks and follows up on missions to ESF 8.

8. Must have a thorough understanding of Multiagency SpNS Discharge Planning Team operations, the Incident Command System, and the emergency support function (ESF) process.

9. Must be proficient in the use of the emergency management EM Constellation.
C. Activation Duties:

1. Obtain situational briefings from the Operations Section Chief at the State Emergency Operations Center to include:
   a. The nature and scope of the event.
   b. The Area(s) of Operation.
   c. Immediate and forecasted risks to life and property.
   d. State and local response actions currently underway and planned.
   e. Locations of Special Needs Shelters (names, locations and contact numbers maintained by ESF 8).
   f. Relevant information regarding weather, Intel forecasts and hazard analyses.
   g. Status of State and federal declarations.
   h. SEOC activation level, hours of operation, briefing schedule.
   i. Participate in state emergency operation center (SEOC) teleconference briefings with county emergency operations centers

2. Ensure that the Multiagency SpNS Discharge Planning Team(s) is ready to activate and receive reports from the Agency Primary Contact.
   a. Activation will occur in two phases:
      i. **Phase One:** Preparation to begin the activation at the time that a Hurricane Warning is issued for a county.
      ii. **Phase Two:** Activation of the Multiagency SpNS Discharge Planning Team(s) upon request from ESF 8 at the SEOC, or upon determination of need for assistance made by the Secretary of Elder Affairs.
b. Agency Primary Contact Activation and Deployment Responsibilities:

i. Upon notification from the Emergency Coordinating Officer from the Department of Elder Affairs, each Agency Primary Contact shall place their designated employees on stand-by for deployment in local districts and regions and confirm contact information, as well as Special Need Shelter phone numbers and key contact information for the County ESF 8 point of contact for each mission and any other guidance document such as the Special Needs Discharge Planning Procedures that may be useful in their fulfilling their role and provided requested assistance to local emergency management officials.

ii. Once deployed, the Agency Primary Contact will ensure the roster of deployed personnel is kept current and provide information to the Emergency Coordinating Officer of the Department of Elder Affairs as requested.

c. County Discharge Planning Response Team Lead

i. The Department of Elder Affairs will serve as the lead agency in each county where a Multiagency Special Needs Shelter Discharge Planning Team(s) has been activated and deployed.

ii. Designated representatives of the Department of Elder Affairs (CARES, Ombudsman or Area Agency on Aging) will have primary responsibility to lead and direct the efforts of the Multiagency SpNS Discharge Planning Team(s) at each affected Special Needs Shelter in each county.

iii. If emergency circumstances prevent a CARES, Ombudsman or Area Agency on Aging Response Team member from serving as the County Discharge Planning Team Lead, the Department of Elder Affairs may designate a Response Team member representing another agency to serve as the County Discharge Planning Team Lead.
3. Ensure that calls or briefing sessions are scheduled to keep Agency Primary Contacts updated and to facilitate communication with deployed Response Teams.

4. Based on the anticipated magnitude of the event, deploy additional Multiagency Special Needs Shelter Discharge Planning Team(s) for a county or counties.

5. Serve as the single point of contact for receiving requests for resources and assistance in discharge planning from the State Emergency Operations Center ESF 8 or an impacted county and for providing status reports and information to the SEOC, ESF 8 and the impacted counties once Discharge Planning Teams have been deployed.

6. Responsible for ensuring that EM Constellation missions are updated with status of deployment and all activities related to the Multiagency Special Needs Shelter Discharge Planning Team(s).

7. Provide ESF 8 with SITREP (Situation Reports) information, as required.

   a. Maintain contact with County Discharge Planning Team Leads (DOEA CARES, Ombudsman and/or AAAs) who have been activated and/or deployed to the counties.

   b. Based on operational tempo, coordinate with the agency primary contacts regarding the feasibility of deactivating the Multiagency Special Needs Shelter Discharge Planning Team(s).

   c. Ensure that SEOC, ESF 8, and impacted counties are made aware of any implemented changes and update information in EM Constellation.

   d. Participate in action planning sessions and SEOC briefings, if scheduled.
D. **Stand Down:**

1. Coordinate with the ESF 8 regarding the deactivation plan for the Multiagency Special Needs Shelter Discharge Planning Team(s).

2. Ensure that EM Constellation missions are updated and completed.

3. Receive reports from each Discharge Planning Team Lead to determine outcomes and issues that still need to be resolved.

4. Develop after-action items for future discussion.
CONCEPT OF OPERATIONS:

A. Agency and Mission Assignment:

1. A request is received by ESF 8 in the SEOC to support local emergency management officials with the continued operations or closure of a special needs shelter(s) after determining that all local efforts and resources have been exhausted (due diligence). The Secretary of Elder Affairs is encouraged to proactively work with other state agencies prior to any natural disasters for which warnings are provided to ensure that Multiagency SpNS Discharge Planning Teams are ready to assemble and deploy rapidly upon a determination by state emergency management officials that a disaster area requires additional assistance or is deemed appropriate and necessary by the Secretary of the Florida Department of Elder Affairs.

2. ESF 8 receives the request from an impacted county EOC or County Health Department and ensures all essential information is provided to the Emergency Coordinating Officer of the Department of Elder Affairs. The resource request should include:

   a. Information on the number of clients needing discharge planning assistance;
   b. Location of the special needs shelter(s);
   c. Shelter phone number (dedicated line);
   d. Duration of operations or date of anticipated closure of the shelter;
   e. Shelter contact person with phone numbers;
   f. A brief description of the request and the mission; and
   g. County ESF 8 local point of contact information for the official requesting the mission in EM Constellation including a direct telephone number for the Discharge Planning Team Lead in each county to use in coordinating the response efforts.
3. When the information is complete, ESF 8 tasks the mission to the Emergency Coordinating Officer of the Department of Elder Affairs to activate the Multiagency Special Needs Shelter Discharge Planning Team(s), as appropriate.

4. The Emergency Coordinating Officer for the Department of Elder Affairs will contact the Agency Primary Contact to provide information and the EM Constellation mission number of the ESF 8 request for deployment of the Multiagency Special Needs Shelter Discharge Planning Team(s), along with details for the activation.

5. The Emergency Coordinating Officer of the Department of Elder Affairs will monitor the progress of all missions within their area(s) of responsibility and maintain regular communications with deployed Planning Team members.

6. The Emergency Coordinating Officer of the Department of Elder Affairs will update the status of missions in EM Constellation and will provide regular updates to county Emergency Operations Centers and SEOC officials, as required.

   a. The county may be able to monitor its resource request(s) on EM Constellation, unless it does not have or cannot get access to EM Constellation.

   b. The resource request in EM Constellation for discharge planning assistance at county special needs shelters must not be checked complete (√) until the Emergency Coordinating Officer of the Department of Elder Affairs has been notified by the Discharge Planning Team Lead within the county that all special needs shelter clients have been placed. In the event that additional resources are required or unmet needs are identified, the mission will not be checked as complete.
B. **Activation Protocols and Notification to Agencies:** Activation will occur in two phases:

1. **Phase One – Preparation to Activate:** Notification will be made to the Agency Primary Contacts to begin preparation for activation at the time that a Hurricane Warning is issued for a county.

2. **Phase Two – Activation:** Notification will be made to each Agency Primary Contact to activate the Multiagency Special Needs Shelter Discharge Planning Team(s) upon request from ESF 8 at the SEOC, or upon determination of need for assistance made by the Secretary of Elder Affairs.

C. **Role of Agency Primary Contact:** Each Agency Primary Contact is responsible to ensure a state of readiness is maintained by:

Ensuring the development and maintenance of a roster of personnel who will serve on Discharge Planning teams including names, contact numbers, locations, areas to which the individual could be assigned and expected deployment duration and provide the information to the Emergency Coordinating Officer of the Department of Elder Affairs as requested. Each member of the agency response team will be given the contact information for the Discharge Planning Team Lead for the Discharge Planning Team to which the individual is assigned and instructed to make contact to provide information regarding estimated time of arrival at the Special Needs Shelter and obtain any additional updates that may be available regarding deployment.

Ensuring that members of the Multiagency Special Needs Shelter Discharge Planning Team(s) are provided current copies of the Standard Operating Procedures for Response Teams, the Discharge Planning Tool for Rapid Needs Evaluation and the Discharge Planning Tool for Rapid Needs Evaluation Procedures

Encouraging agency Response Team members to complete CERT (Community Emergency Planning Team) training and to obtain County Emergency Operations Center identification badges to facilitate the members’ ability to purchase fuel on a prioritized basis, obtain supplies and travel within the declared impacted area after curfew.
D.  **Recommended Materials and Supplies for the Multiagency Special Needs Shelter Discharge Planning Team(s) Members** (see Appendix 1 for additional recommended supplies):

1. Telephone (cell, satellite, blackberry, if available);
2. GPS (if available);
3. Laptop with wireless internet access;
4. Writing pads, pens and pencils;
5. *Multiagency Special Needs Shelter Discharge Planning Team Standard Operating Procedures*;
7. County EM, ESF 8, and County Health Department contacts and phone lists;
8. State agency internal/external contact phone list; and
9. Planning Team rosters including home, office and work cell (if applicable) phone list.
E. **Reporting of Discharge Assistance:** The ECO of Elder Affairs will update the status of missions in EM Constellation and will provide regular updates to ESF 8, county EOCs and SERT (State Emergency Response Team) Liaisons, as required, based on information received from the lead designated area coordinators (CARES, Ombudsman or Area Agency on Aging).

1. The county may be able to monitor its resource request on EM Constellation, unless it does not have or cannot get access to EM Constellation.

2. The resource request must **not** be checked complete (✔) in Constellation until the Emergency Coordinating Officer of the Department of Elder Affairs has been notified that all clients have been placed. If additional resources are required or unmet needs are identified to place the remaining clients, the mission will not be checked as complete until all clients have been placed.
SPECIAL NEEDS SHELTER DISCHARGE PLANNING RESPONSE TEAM PROCEDURES:

A. Purpose: The Special Needs Shelter Discharge Planning Procedures establishes the framework for an effective system to ensure that clients sheltering in special needs shelters will be assisted in:

1. Identifying and relocating to post-event housing.

2. Ensuring continuity of care should the individual be unable to return to the pre-event residence due to damage to the structure, lack of societal underpinnings (fire protection, EMS, law enforcement, power, water and sewer), and/or lack of services for continuity of care.

3. The Special Needs Shelter Discharge Planning Procedures encourage the utilization and identification of all available community resources to achieve a comprehensive, client-based approach to the discharge and transition planning process for special needs shelter clients who require discharge planning assistance.

B. Initial Actions:

1. The Discharge Planning Team Lead for a county will make initial telephone contact with the local county ESF 8 designated official listed in the EM Constellation message to obtain any updated information and to provide an estimated time of arrival at the Special Needs shelter.

2. The Discharge Planning Team Lead for each county will be provided with a roster of deployed agency representatives to facilitate communication and to provide to team members upon their arrival at the shelter.

3. Upon arrival at the special needs shelter, Discharge Planning Team members will identify themselves to each other and present their identification badges (agency badges, SERT or CERT) to the special needs shelter unit leader (SpNS Unit Leader).

4. Inquiry should be made by the discharge planner to determine if a county guide is available to identify local resources that can assist clients with services such as housing, transportation, basic living activities, debris removal, nutrition and community and volunteer outreach.
The Discharge Planning Team Lead for a county will brief the SpNS unit leader on the responsibilities of the Response Team.

The Discharge Planning Team Lead for a county will request the SpNS unit leader to identify clients who require Response Team discharge planning assistance.

The Discharge Planning Team Lead for a county will request access to all pre-registration and intake/admission forms that have been completed for clients who have been identified as requiring discharge planning assistance.

Discharge Planning Team members will confer to review the client information provided by the SpNS unit leader.

Discharge Planning Team members will determine the assignment of each client to specific members of the Team for discharge planning.

Discharge Planning Team members will review the records of assigned clients and begin completing the Discharge Planning Tool for Rapid Needs Evaluation for each assigned client inserting requested information that is available from pre-existing client records such as special needs shelter registrations or intake forms. (Refer to the Discharge Planning Tool for Rapid Needs Evaluation Procedures.)

C. Discharge Planning:

1. Discharge Planning Team members will use the Discharge Planning Tool for Rapid Needs Evaluation to determine if the client has a viable relocation plan should the client be unable to return to their pre-event residence once the special needs shelter closes.

2. Discharge Planning Team members will identify themselves to assigned clients (ensuring that photo identification badges are displayed always) and explain to the client the role of the Response Team.

3. Discharge Planning Team members will determine if the client requires the assistance of the client’s caregiver (if available) to provide the necessary information for discharge planning.
4. Discharge Planning Team members will complete the *Discharge Planning Tool for Rapid Needs Evaluation* by conducting one-on-one interviews with the client and/or the client’s caregiver.

5. The Discharge Planning Team member will determine if the **client can return to their pre-event residence** (refer to Section I of the *Discharge Planning Tool for Rapid Needs Evaluation Procedures* for methods of determining the status of the pre-event residence). Criteria for returning to the pre-event residence include:
   
   a. The pre-event residence is habitable;
   
   b. Societal underpinnings (fire protection, EMS, law enforcement, power, water and sewer) are available at the pre-event residence; and
   
   c. Continuity of care and additional services, as appropriate, can be assured at the pre-event residence.

6. If the Discharge Planning Team member determines that the **client cannot return to the client’s pre-event residence** (refer to the *Discharge Planning Tool for Rapid Needs Evaluation Procedures* for methods of determining the status of the pre-event residence), the Discharge Planning Team member must determine if the client has a viable plan for alternative housing. Every effort should be made to take into consideration the client’s preferences for relocation options. A viable alternative plan must ensure:
   
   a. Continuity of care and access to transportation, medical services and medical care;
   
   b. Availability of food, water, power, sewer, fire protection and law enforcement; and
   
   c. A habitable residence.

7. If the Discharge Planning Team member determines that the client does not have a viable alternate plan for post-event housing, the Team will complete Section II of the *Discharge Planning Tool for Rapid Needs Evaluation* to identify viable post-event housing that will ensure continuity of client care (refer to the *Discharge Planning Tool for Rapid Needs Evaluation Procedures* for completion of Section II).
D. **Post-Event Housing:** To determine the viable options for a client’s post-event housing, the Response Team member should complete the Comprehensive Assessment form appropriate for the client receiving discharge services. (DOEA Form 701B Comprehensive Assessment, DCF Form CF-ES 2237 ACCESS Florida Application, or other agencies’ assessment forms, as appropriate.)

Discharge Planning Team member will identify viable housing resources available to discharge the client to the appropriate setting.

Resources to assist in discharge planning for housing can be found in the *Alternate Site Discharge Planning Resource Guide* and include the following:

1. **Red Cross Assistance** – The Red Cross may be able to provide emergency temporary housing assistance to individuals requiring housing assistance. A Red Cross Case Manager must be contacted and complete the necessary paperwork to obtain the emergency temporary housing assistance.

2. **Agency for Health Care Administration (AHCA)** generates and provides a census of local health care facility bed availability information through their Emergency Status System (ESS) Health Care Provider database: http://ahcaxnet.fdhc.state.fl.us/essweb

3. **Florida Housing Finance Corporation (Florida Housing)** helps Floridians obtain safe, decent housing that might otherwise be unavailable to them.

4. **The Federal Emergency Management Agency (FEMA)** provides financial assistance and, if necessary, direct services to eligible individuals and households who, as a direct result of a major disaster, have necessary expenses and serious needs and are unable to meet such expenses or needs through other means. Individuals can register with FEMA by calling 1-800-621-FEMA (3362) and/or calling the FEMA Housing Locator at 1-800-762-8740 (TTY 1-800-462-7585) to get assistance and find places to call home.

5. Local religious establishments and/or places of worship. (i.e. churches, synagogues, etc).
E. Transportation:

1. Prior to discharging the client, the Discharge Planning Team member will determine if the client has an acceptable mode of transportation that will accommodate the client and ensure the safe transport of any medical equipment or supplies.

2. If the client’s transportation is not appropriate or if the client does not have transportation, the Discharge Planning Team member will work with the SpNS unit leader to arrange transportation.

F. Discharge:

1. Prior to discharging the client, the Discharge Planning Team member must complete the Discharge Planning Tool for Rapid Needs Evaluation (see Discharge Planning Tool for Rapid Needs Evaluation Procedures), sign the form, include the discharge time and date, and give all completed forms to the Discharge Planning Team Lead designated for each county. Forms will be stored in a secured location in compliance with State Guidelines and Record Retention Schedules.

2. Discharge Planning team members should make special effort as appropriate to ensure that services necessary for the continuity of care for the special needs shelter client will be available to the client upon transition to the post-event residence. In some cases, it will be appropriate to recommend that additional follow-up actions are taken or arrangements made to contact the client after they are discharged (including home visits) to verify that services have resumed.

3. If it is determined that the client requires relocation to a health care facility (e.g., nursing home, assisted living facility, community residential home, or hospital, if medically necessary) and financial assistance is not available from any other source (e.g., Medicaid, Medicare, other 3rd party insurer, FEMA Independent Family Grant Program, etc.) to cover any FEMA eligible associated costs, the Response Team member must complete a Florida Department of Health’s Reimbursement Form. The Discharge Planning Team Lead for each county will submit the form to the Florida Department of Elder Affairs Emergency Coordinating Officer or his or her designee, who will then forward the request to the Florida Department of Health. Upon approval of the placement and associated costs by DOH, the client can be discharged to the approved receiving facility.
4. Medical Necessity: If a health care professional determines at any time that the shelter client’s medical condition has deteriorated and hospitalization may be necessary, Discharge Planning Team members should arrange for appropriate transportation to the hospital emergency department.
### SECTION I:  
**Part A: Client Information**

1. Client’s Name: __________________________  
2. Nickname: __________________________  
   
<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
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<tbody>
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</tbody>
</table>

3. SSN (last four digits only): _______  
4. Date of Birth: __________  
5. Shelter Arrival Date/Time: __________  
6. If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here?  
   - Yes  
   - No  
7. Do we have permission to tell them where you have relocated once you leave the shelter?  
   - Yes  
   - No  
8. Signature: __________________________  
   Date: __________  
   Time: __________  

**Part B: Insurance Information and ID Number**

<table>
<thead>
<tr>
<th>Medicare: __________________________</th>
<th>Medicaid: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Champus: __________________________</td>
<td>Private Insurance: __________________________</td>
</tr>
<tr>
<td>TriCare for Life: __________________</td>
<td>Other: __________________________</td>
</tr>
</tbody>
</table>

**Part C: Pre-event Living Situation**

1. Private Home  
   - Yes  
   - No  
2. Manufactured Housing  
   - Yes  
   - No  
3. Apartment/Condo  
   - Yes  
   - No  
4. HUD Housing  
   - Yes  
   - No  
5. Assisted Living Facility  
   - Yes  
   - No  
6. Independent Living Facility/Group Home  
   - Yes  
   - No  
7. Nursing Home  
   - Yes  
   - No  
8. Hotel  
   - Yes  
   - No  
9. Other: __________________________  
10. If you live alone, do you have someone to assist you?  
    - Yes  
    - No  
11. If no, with whom do you live? __________________________  

**Part D: Additional Information**

1. If you can’t return home when the shelter closes, do you have an alternative plan for housing?  
   - Yes  
   - No  
2. If yes, where will you go?  
   Contact information for relocation site:  
   Name: __________________________  
   Phone: __________________________  
   Street Address: __________________________  
   City: __________________________  
   State: __________________________  
3. Do you have transportation?  
   - Yes  
   - No  
   If yes, describe: __________________________  
4. Do you receive services from an outside agency?  
   - Yes  
   - No  
5. If yes, Agency Name(s): __________________________  
   Contact: __________________________  
   Phone: __________________________  
6. Do you have a pet?  
   - Yes  
   - No  
   If yes, type of pet: __________________________  
   If you have a pet and it’s not with you, where is it? __________________________  
7. Do you have a service animal with you?  
   - Yes  
   - No  
   If yes, type of animal: __________________________  
   Service: __________________________  

**Part E: Post-event Status of Housing Conditions**

1. Do you have any information concerning the status of your residence?  
   - Yes  
   - No  
   Date/Time: __________  
2. Can you return to your residence?  
   - Yes  
   - No  
   - Unknown  
   If no, give reason:  
   - No Power  
   - Damage to Residence  
   - No Services  
   - No Caregiver  
   - Residence Flooded  
   - No Water  
   - Debris Blocking Residence  
   - Other: __________________________  

**Part F: Signature**

The information above is true and correct to the best of my knowledge.  
1. Client/Caregiver Signature: __________________________  
   Client  
   Caregiver  
   Printed Name: __________________________  
   Date/Time: __________  
2. Discharge Planner’s Signature: __________________________  
   Printed Name: __________________________  
   Date/Time: __________  
   Contact Number: __________________________  
   Agency: __________________________  

If the client has no post-shelter plan or if the plan is not viable, refer the client to the shelter discharge planner.
**SECTION II**

**Part A: Client Information**
1. Client’s Name: ____________________  
2. SSN (last four digits only): ____________  
3. Veteran □ Yes □ No  
4. Date of Birth: ______________________

**Part B: Identify Housing Resources for Client**
1. □ Family  □ Friends  □ Caregiver  
2. □ Independent Living Facility □ Assisted Living Facility □ Nursing Home □ Other ____________________  
3. □ Hotel  
4. Does the client need Red Cross assistance? □ Yes □ No  
5. Are you willing to relocate temporarily to another county or state? □ Yes □ No  

**Part C: Services/Supplies**
1. Is client in need of services? □ Yes □ No  
(Record services information below)

<table>
<thead>
<tr>
<th>Services</th>
<th>Yes</th>
<th>No</th>
<th>Provider</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food/Meals</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Water</td>
<td></td>
<td></td>
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<tr>
<td>Clothing</td>
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<tr>
<td>Personal Care</td>
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<tr>
<td>Toileting</td>
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<tr>
<td>Transfer</td>
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<tr>
<td>Walking/Mobility</td>
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<tr>
<td>Transportation</td>
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<tr>
<td>ESS/Food Stamps</td>
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</tr>
<tr>
<td>Medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

2. Medical Equipment Inventory (list supplier if applicable):

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Inventory</th>
<th>Need</th>
<th>Serial Number/Shelter Number</th>
<th>Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wheelchair</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nebulizer/Oxygen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walker/Cane</td>
<td></td>
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</tbody>
</table>

**Part D: Relocation**
1. Relocation contact information: Contact Name: ____________________  
   Phone: ________________  
   Facility Name: ____________________  
   (if applicable): ______  
   Address: City: ______  
   State: ______  
2. Mode of Transportation to Relocation: ____________________  
   Transported by whom: ____________________  
3. List any additional comments you think are relevant and/or are stated concerns of the client: ____________________

4. Client/Caregiver Signature: ____________________  
   □ Client  □ Caregiver  
   Printed Name: ____________________  
   Date: ____________  
   ▼ Submit Reimbursement form to the Department of Health Authorized Personnel For Signature (if needed).  
5. Discharge Planner Signature: ____________________  
   Printed Name: ____________________  
   Date/Time: ____________________  
   Agency: ____________________

6. Discharge Date: ____________  
7. Action Taken/Recommendation: ____________________

8. Follow Up Needed: ____________________
INSTRUCTIONS FOR COMPLETING THE DISCHARGE PLANNING TOOL FOR RAPID NEEDS EVALUATION:

Department of Elder Affairs Form 590:

PROCEDURES:

General Information: Please legibly **print** all information on the form, using **black** ink.

**INTRODUCTION:**

Natural and man-made emergencies and disasters impact homes, businesses and public infrastructure, often quickly overwhelming the response capabilities of local agencies. During such events, individuals who require assistance with activities of daily living may choose to evacuate to Special Needs Shelters as a last resort. A special needs shelter is a temporary emergency facility capable of providing care to residents whose medical condition is such that it exceeds the capabilities of the Red Cross General Population Shelter, but is not severe enough to require hospitalization.

The Secretary of the Florida Department of Elder Affairs (DOEA) is required to convene Multiagency Special Needs Shelter Discharge Planning Teams, at any time that he or she deems appropriate and necessary, or as requested by county emergency management officials, to assist local areas that are severely impacted by a natural or manmade disaster (once all local resources have been depleted) that requires the use of special needs shelters. The teams are activated to provide resource and logistical support to local jurisdictions to assist with discharge planning and transition of clients to appropriate services and resources within their community.

The **Discharge Planning Tool for Rapid Needs Evaluation** is to be used to assist discharge planners in determining if a special needs client has a viable discharge plan to transition successfully back to their pre-event residence, or if the special needs client needs assistance in obtaining services to develop an alternate relocation plan.

This form is intended for use at Special Needs Shelters, Disaster Recovery Centers, or also in conjunction with Community Outreach efforts to determine the status of elderly and vulnerable populations impacted by a disaster and to assist in determining their ability to successfully transition back into their community.
SECTION 1:

The purpose this section is to verify the ability of the special needs shelter client to return to their pre-event residence, or to determine if the special needs shelter client has a viable relocation plan should the client be unable to return to his/her pre-event residence once the special needs shelter closes. Section 1 is to be completed by a discharge planner at the Special Needs Shelter, or a designated member of the Multiagency Special Needs Shelter Discharge Planning Team, if activated. The information is to be obtained during a one-on-one interview of the client and/or the client’s caregiver.

Part A: Client Information:

1. Record the client’s full name (last name, first name, middle initial).
2. Record the name by which the client is commonly called (nickname).
3. Record the last four digits of the client’s social security number.

NOTE: This number is a unique client identifier by which additional client records, such as listings of provider agency clients and services, can be accessed. The last four digits of the social security number is the preferred unique client identifier and will only be used by authorized personnel to obtain and/or ensure delivery of services on behalf of the client. If the client refuses to provide this information, ensure that the date of birth is recorded.

4. Record the client’s date of birth.

NOTE: This information is a unique identifier of the client and is optional if the four digits of the social security number are recorded. This information will only be used by authorized personnel to obtain and/or ensure delivery of services on behalf of the client. If the last four digits of the social security number are not recorded, ensure that the date of birth is recorded.

5. Record the date and time that client arrived at the special needs shelter.

6. Ask the client, “If someone calls to inquire if you are in this shelter, do we have permission to tell them you are here?” Mark the client’s answer.
NOTE: If the client does not give permission to tell family, friends, or others that they are at the shelter, this information *may not be released*. Ensure that shelter staff members are informed of the client’s permission or refusal to release this information.

7. Ask the client, “Do we have permission to tell them where you have relocated once you leave the shelter?” Mark the client’s answer.

NOTE: If the client does not give permission to tell family, friends, or others where they have relocated, this information *may not be released*. Ensure that shelter staff members are informed of the client’s permission or refusal to release this information.

8. Request that the client sign line 8 to indicate that the responses to items 6 and 7 are correct as marked. If the client is unable to sign, the caregiver may sign for the client. Record both the date and time line 8 is signed.

**Part B: Insurance Information and ID Number:**

Ask the client to provide the names and policy/identification numbers of all health/medical insurance policies in force or coverage available for the client and mark the appropriate responses. If “Other” is marked, record the name and policy number of the insurance company. Examples of other insurance might include long-term care insurance or disability insurance. If the client has no insurance coverage or policies in force, mark “Other” and record “no insurance” on the line next to the marked box “Other.”

**Part C: Pre-Event Living Situation:**

1. Ask the client about the type of housing (home, apartment, assisted living facility, adult family care home, etc.) the client had prior to entering the special needs shelter (pre-event) and mark the appropriate response. If “Other” is marked, specify the type of housing.

2. Ask if the client owns or rents their housing and mark the response.

**NOTE:** If the client does not own or rent his/her housing, but lives in someone else’s home, leave this item unmarked.

3. Ask if the client lived alone prior to entering the special needs shelter and mark the response. If the client did not live alone, record with whom the client resides (spouse, family, friend, other).
4. Ask if the client has access to a generator and mark the response. If yes, ask if the client has access to fuel and knowledge of how to safely operate and refuel the generator and mark the responses.

**NOTE:** Access to a functioning generator could enable the client to return to their pre-event residence if the residence is lacking power, but is otherwise habitable. The Discharge Planner should ensure that the client is made aware that safety precautions must be taken when operating emergency generators. (See Appendix 2, American Red Cross, “Using a Generator When Disaster Strikes” in English and Spanish.)

**Part D: Additional Information:**

1. Ask if the client has an alternate plan for housing if the client is unable to return to their pre-event residence and mark the response.

2. If the client has an alternate plan for housing, record a general description of where the client will go (ex: daughter’s home, sister’s apartment, hotel) and the contact information for the relocation site. Record the contact name and phone number for the individual at the alternate relocation site. Record the street address, city, and state.

3. Ask if the client has arranged for transportation from the special needs shelter once the client leaves the shelter and mark the response. If the client has a transportation plan, describe/explain the plan.

**NOTE:** This information must be verified by the discharge planner prior to releasing the special needs client from the shelter to ensure that the transportation is appropriate to meet the needs of the client including the safe transport of their medical equipment.

4. Ask if the client receives services or assistance from an outside agency and mark the response. If the client receives services or assistance, record the name of the agency(s) and the agency’s contact information.

5. Ask if the client has a pet and mark the response. If the client has a pet, mark if the pet is with the client and record the type of pet. If the pet is not with the client, record the location of the pet.
NOTE: In some cases, pets may not be allowed to accompany the client to an alternate relocation site. To minimize the emotional impact on the special needs client of becoming separated from their pet(s), the status of the pet’s care should be confirmed when making discharge plans for the client. Plans, which may involve contact with family members, friends, or local animal control or county animal shelter officials if necessary, should be made to ensure the safety of the pet(s).

6. Ask if the client has a service animal and mark the response. If the client has a service animal, record the type of service animal (dog, bird, horse, monkey, etc.) and the service the animal provides for the client.

NOTE: Service animals **must** be allowed to accompany the client to an alternate relocation site. Transportation arrangements must account for the needs of the client and the service animal.

**Part E: Post-Event Status of Housing Conditions:**

1. Ask if the client has information about the post-event condition of their residence and mark the response, recording the date and time.

2. Ask if the client can return to their pre-event residence and mark the response. If the client cannot return to the pre-event residence, record the reason and/or mark all the issues that are listed and apply. If “Other” is marked, record the issue.

NOTE: Additional contact information may be needed to contact neighbors of the special needs client to assist in determining the status of the pre-event residence and neighborhood. Other means of determining the habitability of the pre-event residence include: checking with the local emergency operations center to determine the status of the neighborhood, requesting that local responders (fire, police, public works, or volunteers if available) check the residence, or calling the home to learn if the client’s answering machine works to determine if there is power to the home. Discharge Planners should check with shelter operations staff to determine if additional resources are available. Services may be needed to remove debris, restore power, or install tarps on roofs before the client can safely return to the pre-event residence.
Part F: Signature:

1. Request that the client sign the Discharge Planning Tool Rapid Needs Evaluation form attesting to the statement, “The information above is true and correct to the best of my knowledge.” If the client is unable to sign, the caregiver may sign for the client. Mark who signed—client or caregiver. Print the name of the person signing the form. Record the date and time.

2. The Discharge Planner completing the Discharge Planning Tool for Rapid Needs Evaluation form must sign the document, print their name, record the date and time, record their contact number (office or cell), and record the name of their employing agency.

NOTE: If the special needs shelter client is unable to return to their pre-event residence, and does not have a viable alternate relocation plan for post-shelter housing, Section 2 of this form must be completed.

If the special needs shelter client is approved to return to the pre-event residence or has a viable alternate plan for housing, the Discharge Planner should give the client’s signed Discharge Planning Tool for Rapid Needs Evaluation to the County Response Team Lead (Department of Elder Affairs CARES, Ombudsman or Area Agency on Aging, or another agency’s representative who has been designated the Lead for the Response Team). The County Response Team Lead will retain completed Discharge Planning Tool for Rapid Needs Evaluation Forms.

SECTION 2:

The purpose this section is to assist in the development of an alternate plan for housing that will include the provision of essential services and ensure continuity of care for special needs shelter clients who are unable to return to their pre-event residence or do not have a viable existing alternate plan for housing once the special needs shelter closes. Section 2 is to be completed by a designated member of the Multiagency Special Needs Shelter Discharge Planning Response Team. The information is to be obtained during a one-on-one interview of the client and/or the client’s caregiver.

NOTE: If the special needs shelter client has a viable plan for post-shelter housing, the residence is habitable and continuity of care is ensured, do not complete Section 2.
Part A: Client Information:

1. Record the client’s full name (last name, first name, middle initial).

NOTE: This information is requested to ensure that Section 1 and Section 2 are correctly matched should the *Discharge Planning Tool for Rapid Needs Evaluation* form be copied on two pages rather than on one page, front and back, or if partial information is copied to assist in obtaining services.

2. Record the last four digits of the client’s social security number.

NOTE: This information is requested to ensure that Section 1 and Section 2 are correctly matched should the *Discharge Planning Tool for Rapid Needs Evaluation* form be copied on two pages rather than on one page, front and back, or if partial information is copied to assist in obtaining services. The last four digits of the social security number are a unique client identifier by which, additional client records, such as listings of provider agency clients and services, can be accessed. The last four digits of the social security number is the preferred unique client identifier and will only be used by authorized personnel to obtain and/or ensure delivery of services on behalf of the client. If the client refuses to provide this information, ensure that the date of birth is recorded.

3. Ask if the client is a veteran and mark the response.

NOTE: If the client is a veteran, the options for post-event relocation could include placement in a Veterans’ Affairs hospital or nursing home. If appropriate, these options should be pursued prior to utilizing available beds in non-veteran hospitals or nursing homes if possible.

4. Record the client’s date of birth.

NOTE: This information is requested to ensure that Section 1 and Section 2 are correctly matched should the *Discharge Planning Tool for Rapid Needs Evaluation* form be copied on two pages rather than on one page, front and back, or if partial information is copied to assist in obtaining services. The date of birth is a unique identifier of the client and is optional if the social security number is recorded. This information will only be used by authorized personnel to obtain and/or ensure delivery of services on behalf of the client. If the social security number is not recorded, ensure that the date of birth is recorded.
Part B: Identify Housing Resources for Client:

This section requires the ability of the Discharge Planner to determine the needs of the special needs client, client’s preferences for relocation options, availability of finances and/or insurance, and the duration of care and services needed, if the client cannot return to their pre-event residence. Additional forms (ex: Form CF-ES 2237 ACCESS Florida Application, CARES 701B Comprehensive Assessment or other agencies’ assessment forms) may be required to assist a client with qualifying or determining eligibility for services and assistance (ex: food stamps) and recommending an appropriate level of care needed (ex: independent living facilities, assisted living facilities, nursing homes, hospitals, etc.). Inquiry should be made by the discharge planner to determine if a county guide is available to identify local resources that can assist clients with services such as housing, transportation, basic living activities, debris removal, nutrition and community and volunteer outreach.

1. Inquire if the client has family, friends or a caregiver with whom the client can reside once the special needs shelter is closed and mark the response.

NOTE: If the client does not have family, friends or a caregiver to rely upon as a resource to develop an alternate plan for housing, then some or all of the following choices in questions #2, #3, #4, and #5 may be options for the client to consider:

2. If the response to #1 is “no,” ask if the client would consider residing in an independent living facility, assisted living facility, nursing home and/or some other facility (as appropriate for the client based on the client’s needs) and mark the response.

NOTE: This option will be conditional upon the ability of the client to pay for housing, or may be contingent upon funding available from local resources or the Department of Health. If the client does not have resources to fund their relocation to a facility, a separate Reimbursement Form must be completed, submitted to, and agreed to by local resources or the Florida Department of Health before placing a special needs shelter client in a facility. NOTE: If a health care professional determines at any time that the shelter client’s medical condition has deteriorated and hospitalization may become necessary, Response Team members should arrange appropriate transportation or contact EMS for transport to the hospital emergency department. If a special needs shelter client is hospitalized, this should be noted under “Other.”

3. If the response to #2 is “no,” ask the client if they are willing to relocate to a hotel at their own expense or if local resources are available to fund their stay (if this is appropriate for the client).
NOTE: This option will be conditional upon the ability of the client to pay for temporary housing at a hotel, or may be contingent upon funding available from local sources or the American Red Cross. Costs should be considered for food and other basic necessities. The client should be evaluated for their ability to obtain basic necessities on their own in order to determine the appropriateness of this temporary placement.

4. Determine if the client requires American Red Cross assistance to pay for hotel costs or for other relocation expenses and mark the appropriate response.

NOTE: If the client appears to need financial or other assistance from the American Red Cross, an American Red Cross case manager must be contacted to conduct the appropriate client assessment and processing.

5. In the event that local resources are not available or inappropriate for the needs of the special needs client, ask if the client would be willing to relocate outside the county or state and mark the response.

NOTE: If the client is willing to relocate outside the county or state, additional options for post-shelter relocation may be available. If this option is the only viable plan, the discharge planner should immediately contact the ESF#8 administrator at their county emergency operations center to determine availability of resources outside the county of residence.

Part C: Services/Supplies:

1. Determine if the client will require services upon discharge from the special needs shelter. These services may include pre-existing services that must be continued to ensure the continuity of care the client was receiving pre-event, or may be new services which have been identified to ensure the successful transition of the special needs client post-event. **Mark “yes” or “no” for each service listed.** If a specific provider is required for a service, or was providing a service pre-event to the special needs shelter client, record the name of the provider and phone number (if known). Record the length of time and frequency that each service will be required. This information is critical to ensuring the client’s continuity of care and reviewing the needs of the special need shelter client to determine if any additional services will be required.
2. Determine if the client will require medical equipment upon discharge from the special needs shelter or brought medical equipment with them to the special needs shelter. If the client brought medical equipment with them, check “inventory” for the appropriate item or write in the item on the blank lines that are provided. If the client requires additional equipment, check “need” for the appropriate item or write in the item on the blank lines that are provided. Record the serial number of the equipment that arrived with the special need shelter client at the time of admission, or list the shelter number of the equipment provided to the client upon admission to the special needs shelter (if appropriate). Record the name and phone number of the medical equipment provider (if known).

**NOTE:** If the client refuses services or medical equipment, please make notation in Section II, Part D, #7 under Action Taken/Recommendation that the client has refused services and/or medical equipment.

**Part D: Relocation:**

1. Record the contact information for the relocation site to which the client will be discharged. Include the name and phone number of the contact person for the relocation site or residence. If the relocation site is a facility, include the name of the facility. Record the address, city and state.

2. Record the mode of transportation to the relocation site and the name of the transportation provider.

**Note:** This information must be verified by the discharge planner prior to releasing the special needs client from the shelter to ensure that the transportation is appropriate to meet the needs of the client including the safe transport of their medical equipment.

3. Record additional relevant comments or client stated concerns that should be taken into consideration in discharging the special needs client to an appropriate facility or residence.

4. Ask the client or caregiver to sign the form to indicate that the information contained in Section II is correct and accurate to the best of their knowledge, and that they agree with the alternate plan for housing. Mark who (client or caregiver) signs the form. Print the signature name and record the date signed.
5. The discharge planner must sign the form, print their name, record the date and time the form was signed, and record the name of their employing agency. If a Reimbursement Form is required to be submitted to the Florida Department of Health, mark the box next to the reimbursement form statement and verify that the Florida Department of Health has agreed to the terms of the reimbursement agreement. (Separate instructions are available for completing the Florida Department of Health reimbursement form.) Copies of the Reimbursement Form should be given to the Discharge Planning Team Lead (Department of Elder Affairs CARES, Ombudsman or Area Agency on Aging, or another agency’s representative who has been designated the Lead for the Planning Team), the Florida Department of Health, the receiving facility, and the special needs client.

6. Inquiry should be made if the special needs shelter requires a copy for the client’s file.

7. Record the date and time the client was discharged from the special needs shelter.

8. Record the summary of the action taken on behalf of the client and/or additional recommendations of the discharge planner (ex: notes regarding care, pets, location of relatives, or other helpful information). If client has refused services or medical equipment, please make the appropriate notation of such refusal.

9. Record specific information about required follow-up actions needed to ensure that the client relocation is successful and that continuity of care and services is provided.

The Discharge Planner should give the client’s signed Discharge Planning Tool for Rapid Needs Evaluation to the Discharge Planning Team Lead (Department of Elder Affairs CARES, Ombudsman or Area Agency on Aging, or another agency’s representative who has been designated the Lead for the Planning Team). The County Response Team Lead will retain completed Discharge Planning Tool for Rapid Needs Evaluation Forms.
ELDER HELPLINE: STANDARDS FOR PROFESSIONAL INFORMATION AND REFERRAL:

A. The Elder Helpline shall have a written disaster plan that specifically addresses incidents common to the area, and prepares for emergencies in general. The plan shall have two components:

Relationships with Emergency and Relief Operations: The Elder Helpline shall have a component that includes participating in ongoing cooperative disaster response planning in the community and establish relationships, as necessary to become recognized as an integral part of the community’s emergency preparedness and response network. The Elder Helpline shall also ensure active participation in community meetings that address plans for disaster preparedness, mitigation, response, relief, and recovery.

Continuity of Operations Plan (COOP): The Elder Helpline shall have a component that references emergency preparedness and mitigation activities such as structural alterations and changes in business operations; and delineates the steps to be taken before, during, and after an emergency to prevent or minimize interruptions in business operations and ensure long-term recovery.

1. The Helpline shall have written policies and procedures to ensure that the organization’s mission-essential functions are continued if the area in which the program is located is threatened and incapacitated and relocation of these functions is required.

2. The Helpline shall have written procedures that address specific types of emergencies including power outages, fires, medical emergencies, bomb threats, radiological threats, workplace violence, and other incidents that may require different forms of response, e.g., duck, cover, and hold during an earthquake or sheltering in place during a radiological emergency. Procedures for contacting emergency personnel will be included.

3. The Helpline shall have written procedures for emergency evacuation of the facility following a disaster that impacts the immediate area surrounding the facility and potentially threatens staff safety. Procedures shall include special arrangements for helping staff or visitors with a disability leave the building.

4. The Helpline shall have written procedures for maintaining service delivery (i.e., answering inquiries and continuing to update community resources) during and after an emergency including relocation or alternative modes of service delivery. If the I&R service plans to relocate in the event of loss of facilities, alternative sites will be identified.

5. The Helpline shall maintain critical contact and infrastructure information (e.g., telephone service provider and building management).
B. **Disaster Resources:** The Elder Helpline shall maintain and/or use an accurate, up-to-date resource database that contains information about available community resources that provide services to elders and their caregivers in times of disaster. Database records shall include descriptions of the services organizations provide and the conditions under which services are available.

1. The Elder Helpline shall include in the resource database information about permanent local, state and federal disaster-related resources.

2. The Elder Helpline shall add information about organizations that have no formal role in emergency response but emerge in the context of particular disaster, specific relief and recovery services that come to life in response to the specific needs of the community and information about specific services offered by agencies in the standing disaster database (such as Red Cross Service Centers, special needs shelters, etc.).

3. The Elder Helpline shall update the disaster resources at least annually, prior to an anticipated disaster, throughout the response, relief, and recovery periods.

4. The Elder Helpline shall have an alternative means for allowing staff to access disaster resources if computerized access is unavailable.

5. The Elder Helpline shall verify all information before sharing it with others during a disaster. A streamlined verification process must provide a sufficient level of data validation to ensure accuracy.
C. **Disaster-Related Information and Referral Service Delivery:** The Elder Helpline shall provide information and referral services to elders and their caregivers in the community during, (when possible) and following a disaster or other emergency. This service shall include assessing the needs of the inquirer, evaluating appropriate resources, indicating organizations capable of meeting those needs, helping inquirers for whom services are unavailable by locating alternative resources and actively participating in linking inquirers to needed services or volunteer opportunities.

1. The Elder Helpline shall ensure adequate staff to meet potential increases in inquirer needs.

2. The Elder Helpline shall have documented mutual assistance agreements in place with other I&R providers for services to elders and their caregivers that include provisions for relocation of staff and/or redirection of calls.

3. The Helpline shall have a written protocol for staff who are assigned to provide information and referral at local assistance centers (LACs) or other off-site locations.

4. I&R specialist shall have the skills to respond effectively to people in crisis, work cooperatively with other organizations, remain flexible in a rapidly changing environment, be willing to work under adverse conditions (e.g., long hours, uncomfortable surroundings), be aware of their own stress level and coping mechanisms, respond appropriately in face-to-face communications and work within boundaries of their I&R role.

5. The Helpline shall ensure I&R specialists understand the government emergency response service delivery system, the types of services people typically need before, during, and following a disaster, the organizations that generally provide them, the types of organizations that may be closed or otherwise unable to deliver services due to the emergency (e.g., government offices, the courts), atypical services people may need to access (e.g., open hardware stores, functioning ATM machines), and the structure and contents of the disaster database and/or other approved sources of disaster-related information.

D. **Disaster-Related Inquirer Data Collection/Reports:** The Elder Helpline shall track inquirer requests for service, referrals and when appropriate, demographic information about the inquirer. The Elder Helpline shall be prepared to produce reports regarding requests for disaster-related services and referral activity.

Following all emergencies that necessitate implementation of the provisions of the Disaster Preparedness standards, the I&R service shall produce an after-
action report that documents the special activities of the agency with a focus on what worked well and what needs to be improved through revisions of the agency’s disaster plan or additional training.

E. Disaster-Related Technology Requirements: The Elder Helpline shall have technology in place that facilitates the ability of the organization to maintain service delivery during times of disaster or a localized emergency. Recommendations for continued operations include an emergency generator, back-up systems for telephones, or an alternate phone number in a different location for staff to access the agency, in case of an emergency that makes the regular phone lines inaccessible.

1. The Helpline shall ensure regular and emergency methods of electronic communication (via email, instant messaging, text/SMS messaging, satellite phones, or mobile devices), between staff and management for use internally, for after-hours contacts, and when necessary for pre-and post-disaster events.

2. The Elder Helpline shall establish a relationship with its telephone service provider, Internet Service Provider (ISP), website hosting vendor, and I&R software vendor to ensure that the organization is given high priority for continued service in times of disaster.

F. Disaster Training and Exercise: The Elder Helpline shall train staff on emergency operations and business expectations. It is recommended that the agency provide ongoing training thereafter. The Elder Helpline shall provide general training for staff that addresses the specific types of disasters common to the area; the Helpline’s role and mission in times of disaster; the phases of disaster; federal, state/provincial and local response plans and resources; and other topics that will help prepare staff for an emergency and ensure that they understand their Helpline’s commitments.
Information and Referral Lines and Reciprocal Agreements:

The AAA should ensure that the Information and Referral Service (Elder Helpline) provides services to the community during (when appropriate) and following a disaster or other emergency. The service shall include assessing the needs of the inquirer, evaluating appropriate resources, indicating organizations capable of meeting those needs, helping inquirers for whom services are unavailable by locating alternative resources, and actively participating in linking inquirers to needed services or volunteer opportunities.

The AAA shall have in place mutual assistance agreements with other I&R services that include provisions for relocation of staff and/or redirection of calls in the event of a COOP activation. If catastrophic conditions warrant, DOEA has established a toll-free helpline to assist with emergency overflow calls. The designated phone number is 1-877-363-2825 (requires activation and staffing).
RESPONSE ACTIVITY TOOLS:

A. Hardcopy of client files.

B. The list of phone numbers (AAA staff personal contact numbers, lead agencies and service providers, emergency management and response, DOE).

C. A copy of this handbook on flash drive.

D. A hard copy of the DOE Program and Services Handbook.

E. Hardcopies of the Comprehensive Emergency Management Plan, Continuity of Operations Plan and the Pandemic Annex (Note: DOEAs COOP and CEMP plans are provided only to designated members of senior management, as they have been deemed confidential by Florida Statute.)

F. Name badges and credentials for identification.

G. Intake forms and rapid needs assessment forms.

H. First Aid Kit.

I. Insect repellent.

J. Flashlight.

K. Radio with working batteries.

L. Cellular phone, satellite phone, blackberry, two-way radio.

M. List of 4-wheel drive vehicles and boat owners.

N. List of Ham Radio Operators.

O. Office supplies.

P. Rubber and/or latex gloves

Q. Laminated map of exits throughout your building.

R. Laminated map of streets in local town and city.

S. Cash

T. Comfortable walking shoes
DISASTER/EMERGENCY CHECKLIST:

Unless otherwise specified in parentheses, e.g., (DOEA) or (AAA), the duties outlined in this Disaster/Emergency Checklist apply to both the Department of Elder Affairs (DOEA) and the Area Agencies on Aging (AAAs).

A. STAFF ALERT:

1. Institute Planned Call Tree:
   a. Telephone communication may not be possible; contingency plans for this should be in place. For instance, will you all meet at the office? Where will you meet if the office is destroyed? Remember, if the office is destroyed, the office across the street may also be in trouble. PLAN for alternate measures!
   b. Depending on the scope of the disaster, your staff may be victims. The first questions to your staff should be: “How are you and members of your family?” “Are you safe and secure?” “What can we do to assist you so you can return to work to assist elders?”

2. Assign Duties:
   a. Assign staff duties from the prepared list.
   b. Include plans for staff at the State Emergency Control Center (DOEA)
   c. Provide for the prompt assignment of personnel to the area affected by the disaster/emergency. They need to be on-site as quickly as possible, offering support and accurate information and providing a clear view of the situation to DOEA and the AAAs.
   d. Review assignments given during the preparation phase.

3. When Advance Warning is Possible:
   a. The duties cited in A.1. and 2. above may begin in anticipation of the disaster/ emergency.
   b. Staff transportation will be an important requirement. Be sure all gas tanks are full.
c. Staff communications will be important. Ensure that all cell phones, satellite phones, and/or blackberries are charged.

d. Staff must have proper identification to ensure they are recognized as authorized emergency support staff. Have AAA and (if available) emergency support staff credentials and identification. These should be coordinated with local emergency management officials.

4. **Contact AAAs (DOEA):**
   
a. Confirm all have disaster/emergency contingency plans.
   
b. Emphasize the critical need for recordkeeping, particularly records from service providers.

5. **Contact other State Agencies (DOEA):**
   
a. Provide such technical assistance as may be necessary to ensure that the unique needs of older persons are adequately met.
   
b. Be prepared to provide any relevant or useful information available to the Department of Elder Affairs or to the AAAs.

B. **ORGANIZATION:**

1. **Commence Recordkeeping:** This is critical. You will need these records to receive reimbursement from the appropriate federal sources later. This must be impressed upon AAAs. Record keeping shall include:
   
a. Mission number in EM constellation (if available)
   
b. Staff time (including overtime).
   
c. Any supplies.
   
d. Number of senior contacts.
   
e. Type and unit of service provided.
   
f. Resource inventory used.
g. Intake forms for all seniors

h. Any contracted services.

i. Personal expenses.

j. Phone log—be specific.

2. Commence to assemble applications for funds: These applications must be based on plans developed by AAAs.

C. ASSESSMENT:

1. Collect sufficient information to determine the type, scope and location of disaster/emergency assistance activities requested, required or provided by AAAs and others. The AAAs should complete their first effort within 24 hours of the beginning of the disaster/emergency. This information will help determine the allocation of resources.

2. Collect information on:

   a. Numbers of affected elders, including clients and those not typically receiving services, but who, under normal circumstances, are able to live independently;

   b. Acquire and disseminate information from state-level resources regarding available beds, e.g., Agency for Health Care Administration;

   c. The kinds of services needed. Check indirect as well as direct needs, e.g., have water and electricity been interrupted? DOE can coordinate information concerning widespread effects;

   d. The scarcity and disruption of transportation; and

   e. The need for medical assistance.
3. **Assess geographic scope of the disaster/emergency:**

   a. Assess the amount of damage inflicted on seniors, including the type of elders (frail, low-income) that are victims and their short and long-term needs.

   b. Assume this initial assessment will be incomplete and imprecise.

   c. Look for service gaps and advocate where additional services and resources are needed.

   d. Report to DOE and county emergency operations as soon as possible and as frequently as appropriate. Provide an emailed report.
INDICATORS OF EXPLOITATION:

A. **Definition of Exploitation**: Exploitation of the disabled and the elderly due to a disaster is defined as any activity that takes advantage of a disaster circumstance in order to improperly, and/or illegally utilize funds, assets or property of that person via fraud, forgery, coercion or deception, etc.

B. **Indicators of Exploitation**: The following signs and symptoms of financial or material exploitation can indicate exploitation. It is important to be particularly wary of these signs following a disaster.

1. Sudden changes in bank account or banking practices, including an unexplained withdrawal of large sums of money by a person accompanying the elder;

2. The inclusion of additional names on an elder’s bank signature card;

3. Unauthorized withdrawal of the elder’s funds using the elder’s ATM card;

4. Abrupt changes in a will or other financial documents;

5. Unexplained disappearance of funds or valuable possessions;

6. Substandard care being provided or bills unpaid despite the availability of adequate financial resources;

7. Discovery of an elder’s signature being forged for financial transactions or for the titles of his/her possessions;

8. Sudden appearance of previously uninvolved relatives claiming their rights to an elder’s affairs and possessions;

9. Unexplained sudden transfer of assets to a family member or someone outside the family;

10. The provision of services that are not necessary; or

11. An elder’s report of financial exploitation.
C. To Report Exploitation within a FEMA Program:

1. Call the Fraud Hotline at (800) 323-8603. The hotline is operated 24 hours a day, seven days a week.

2. Written alerts or complaints can be mailed to:

   Office of Inspector General  
   Federal Emergency Management Agency  
   500 C Street, SW  
   Washington DC 20472

3. If civil rights have been violated while receiving disaster assistance, contact FEMA’s Equal Rights Office. Officers ensure equal access to all FEMA disaster programs. The FEMA Equal Rights Office can be contacted at (202) 646-3535 (TTY: (202) 646-7651).

D. How to Protect Yourself: Fraud & Price-Gouging After a Hurricane:

1. **Reporting:** Within the State of Florida during a declared emergency, call the Florida Attorney General’s Hotline at 1-866-966-7226.

2. **Price-Gouging:** The State of Florida enacted a law that prohibits "price-gouging" after a declared state of emergency. The law bans unconscionable prices in the rental or sale of essential commodities, which would include lumber, ice, water, chemicals, generators and other necessary goods and services following a disaster.

3. **Checking on Contractors:** Even in such a situation as a disaster, it is still important to obtain more than one estimate for repairs and to check on the qualifications and credentials of any one working on your home. You can contact local consumer agencies, as well as your county occupational license bureau and the state professional regulation division, to determine if the contractor is licensed, has any complaints or violations on record, and is insured. You will also want to ask for references of satisfied customers, and contact those people and examine the work done.

4. **Check the Contract Payment Terms:** Contracts can be negotiated so they do not totally favor the contractor. You never want to pay the contractor too much in advance and especially not for work yet to be performed. Payments should be broken down such as one-third up front, one-third when a certain significant stage of work is done, and the final payment when all work is completed. You will also want to obtain releases of liens and a final contractor’s affidavit.
5. Only do business with reputable contractors and businessmen.

E. How to File a Complaint with the Department of Agriculture and Consumer Services: The Florida Department of Agriculture and Consumer Services (DACS) functions as the state’s clearinghouse for consumer complaints. They assist consumers with information, protection and complaints, regardless of whether we regulate that particular industry. Upon receipt, they review each complaint and take the following action:

1. If the complaint falls within another agency's jurisdiction, it is referred to that agency;

2. If the complaint falls within DACS jurisdiction, we attempt informal mediation to resolve the consumer's dispute and evaluate the business for compliance with applicable statutory provisions; or

3. If a complaint is filed against a business that is not regulated by any federal, state or local government entity, DACS will attempt informal mediation to resolve the consumer's dispute.

4. If a complaint is filed against a business that is not regulated by any federal, state or local government entity, DACS will attempt informal mediation to resolve the consumer's dispute.

5. Contact Information: If you have any additional questions, please contact the Florida Department of Agriculture and Consumer Services at 1-800-HELP-FLA (435-7352) if you are calling from within Florida; (850) 410-3800 if you are calling from outside of Florida; or 1-800-FL-AYUDA (352-9832) ¡Español!

F. Long-Term Care Ombudsman Program: The Long-Term Care Ombudsman Program (LTCOP) advocates for residents of skilled nursing facilities, assisted living facilities and adult family care homes. The program is housed within the Department of Elder Affairs (DOEA).

1. Composition: The LTCOP is comprised of 18 local councils across Florida, all offering free, localized services to residents of long-term care facilities and their families.

2. Responsibilities: Ombudsmen investigate and resolve complaints submitted by, or on behalf of, residents of long-term facilities who are 60 years or age or older (F.S.400.0060).
a. Monitor development and implementation of federal, state and local laws, regulations and policies applicable to long-term care facilities and recommend any policy changes;

b. Maintain a statewide reporting system to collect and analyze data;

c. Provide information regarding long-term care facilities; and

d. Annually inspect each long-term facility to ensure the health, safety and welfare of the residents.

3. Contact Information: To ask for an Ombudsman’s assistance, request a group presentation, or learn more about the program, call toll-free 1-888-831-0404.
Chapter 9

Administration of the Respite for Elders Living in Everyday Families (RELIEF) Program
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Purpose of the RELIEF Program

PURPOSE OF THE RELIEF 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 Respite for Elders Living in Everyday Families (RELIEF) program.

B. **Purpose:** The RELIEF program provides volunteer-based respite services designed to support family caregivers of frail homebound elders age 60 and over and those with Alzheimer’s disease and related dementia. Additionally, the RELIEF program provides the following:

1. Opportunities for multi-generational corps of volunteers to contribute to their communities; and

2. Stipends to those who qualify, and reimbursements to volunteers to enable them to provide services at no cost to themselves.
LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

Legal Basis: The authority for this program is provided by:

Specific Authority:

1. Section 430.071, Florida Statutes.
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. Activities may include conversation, reading together, playing games, going for walks or preparing a light snack.
GENERAL CLIENT ELIGIBILITY CRITERIA:

Listed below are the eligibility criteria for the RELIEF program:

1. Individuals are 60 years of age or 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 family unit’s assistance.

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.
Client Assessment

The demographic portion of the 701A client assessment must be completed for each client for enrollment in the RELIEF program.

RELIEF clients will be enrolled in CIRTS based on demographics 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 with the exception of 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)
Volunteer Management

General Volunteer Qualifications

Volunteer qualifications shall be included in all position descriptions and recruitment advertisements. Qualified volunteers shall:

1. Be age 18 or older;

2. Pass a level II criminal background screening (initiated through the provided clearinghouse website and updated every five years) in accordance with Ch. 435; and

3. Committed to serve at least 4 hours per week.

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. Volunteers may not begin training or any other related service until receiving criminal history 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 with respect to elder and respite-care issues including: (1) Physiological, psychological and social aspects of aging; (2) Health and personal-care assistance; (3) Communication techniques; (4) Problem behaviors and problem solving; and (5) Review of applicable RELIEF policies and procedures.
Volunteer Orientation

Volunteers are required to complete orientation before providing any direct service to clients. Orientation training must provide information that improves the volunteer’s knowledge and abilities 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 volunteer
5. A description of the objectives of their respite service
6. Information concerning the roles and activities involved in being RELIEF volunteer
7. Information about available community service to enable the volunteer to be better advocates for their clients; and
8. General information regarding the economic, social and psychological aspects of aging

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 hours of training each quarter. 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;
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.
Volunteer Training Reimbursement

All volunteer orientation and in-service training hours are reimbursable. Volunteer training hours must be recorded on the standard RELIEF 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.

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. Volunteer service hours must be recorded on the standard RELIEF 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;
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 services will be provided, allowable and unallowable activities and information regarding how to contact the designated volunteer supervisor. 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.
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 will include the name of the staff member(s) authorized to supervise volunteer activities. Supervision 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 in order to enhance skills related to assignments and provide information on community services

Volunteer Performance Appraisals

Volunteers shall receive performance evaluations at least once during each calendar year. Provider agencies must volunteer of the timing, content, and process of performance reviews. Performance reviews will acknowledge volunteer work done well, as well as identify any areas that may need improvement. Volunteer performance reviews shall be documented 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.
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 services 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 local newspapers, newsletters and other media available. Provider agencies shall also participate in the Department of Elder Affairs volunteer recognition efforts during Volunteer Appreciation Month held each April.
Volunteer Management

Volunteer Records

Provider agencies shall ensure the collection of current and accurate data for each volunteer. Volunteer records must be maintained 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
Program Reporting Requirements

Service Unit

The service unit for the RELIEF program shall be measured as one hour of respite care and/or one 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
Program Reporting Requirements

Only direct service hours documented on the RELIEF Program Time and Travel Logs and reported on the Monthly Service Record shall be reported in CIRTS. Training hours documented on RELIEF Program Time and Travel Logs and reported on the Monthly Service Record are not required to be reported in CIRTS.

AAAs shall provide access and CIRTS training to all provider agencies. In accordance with DOEA NOTICE # 040114-1-I0SWCBS, AAAs shall direct all direct questions, comments suggestions and issues regarding CIRTS to the established CIRTS email address:

CIRTSComments@elderaffairs.org
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 contract agencies.

   k. Provide ongoing technical assistance.
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.
Chapter 9: Respite for Elders Living in Everyday Families (RELIEF) Program

Program Requirements

Responsibilities of Stakeholders

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.

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 in order 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, CIRTS reporting and monthly invoice.
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<th>Program Requirements</th>
<th>Responsibilities of Stakeholders</th>
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<td><strong>f.</strong> 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.</td>
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<td><strong>g.</strong> Establish and follow procedures for handling recipient complaints concerning such adverse actions as service termination, suspension or reduction in services.</td>
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<tr>
<td><strong>h.</strong> Conduct client satisfaction surveys to evaluate and improve service delivery.</td>
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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: