

VALLEY AREA AGENCY ON AGING

Operational Guidelines & Minimum Standards

for

Older American's Act Services

Paid for with funds received from the Aging and Adult Services Agency (AASA)
2017

VALLEY ARE AGENCY ON AGING

TABLE OF CONTENTS

I.	MINIMUM STANDARDS	
	A.	General Minimum Standards for All Service Specifications.....4
	B.	General Minimum Standards for Access Services.....12
	C.	General Minimum Standards for In-home Services.....13
II.	SERVICE SPECIFICATIONS.....	18

GENERAL MINIMUM STANDARDS FOR ALL SERVICE PROGRAMS

Attached to this Contract, and incorporated as an official part hereof, are service specifications and limitations for all programs and for each contract objective. These specifications provide the minimum criteria and requirements of operation for each program, in accordance with Michigan Office of Services to the Aging minimum standards.

The specifications are not intended to take the place of the expertise and knowledge of individual respondents in developing the proposals. The responsibility for the program design rests with the Subcontractor.

LOCAL MATCH

All contractors must supply a 20 percent local match, which may be cash or in-kind. **This means 20% of Net Costs, as indicated in the Summary Budget, will be provided by the applicant; the remaining 80% of Net Costs should equal the grant(s) available.**

SUBGRANTEE BACKGROUND

The VAAA is the federally-mandated agency responsible for planning, coordinating, and monitoring senior citizens services in Genesee, Lapeer, and Shiawassee Counties. As a function of these mandates, the VAAA will provide funding for services which have been identified as necessary to meet the needs of the senior citizen community. It is the intent of VAAA to select Subcontractors who will provide the most efficient, effective, and sensitive services to the elderly of Region V.

A. Eligibility and Targeting of Participants*

1. Services shall be provided only to persons 60 years of age and older. Substantial emphasis must be given to serving eligible persons with greatest social and/or economic need, with particular attention to low-income minority individuals. "Substantial emphasis" is regarded as an effort to serve a greater percentage of older persons with economic and/or social needs than their relative percentage to the total elderly population within the geographic service area.

Each provider must be able to specify how they satisfy the service needs of low-income minority individuals in the area they serve. Each provider, to the maximum extent feasible, must provide services to low-income minority individuals in accordance with their need for such services. Each provider must meet the specific objectives established by the area agency on aging for providing services to low-income minority individuals in numbers greater than

their relative percentage to the total elderly population within the geographic service area.

2. Participants shall not be denied or limited services because of their income or financial resources. Where program resources are insufficient to meet the demand for services, each service program shall establish and utilize written procedures for prioritizing clients waiting to receive services, based on social, functional and economic needs.

Indicating factors include:

- For Social Need – isolation, living alone, age 75 or over, minority group member, non-English speaking, etc.
- For Functional Need – handicaps (as defined by the Rehabilitation Act of 1973 for the American's With Disabilities Act), limitations in activities of daily living, mental or physical inability to perform specific tasks, acute and/or chronic health conditions.
- For Economic Need – eligibility for income assistance programs, self-declared income at or below 150% of the poverty threshold, etc. (Note: National Aging Program Information System (NAPIS) reporting requirements remain based on 100% of the poverty threshold.) Each provider must maintain a written list of persons who seek service from a priority service category (Access, In-Home, or Legal Assistance) but cannot be served at that time. Such a list must include the date service is first sought, the service being sought, and the county, or the community if the service area is less than a county, of residence of the person seeking service. The program must determine whether the person seeking service is likely to be eligible for the service requested before being placed on a waiting list.

Individuals on waiting lists for services for which cost sharing is allowable, may be afforded the opportunity to acquire services on a 100% cost share basis until they can be served by a funded program.

3. Service provided under Title III-E (the National Family Caregiver Support Program) may be provided to caregivers age 60 or over, caregivers of any age when the care recipient is aged 60 or over, and to kinship care recipients when the caregiver is aged 60 and over.
4. Services provided under Merit Respite Care (adult day services and respite care) may be provided to adults aged 18 and over.
5. Elderly members of Native American tribes and organizations in greatest economic and/or social need within the program service area are to receive services comparable to those received by non-Native American elders. Service providers within a geographic area in which a reservation is located must

demonstrate a substantial emphasis on serving Native American elders from that area.

B. Contributions*

1. All program participants shall be encouraged and offered a confidential and voluntary opportunity to contribute toward the cost of providing the service received. No one may be denied service for failing to make a donation.

2. Fees may not be charged for services funded in whole or in part by federal and state funds.

3. Except for program income, no paid or volunteer staff person of any service program may be allowed to solicit contributions from program participants, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any program participant.

4. Cost sharing may be implemented according to the Michigan Office of Services to
to
the Aging Cost Sharing Policy. Private pay or locally funded fee-for-service programs must be separate and distinct from grant funded programs.

C. Confidentiality

Each service program must have procedures to protect the confidentiality of information about older persons collected in the delivery of services. The procedures must ensure that no information about an older person or obtained from an older person by a service provider is disclosed in a form which identifies the person without the informed consent of that person or his or her legal representative; however, disclosure may be allowed by court order or for program monitoring by authorized federal, state, or local agencies (which are also bound to protect the confidentiality of client information), so long as access is in conformity with the Privacy Act of 1974. All client information should be maintained in controlled access files. It is the responsibility of each service program to determine if they are a covered entity with regard to HIPAA regulations.

D. Referral and Coordination Procedures

Each service program shall demonstrate working relationships with other community agencies for referrals and resource coordination to ensure that participants have maximum possible choice.

Each program shall be able to demonstrate linkages with agencies providing access services. Each program must establish written referral protocols with Case Coordination and Support, Care Management, and Home and Community Based Medicaid Programs operating in the respective service area.

E. Insurance Coverage

1. Each program shall have sufficient insurance to indemnify loss of federal, state, and local resources due to casualty, fraud or employee theft. All buildings, equipment, supplies, and other property purchased in whole or in part with funds awarded by the Older Americans Act are to be covered with sufficient insurance to reimburse the program for the fair market value of the asset at the time of loss. The contracted service provider shall add VAAA as an additional insured and provide VAAA with a certificate of insurance showing the limits of liability, policy dates and insurance carriers. Please note: Failure to provide certificate will result on a reduction in payment to reimburse VAAA for General Liability and Worker's Compensation premiums.

The following insurances are REQUIRED for each contracted service provider:

- a. Worker's compensation (minimum coverage amount: \$500,000/\$500,000/\$500,000 required)
- b. Fidelity bonding (for persons handling cash)
- c. Auto Liability Insurance (for agency owned vehicles or those persons who use privately owned vehicles for agency business)
- d. Insurance to protect the contracted service provider from claims against or contracted service provider drivers and/or passengers,
- e. Professional liability (minimum coverage amount: \$1,000,000 /\$2,000,000 required with VAAA named as additional insured)
- f. Personal Liability Insurance
- g. General liability (minimum coverage amount:\$1,000,000 per occurrence /\$2,000,000 aggregate required with VAAA named as additional insured)

2. The following insurances are recommended for each contracted service provider:

- Insurance for Board members and officers,
- Umbrella liability; and
- Special multi-peril.

Entities utilizing Independent Contractors must notify VAAA prior to contracting, as special insurance waivers are needed. Failure to do so may result in termination of contract. Entities utilizing independent contracts must ensure said contractors have the appropriate licensures, insurances and/or certifications.

F. Volunteers

Each program utilizing volunteers shall have a written procedure governing the recruiting, training, and supervising of volunteers that is consistent with the procedure utilized for paid staff. Volunteers shall receive a written position description, orientation training, annual criminal background checks and a yearly performance evaluation, as appropriate.

G. Staffing

Each program shall employ competent and qualified personnel sufficient to provide services pursuant to the contractual agreement. A minimum of 3 reference checks must be completed prior to employment or engagement. Each program shall be able to demonstrate an organizational structure, including established lines of authority. Each program must conduct, prior to employment or engagement, a criminal background review through the Michigan State Police for all paid and volunteer staff. Criminal background checks must also be completed on an annual basis for all paid and volunteer staff. An individual with a record of a felony conviction may be considered for employment at the discretion of the program. The safety and security of program clients must be paramount in such considerations. Should a person felony conviction be approved for employment, a written justification must be attached to the criminal background check and placed in the employee file.

Each program shall provide, or have access to, multi-lingual staff in order to interpret for persons with Limited English Proficiency at no cost to the client, and shall translate written documents to reflect LEP as part of its overall language assistance program.

H. Staff Identification

Every program staff person, paid or volunteer, who enters a participant's home must display proper identification which is either an agency picture identification card or a Michigan driver's license and some other form of agency identification.

I. Orientation and Training Participation

New program staff must receive orientation training that includes at a minimum, introduction to the program, the aging network, maintenance of records and files (as appropriate), the aging process, ethics and emergency procedures. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation.

Service program staff are to participate in relevant OSA- or area agency-sponsored or approved in-service training workshops, as appropriate and feasible. Records identifying dates of training and topics to be covered are to be maintained in employee personnel files. Training expenses are allowable costs against grant funds. Each service program should budget an adequate amount to address its respective training needs.

J. Complaint Resolution and Appeals

Complaints – each program must have a written procedure in place to address complaints, from individual recipients of services under the contract, which provides for protection from retaliation against the complainant.

Appeals – each program must also have a written appeals procedure for use by recipients with resolved complaints, individuals determined to be ineligible for services or by recipients who have services terminated. Persons denied service and recipients of service who have service terminated, or who have unresolved complaints, must be notified of their right to appeal such decisions and the procedure to be followed for appealing such decisions.

Each program must provide written notification to each client, at the time service is initiated, of his/her right to comment about service provision and to appeal termination of service.

Complaints of Discrimination – each program must provide written notice to each client, at the time service is initiated, that complaints of discrimination may be filed with the U. S. Department of Health and Human Services, Office of Civil Rights, or the Michigan Department of Civil Rights.

K. Civil Rights Compliance

Each program must not discriminate against any employee, applicant for employment, or recipient of service pursuant to the Federal Civil Rights Act of 1964, the Elliot-Larsen Civil Act (P.A. 453 of 1976), the Michigan Handicappers Civil Rights Act (P.A. 220 of 1976), and Section 504 of the Federal Rehabilitation Act of 1973. Each program must complete an appropriate DHHS (Federal Department of Health & Human Services) form assuring compliance with the Civil Rights Act of 1964. Each program must clearly post signs at agency offices and locations where services are provided in English and other languages, as may be appropriate, indicating non-discrimination in hiring, employment practices, and provision of services.

L. Equal Employment

Each program must comply with equal employment opportunity principles, in keeping with Executive Order 1979-4 and Civil Rights Compliance in state and federal contracts.

M. Publicity

Services funded herein must be publicized to the prospective client population through a variety of media. The Valley Area Agency on Aging must be noted as a funding source in all publicity.

N. Unit-Rate Reimbursement Policy

In finalizing service contracts, a unit-rate reimbursement policy may be established. Unit rates shall be determined by dividing the total value of the service contract by the number of service units specified in the contract.

Request for reimbursement in a given month shall be based on contractual costs per unit multiplied by the number of units served that month. Subcontractor shall take appropriate action to ensure that monies are available to provide service units in all 12 months of the program year.

This reimbursement rate shall only be altered if the subcontractor establishes clear and definite hardship mandating change; such requests shall be submitted to VAAA in writing prior to July 1 of the contract year. VAAA shall verify the accuracy of the program reporting system to be used to determine reimbursements, based on actual amounts of service provided.

O. Service Termination Procedure

Each program must establish a written service termination procedure that includes formal written notification of the termination of services and documentation in the client files. The written notification must state the reason for the termination, the effective date, and advise about the right to appeal. Reasons for termination may include, but are not limited to, the following:

1. The client's decision to stop receiving services
2. Reassessment that determines a client to be ineligible
3. Improvement in the client's condition so they no longer are in need of services
4. A change in the client's circumstances which makes them eligible for services paid for from other sources.
5. An increase in the availability of support from friends and/or family
6. Permanent institutionalization of client in either an acute care or long-term care facility. If institutionalization is temporary, services need not be terminated but may be placed on hold.
7. The program becomes unable to continue to serve the client and referral to another provider is not possible (may include unsafe work situations for program staff or loss of funding.)

P. Service Quality Review

Each provider must employ a mechanism for obtaining and evaluating the views of service recipients about the quality of services received. The mechanism may include client surveys, review of assessment records of in-home clients, etc.

Q. Universal Precautions

Each program must evaluate the occupational exposure of employees to blood or other potentially hazardous materials that may result from performance of the employee's duties and establish appropriate universal precautions. Each provider with employees who may experience occupational exposure must develop an exposure control plan which complies with Federal regulations implementing the Occupational Safety and Health Act.

R. Drug Free Workplace

Each program must agree to provide drug-free workplaces as a precondition to receiving a federal grant. Each program must operate in compliance with the Drug-Free Workplace Act of 1988.

S. American's With Disabilities Act

Each program must operate in compliance with the American's With Disabilities Act.

T. Workplace Safety

Each program must operate in compliance with the Michigan Occupational Safety and Health Act (MIOSHA). Information regarding compliance can be found at www.michigan.gov.

U. Services Publicized

Each service program must publicize the service(s) in order to facilitate access by all older persons which, at a minimum, shall include being easily identified in local telephone directories.

V. Older Persons at Risk

Each service program shall have a written procedure in place to bring to the attention of appropriate officials for follow-up, conditions or circumstances that place the older person, or the household of an older person, in imminent danger (e.g., situations of abuse or neglect.)

W. Emergency and Disaster Response

Each service program must have established, written emergency protocols for both responding to a disaster (both weather and non-weather related) and undertaking appropriate activities to assist victims to recover from a disaster, depending upon the resources and structures available.

X. Working Agreements

Each service program provider must have working agreements with all other VAAA service program providers, in addition to any other working agreements necessary to provide services.

Y. Payment/Reporting System

Providers receive payment for services on a monthly basis by submitting the reports to VAAA for services provided. Bills and/ or cash requests MUST be correct and submitted and date stamped by VAAA no later than the 10th day of the month following the month in which services are provided. In the event VAAA is closed on said day, bills and/or cash requests MUST be received and date stamped on the next open business day. Reports must cover a one-month period-from the first day of the month through the last day of the month. To receive prompt payment, reports must be received by above stated time frame and must be thoroughly completed

with correct information. The reports are checked to verify the services ordered, with payment issued within 30 days after the 10th. If the information submitted is incomplete or incorrect, payment will be delayed until the next billing cycle. Quarterly Reports MUST be submitted by the following cycle:

- January 10th - submission date for 1st quarter reports (Oct., Nov., Dec.)
- April 10th – submission date for 2nd quarter reports (Jan., Feb., March)
- July 10th – submission date for 3rd quarter reports (April, May, June)
- October 10th - submission date for 4th quarter reports (July, August, Sept.)

It is required that the VAAA report forms be used. Electronic versions of the forms are available by request to subcontractors.

All billing information should be addressed:

Valley Area Agency on Aging
225 E. Fifth Street, Suite 200
Flint, MI 48502

SERVICE DEFINITIONS AND SPECIFIC MINIMUM STANDARDS

All services with definitions approved by the MCSA are contained in the following section. All specific minimum standards for each service are identified in the following section. Fundable services, grouped according to category, are as follows:

A. Access

Care management, case coordination and support, disaster advocacy and outreach, information and assistance, outreach and transportation.

B. In-Home

Chore, home care assistance, home injury control, homemaking, home delivered meals, home health aide, medication management, personal care, personal emergency response system, respite care, and friendly reassurance.

C. Community

Adult day services, dementia adult day care, congregate meals, nutrition counseling, nutrition education, disease prevention and health promotion services, health screening, assistance to the hearing impaired and deaf, home repair, legal assistance, long-term care ombudsman/advocacy, senior center operations, senior center staffing, vision services, programs for prevention of elder abuse, neglect and exploitation, counseling services, specialized respite care, caregiver supplemental services, kinship support services, and caregiver education, support and training.

A. GENERAL REQUIREMENTS FOR ACCESS SERVICE PROGRAMS

In addition to the general requirements for all service programs, the following general standards apply to all access service categories unless otherwise specified:

Statement of Intent

Case Coordination and Support (CCS), Care Management (CM) and the Home and Community Based Services for the Elderly and Disabled (HCBS/ED) waiver programs are considered to be long-term care client support services. These three programs have many common functions and activities as well as a consistent focus. The general requirements for access service programs are intended to provide a framework for efficient and effective integration of these programs within the Michigan aging network.

1. A long-term care client shall be served by the CCS program until it has been determined they are in need of a nursing facility level of care based on functional limitations. Once such a determination has been made, the client is to be referred to the appropriate CM program. CCS programs are to be funded through Older Americans Act Title III, Part B.

2. A long-term care client shall be served by the CM program when they have been determined to need a nursing facility level of care based on functional limitations but is not determined to be Medicaid eligible. Once Medicaid eligibility has been determined, the client is to be referred to the appropriate waiver program. CM programs are to be funded through state care management funds and may utilize Older Americans Act Title III, Part B funds.

3. A long-term care client shall be served by the waiver program when they have been determined to need a nursing facility level of care based on functional limitations and is Medicaid eligible. Waiver programs are to be funded through Medicaid.

4. The in-home support services for any long-term care client may be funded from a combination of federal, state, local, private and Medicaid resources (dependent upon Medicaid eligibility).

5. Each access program shall demonstrate effective linkages with agencies providing long-term care client support services within the program area. Such linkages must be sufficiently developed to provide for prompt referrals whether for initiating services or in response to a client's changing needs or respective eligibility status.

GENERAL REQUIREMENTS FOR IN-HOME SERVICE PROGRAMS

In addition to the General Requirements for all Service Programs, the following general standards apply to all in-home service categories unless otherwise specified.

1. Service from Other Resources

Each in-home service program, prior to initiating service, shall determine whether a potential client is eligible to receive the respective service(s) or any component support service(s) through a program supported by other funding sources, particularly programs funded through the Social Security Act. If it appears that an individual can be served through other resources, an appropriate referral should be made or third-party reimbursement sought. Each program must establish coordination with appropriate local Department of Human Services (DHS) offices to ensure that funds received from OSA

are not used to provide in-home services which can be paid for or provided through programs administered by DHS.

Older Americans Act (OAA) funding may not be used to supplant (or substitute for) other federal, state or local funding that was being used to fund services, prior to the availability of OAA funds. OAA programs do not qualify as third party payers for Medicaid purposes.

2. Individual Assessment of Need

Each in-home service program, as identified in the table below, shall conduct an assessment of individual need for each client. Each program with required assessments shall avoid duplicating assessments of individual clients to the maximum extent possible. In-home service providers may accept assessments, and reassessments, from case coordination and support programs, care management programs, home and community based Medicaid programs, other aging network home care programs, and Medicare certified home health providers. Clients with multiple needs should be referred to care management programs.

Clients shall be assessed within 14 calendar days of initiating service. If services are to be provided for 14 calendar days or less, a complete assessment need not be conducted. In such instances, the program must determine the client's eligibility to receive services and gather the Basic Information specified below).

The assessments are to be used to verify need, eligibility, and the extent to which services are to be provided. The assessment should verify that an individual to be served has functional, physical or mental characteristics that prevent them from providing the service for themselves and that an informal support network is unavailable or insufficient to meet their needs. Eligibility is to be verified against established criteria for each respective service category. If an individual is found to be ineligible, the reason(s) are to be clearly stated. Each assessment shall be conducted face to face and provide as much of the information specified below as it is possible to determine. Programs must refer individuals thought to be eligible for Medicaid to DHS.

Periodic reassessments must be conducted according to the following chart. Reassessments are to be used to determine changes in client status, client satisfaction, and continued eligibility. Each assessment and reassessment should include a determination of when reassessment should take place.

In-Home Services Requiring Assessments	Minimum Reassessment Frequency (unless circumstances require more frequent reassessment)
Homemaking	6 months (180 days)
Home Care Assistance	6 months

Home Delivered Meals	6 months
Medication Management	3 months
Personal Care	6 months
Respite Care	6 months

When assessments are not conducted by a registered nurse (RN), the program must have access to, and utilize, an RN for assistance in reviewing assessments, as appropriate, and maintaining necessary linkages with appropriate health care programs.

Assessors must attempt to acquire each item of information listed below, but must also recognize, and accept, the client's right to refuse to provide requested items. Changes in any item should be specifically noted during reassessments. Assessments must be documented in writing, signed and dated.

Minimum information to be gathered by assessments:

a. Basic Information

- (1) Individual's name, address and phone number
- (2) Source of referral
- (3) The name, address and phone number of person to contact in case of an emergency
- (4) The name address and phone number of caregiver(s)
- (5) Gender
- (6) Age, date of birth
- (7) Race and/or ethnicity
- (8) Living arrangements
- (9) Condition of residential environment
- (10) Whether or not the individual's income is below the poverty level and/or sources of income (particularly SSI)

b. Functional Status

- (1) Vision
- (2) Hearing
- (3) Speech
- (4) Oral status (condition of teeth, gums, mouth and tongue)
- (5) Prostheses
- (6) Limitations in activities of daily living
- (7) Eating patterns (diet history), special dietary needs, source of all meals, and nutrition risk
- (8) History of chronic and acute illnesses
- (9) Prescriptions, medications and other physician orders

c. Support Resources

- (1) Physician's name, address and phone number (for all physicians)

- (2) Pharmacist's name, address and phone number (for all pharmacies utilized)
- (3) Services currently receiving or received in past (including identification of those funded through Medicaid)
- (4) Extent of family and/or informal support network
- (5) Hospitalization history
- (6) Medical/health insurance available
- (7) Clergy name, address and phone number, if applicable

d. Client Satisfaction (at reassessment)

- (1) Client's satisfaction with services received
- (2) Client's satisfaction with program staff performance
- (3) Consistency of services provided

3. Service Plan

Each in-home service program must establish a written service plan for each client, based on the assessment of need, within 14 calendar days of the date the assessment was completed. The service plan must be developed in cooperation with the client, client's guardian or designated representative, as appropriate. The service plan must contain at a minimum:

- a. A statement of the client's problems, needs, strengths and resources.
- b. Statement of the goals and objectives for meeting identified needs.
- c. Description of methods and/or approaches to be used in addressing needs.
- d. Identification of services and the frequency which they are to be provided.
- e. Treatment orders of qualified health professionals, when applicable.
- f. Documentation of referrals and follow-up actions.

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

When the service plan is not developed by an RN, in-home service programs must have access to an RN for assistance in developing service plans, as appropriate. Service plans must be evaluated at each client reassessment.

4. In-home Supervision

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

Each in-home service program, except for home delivered meals, must conduct one in-home supervisory visit for each program staff member, with a program client present, each fiscal year. An RN must be available to conduct in-home supervisory visits when indicated by client circumstances. Additional in-home supervisory visits should be conducted as necessary. The program shall maintain documentation of each in-home supervisory visit.

5. Client Records

Each in-home service program must maintain comprehensive and complete client records which contain at a minimum:

- a. Details of referral to program.
- b. Assessment of individual need or copy of assessment (and reassessment) from referring program.
- c. Service plan (with notation of any revisions).
- d. Programs (except home delivered meals) with multiple sources of funding must specifically identify clients served with funds from OSA. Records must contain a listing of all contacts with clients (dates) paid for with funds from OSA and the extent of services provided (units per client).
- e. Notes in response to client, family, and agency contacts (including notation of all referrals made).
- f. Record of release of any personal information about the client or copy of signed release of information form.
- g. Service start and stop dates.
- h. Service termination documentation, if applicable.
- i. Signatures and dates on client documents, as appropriate.

All client records (paper and electronic) must be kept confidential in controlled access files.

6. In-Service Training

Staff and volunteers of each in-home service program shall receive in-service training at least twice each fiscal year which is specifically designed to increase knowledge and understanding of the program, the aging process, and to improve skills at tasks performed in the provision of service. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation. Records shall be maintained which identify the dates of training, topics covered and persons attending. These records should include:

- The date and duration of each in-service training provided
- The topic(s) covered during each in-service training: and
- The staff in attendance at each in-service training (i.e., sign-in sheet)

SERVICE SPECIFICATIONS

Adult Day Services.....	20
Caregiver Education, Support & Training	25
Care Management	26
Case Coordination & Support.....	28
Disease Prevention/Health Promotion	32
Programs for Prevention of elder Abuse, Neglect & Exploitation.....	33
Home Injury Control	34
Information & Assistance	35
In-Home Services	
• Homemaking	36
• Personal Care	37
Legal Services	39
Long-Term Care Ombudsman/Advocacy.....	42
Medication Management.....	45
Nutrition Services	
• Congregate Meals.....	47
• Home Delivered Meals	54
• Home Delivered Meals Assessments	62
Outreach	66
Assistive Devices & Technologies	76
Respite Care (includes NFCSP Respite & Self-Directed Respite)	70
Kinship Support Services	72

Transportation73

ADULT DAY SERVICES

Service Number: C1 - Service Category: Community

Definition of Service

Daytime care of any part of a day but less than twenty-four hour care for functionally and/or cognitively impaired elderly persons provided through a structured program of social and rehabilitative and/or maintenance services in a supportive group setting other than the client's home.

Unit of Service

One hour of care provided per client.

Minimum Standard

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

a. That participants must require continual supervision in order to live in their own homes or the home of a primary caregiver.

b. Participants must require a substitute caregiver while their primary caregiver is in need of relief, or otherwise unavailable.

c. That participants may have difficulty or be unable to perform activities of daily living (ADLs) without assistance.

d. That participants must be capable of leaving their residence, with assistance, in order to receive service.

e. That participants would benefit from intervention in the form of enrichment and opportunities for social activities in order to prevent and/or postpone deterioration that would likely lead to institutionalization.

2. Each program shall have uniform preliminary screening procedures and maintain consistent records. Such screening may be conducted over the telephone. Records for each potential client shall include at a minimum:

a. The individual's name, address and telephone number.

b. The individual's age or birth date.

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

d. The name, address and telephone number of the person to contact in case of emergency.

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

f. Perceived supportive service needs as expressed by the individual.

g. Race and Sex (Optional)

h. An estimate of whether or not the individual has an income at or below the poverty level. Intake is not required for individuals referred by a case coordination and support, care management or HCBS/ED waiver program.

3. If preliminary screening indicates an individual may be eligible for Adult Day Services, a

comprehensive individual assessment of need shall be performed before admission to the program. All assessments shall be conducted face to face. Assessors must attempt to acquire each item of information listed below, but must also recognize, and accept, the client's right to refuse to provide requested items.

- a. Basic Information
 - (1) Individual's name, address and telephone number
 - (2) Age, date and place of birth
 - (3) Sex
 - (4) Marital status
 - (5) Race and/or ethnicity
 - (6) Living arrangements
 - (7) Condition of environment
 - (8) Income and other financial resources, by source
 - (9) Expenses.
 - (10) Previous occupation(s), special interests and hobbies
 - (11) Religious affiliation
- b. Functional Status
 - (1) Vision
 - (2) Hearing
 - (3) Speech
 - (4) Oral status (condition of teeth, gums, mouth and tongue)
 - (5) Prostheses
 - (6) Psychosocial functioning
 - (7) Cognitive functioning
 - (8) Difficulties in activities of daily living
 - (9) History of chronic and acute illnesses
 - (10) Medication regimen (Rx, OTC, supplements, herbal remedies), and other physician orders
 - (11) Eating patterns (diet history) and special dietary needs
- c. Supporting Resources
 - (1) Physician's name, address and telephone number
 - (2) Pharmacist's name, address and telephone number
 - (3) Services currently receiving or received in the past
 - (4) Extent of family and/or informal support network
 - (5) Hospitalization history
 - (6) Medical/health insurance information
 - (7) Long term care insurance
 - (8) Clergy name, address and telephone number
- d. Need Identification
 - (1) Client perceived
 - (2) Caregiver perceived, if available
 - (3) Assessor perceived
- e. Determination of Whether Individual Is Eligible For Program

An initial assessment is not required for individuals referred by a case coordination and support, care management, or HCBS/ED waiver program. Admission to the program may be based on the referral.

4. A service plan shall be developed for each individual admitted to an Adult Day Service program. The service plan must be developed in cooperation with, and be approved by, the client, the client's guardian or designated representative. The service plan shall contain at a minimum:

- a. A statement of the client's problems, needs, strengths, and resources.
- b. A statement of the goals and objectives for meeting identified needs.
- c. A description of methods and/or approaches to be used in addressing needs.
- d. Identification of basic and optional program services to be provided.

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

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

Each program shall have a written policy/procedure to govern the development, implementation and management of service plans. Each client is to be reassessed every three months to determine the results of implementation of the service plan. If observation indicates a change in client status, a reassessment may be necessary before three months have passed.

5. Each program shall maintain comprehensive and complete client files which include at a minimum:

- a. Details of client's referral to adult day care program.
- b. Intake records.
- c. Assessment of individual need or copy of assessment (and reassessments) from the referring program.
- d. Service plan (with notation of any revisions).
- e. Listing of client contacts and attendance.
- f. Progress notes in response to observations (at least monthly).
- g. Notation of all medications taken on premises (including 1. the medication, 2. the dosage, 3. the date and time, 4. initials of staff person who assisted, and 5. comments).
- h. Notation of basic and optional services provided to the client
- i. Notation of any and all release of information about the client, signed release of information form, and all client files shall be kept confidential in controlled access files. Each program shall use a standard release of information form which is time-limited and specific as to the information being released.

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

- a. Transportation.
- b. Personal care.
- c. Nutrition: one hot meal per eight-hour day which provides one-third of recommended daily allowances and follows the meal pattern of the General Requirements for Nutrition Programs. Participants in attendance from eight to fourteen hours shall receive an additional meal in order to meet a combined two-thirds of the recommended daily allowances. Modified diet menus should be provided, where feasible and appropriate,

which take into consideration client choice, health, Religious and ethnic diet preferences. Meals shall be acquired from a congregate meal provider where possible and feasible.

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

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

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

b. Medical support: laboratory, x-ray, pharmaceutical services provided under order from a physician by licensed professionals.

c. Services within the scope of the Nursing Practice Act.

d. Dental: under the direction of a dentist.

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

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

g. Health counseling.

h. Shopping assistance/escort.

8. Each program shall establish written policies and procedures to govern the assistance to be given participants in taking medications while participating in the program. The policies and procedures must address:

a. Written consent from the client, or client's representative, to assist in taking medications.

b. Verification of medication regimen, including prescriptions and dosages.

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

d. Procedures for medication set up.

e. Secure storage of medications belonging to and brought in by participants.

f. Disposal of unused medications.

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

9. Each provider shall establish a written policy/procedure for discharging individuals from the program that includes, at a minimum, one or more of the following:

a. The participant's desire to discontinue attendance.

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

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

d. Permanent institutionalization of client.

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

10. Each program shall employ a full-time program director with a minimum of a bachelor's degree in a health or human services field or be a qualified health professional. The program shall continually provide support staff at a ratio of no less than one staff person for each ten participants. Health support services may be provided only under the supervision of a registered nurse. If the program acquires either required or optional services from other individuals or organizations, it shall be accomplished through a written agreement that clearly specifies the terms of the arrangement.

11. Program staff shall be provided with an orientation training that includes, in addition to the topics specified in the General Requirements for All Service Programs, assessment/observation skills and basic first-aid. Program staff shall be provided in-service training at least twice each year, which is specifically designed to increase their knowledge and understanding of the program, aging process issues, and to improve their skills at tasks performed in the provision of service. Issues addressed under the aging process may include, though are not limited to, cultural diversity, dementia, cognitive impairment, mental illness, abuse and exploitation. Records shall be maintained which identify the dates of training, topics covered and persons attending.

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

a. All drivers and vehicles shall be appropriately licensed and all vehicles used shall be appropriately insured.

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

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

13. Each program shall have first aid supplies available at the service center. A staff person knowledgeable in first-aid procedures, including CPR, shall be present at all times participants are in the service center.

14. Procedures to be followed in emergency situations (fire, severe weather, etc.) shall be posted in each room of the service center. Practice drills of emergency procedures shall be conducted once every six months. The program shall maintain a record of all practice drills.

15. Each service center shall have the following furnishings:

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

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

c. Storage space for participants' personal belongings.

d. Tables for both ambulatory and non-ambulatory participants.

e. A telephone that is accessible to all participants.

f. Special equipment as needed to assist persons with disabilities.

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

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

CAREGIVER EDUCATION, SUPPORT AND TRAINING

Service Number: C-20 - Service Category: Community

Definition of Service

A program intended to provide assistance to caregivers in understanding and coping with a broad range of issues associated with caregiving. Allowable programs include:

Education programs, including development and distribution of printed materials, pertaining to physical, emotional and spiritual aspects of caregiving as well as current research and public policy concerns.

Initiatives, which provide support activities for caregivers (including kinship caregivers), i.e., support groups, counseling, information and assistance in connecting with community resources, etc.

Training programs pertaining to techniques for providing personal care services to care recipients and to address care giving skills for efficacy and caregiver confidence when caring for the care recipient

Unit of Service

One activity session.

One hour of allowable education, support and/or training program activities

Minimum Standards

1. Each program must maintain linkage with caregiver focal points, and respite care programs, as available, in the PSA to help facilitate opportunities for caregivers to attend education, support and training programs. Respite care may be provided, as an ancillary program component, in conjunction with caregiver education, support and training programs to enable caregiver participation.

2. Each program shall utilize staff that has specific training and/or experience in the particular service area(s) being addressed. Continuing education of staff in specific service areas is encouraged.

3. Caregiver Education, Support and Training programs may be provided to individuals as well as in group settings. Services may be provided in both community and in-home settings.

CARE MANAGEMENT

Service Number: A-1 - Service Category: Access

Definition of Service

The provision of a comprehensive assessment, care plan development, periodic reassessment, and ongoing coordination and management of in-home and other supportive services to individuals aged 60 and over who are in need of a nursing facility level of care due to the presence of functional limitations. Services are brokered or directly purchased, according to an agreed-upon care plan, to assist the client in maintaining

independence. Care management functions include eligibility determination, assessment, care plan development, supports, coordination, reassessment and ongoing monitoring. Activities shall be conducted in accordance with established performance criteria.

Unit of Service

Assessment and ongoing care management of an individual.

Minimum Standards

1. Medical eligibility for care management shall be determined using the MI Choice screen prior to an individual's enrollment in the CM program.
2. Care management functions shall be conducted by a multi-disciplinary team. team may consist of a registered nurse and a licensed social worker (as described within the Michigan Public Health Code) or be comprised of a registered nurse and an individual with a minimum of two years Care Manager experience.
3. Care managers shall establish and maintain a confidential record for each client served. The record shall include but not be limited to the following information:
 - a. Completed telephone screen.
 - b. Completed assessment.
 - c. Client-approved plan of care.
 - d. Documentation of service orders, linkage forms.
 - e. Progress notes which serve as a log for documenting pertinent contacts with client, providers
 - f. Reassessment.
 - g. Correspondence pertaining to client's care.
 - h. Person-centered planning.

4. MIChoice assessment and reassessment forms and protocols shall be utilized to assess an individual's abilities, health and physical functioning, living situation, informal support potential, and financial status. MI Choice assessment and reassessment forms and protocols shall be utilized to assess an individual's abilities, health and physical functioning, living situation, informal support potential, and financial status.
5. A plan of care detailing the services to be arranged or purchased shall be established for each enrolled client. Assessment findings shall be utilized to establish the plan of care. Care plans shall be modified or adjusted based on reassessment findings or other changes in the client's condition.
6. Reassessments shall be conducted:
 - a. Within 90 days of assessment or previous reassessment for active cases, and
 - b. Within 180 days of assessment or previous reassessment for maintenance cases.
7. Ongoing monitoring and follow-up shall be conducted to ensure the client's health and safety, quality of care, and satisfaction with services.
8. Each program shall utilize the MI Choice Information System (MICIS) according to established protocols to track client data, services data, and billing data.
9. Each program shall establish linkages with agencies providing long term care support services within the program area (e.g., in-home services providers, case coordination and support programs, HCBS/ED waiver programs).
10. Programs shall ensure staff is available to assist in disaster management activities coordinated by the local emergency operations center as necessary to protect the health and safety of CM clients.
11. Program shall follow guidelines outline in the General Operational Guidelines for Access Programs.

CASE COORDINATION & SUPPORT

Service Number: A-2 - Service Category: Access

Definition of Service

The provision of a comprehensive assessment of persons aged 60 and over with a complementing role of brokering existing community services and enhancing informal support systems when feasible. Case Coordination and Support (CCS) includes the assessment and reassessment of individual needs, development and monitoring of a service plan, identification of and communication with appropriate community agencies to arrange for services, evaluation of the effectiveness and benefit of services provided, and assignment of a single individual as the caseworker for each client.

Unit of Service

Provision of one hour component CCS functions.

Component Functions

Intake, assessment, reassessment, development of service plan, arrangement for each service.

Minimum Standards

1. Each CCS program must have uniform intake procedures and maintain consistent records. Intake may be conducted over the telephone. Intake records for each potential client must include at a minimum:
 - a. Individual's name, address and telephone number
 - b. Individual's age or birth date
 - c. Physician's name, address and telephone number
 - d. Name, address, and phone number of person, other than spouse or relative with whom individual resides, to contact in case of emergency
 - e. Handicaps, as defined by Section 504 of the Rehabilitation Act of 1973, or other diagnosed medical problems
 - f. Perceived supportive service needs as expressed by individual or his/her representatives.
 - g. Race (optional)
 - h. Gender (optional)
 - i. An estimate of whether or not the individual has an income at or below the poverty level for intake and reporting purposes and at or below 125% of poverty level for referral purposes.

2. If intake indicates a single service need on a one-time or infrequent basis, the individual should be

provided information and assistance services. When intake suggests ongoing and/or multiple service needs, a comprehensive individual assessment of need shall be performed within ten working days of intake. If intake suggests ongoing or multiple complex service needs at a level beyond the scope of the CCS program, a referral shall be made to the CM program. All assessments and reassessments

shall be conducted in person. Each assessment shall provide as much of the following information as is possible to determine:

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

a. Basic Information

- (1) Individual's name, address, and telephone number
- (2) Age, date and place of birth
- (3) Gender
- (4) Marital status
- (5) Race and/or ethnicity
- (6) Living arrangements
- (7) Condition of environment
- (8) Income and other financial resources, by source (including SSI and GA)
- (9) Expenses
- (10) Previous occupation, special interests and hobbies
- (11) Religious affiliation, if applicable

b. Functional Status

- (1) Vision
- (2) Hearing
- (3) Speech
- (4) Oral status (condition of teeth, gums, mouth and tongue)
- (5) Prosthesis
- (6) Psychosocial functioning
- (7) Limitations in activities of daily living (ADLs and IADLs)
- (8) History of chronic and acute illnesses
- (9) Eating patterns (diet history)
- (10) Prescriptions, medications, and other physician orders

c. Supporting Resources

- (1) Physician's name, address, and telephone number
- (2) Pharmacist's name, address and telephone number
- (3) Services currently receiving or received in past (including identification of

those

funded through Medicaid)

- (4) Extent of family and/or informal support network
- (5) Hospitalization history
- (6) Medical/health insurance information
- (7) Clergy name, address and telephone number, if applicable

d. Need Identification

- (1) Client/family perceived
- (2) Assessor perceived and/or identified from referral source/professional community

Each client shall be reassessed every six months, or as needed to determine the results of implementation of the service plan. If reassessment determines the client's identified needs have been adequately addressed, the case shall be closed.

3. A service plan shall be developed for each person determined eligible and in need of CCS. The service plan shall be developed in cooperation with and be approved by the client, client's guardian or designated representative. The service plan shall contain at a minimum:

- a. A statement of the client's problems, needs, strengths, and resources.
- b. Statement of the goals and objectives for meeting identified needs.
- c. Description of methods and/or approaches to be used in addressing needs.
- d. Identification of services and the respective time frames they are to be obtained/provided from other community agencies.
- e. Treatment orders of qualified health professional, when applicable.

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

4. Each program shall maintain comprehensive and complete case files which include at a minimum:

- a. Details of client's referral to CCS program.
- b. Intake records.
- c. Comprehensive individual assessment and reassessments.
- d. Service plan (with notation of any revisions).
- e. Listing of all contacts (dates) with clients (including units of service per client).
- f. Case notes in response to all client or family contacts (telephone or personal).
- g. Listing of all contacts with service providers on behalf of client.
- h. Comments verifying client's receipt of services from other providers and whether service adequately addressed client need.
- i. Record of all release of information about the client, signed release of information form, and all case files shall be kept confidential in controlled access files. Each program shall use a standardized release of information form which is time limited and specific as to the information being released.

5. Each case file must be assigned status in one of the following categories:

- a. Open. From initial referral or reassessment of inactive case through current activity in implementing a service plan.

b. Closed. Client decides to discontinue service, client needs have been met, another program or agency has assumed responsibility for client, client unable to be served and referral of case is not possible, or client's death.

6. Each program shall maintain a current listing of isolated older persons, with active case files, which can be made readily available to agencies providing emergency services in the event of a disaster.

7. Each program shall employ caseworkers who have a minimum of a bachelor's degree in a human service field or who by training or experience have the ability to effectively determine an older person's needs and match those needs with appropriate services. If the program does not employ an individual with an appropriate bachelor's degree, access to such an individual in the community shall be arranged for purposes of technical support and/or consultation. Clients with identified unmet health needs (physical and/or mental) shall be referred to an appropriate health care agency. Only one caseworker may be currently assigned to each individual case.

8. Each CCS program shall provide, as supporting services, information and assistance, and outreach. However, it is not required that such service provision be reported to OSA.

9. Program staff shall receive in-service training at least twice each fiscal year which is specifically designed to increase their knowledge and understanding of the program and clients, and to improve their skills for tasks performed in the provision of service. An individualized in-service training plan should be developed for a staff person, when performance evaluations indicate a need.

DISEASE PREVENTION/HEALTH PROMOTION

Service Number: C-6 – Service Category: Community

Definition of Service

A service program that provides information and support to older individuals with the intent of assisting them in avoiding illness and improving health status. Allowable programs include:

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

Unit of Service

One activity session or hour of related service provision, as appropriate.

Minimum Standards

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

2. Each program, in targeting services, shall give priority to geographic areas which are medically underserved and in which there are a significant number of older individuals who have the greatest economic need for such services.
3. Each program is encouraged to facilitate and utilize a regional health coalition to plan for and implement services. Members of the regional health coalition should include one or more members of the Michigan Primary Care Association and other organizations such as: local public health departments; community mental health boards; cooperative extension agents; local aging service providers; local health practitioners; local hospitals; and local MMAP providers.
4. Disease prevention and health promotion services should be provided at locations and in facilities convenient to older participants.
5. Medication management services may be provided to individual clients with Title III-Part D funds only through use of the “In-home Services Medication Management” service definition, service number B-7 of the Operating Standards for Services Programs.

PROGRAMS FOR PREVENTION OF ELDER ABUSE, NEGLECT AND EXPLOITATION

Service Number: C-15 – Service Category: Community

Definition of Service

Activities to develop, strengthen, and carry-out programs for the prevention and treatment of elder abuse, neglect, and exploitation.

Unit of Service

One hour of contact with organizations to develop coordinated, comprehensive services for the target population. In addition to contact with other aging subcontract organizations, elder abuse subcontract agencies shall count contact with the Department of Human Services, Adult Protective Services, law enforcement, health care professionals, community mental health, and other relevant service entities when the reason for the contact is to meet the above service definition.

Minimum Standards

1. Professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.
2. The coordinated, comprehensive approaches to prevent elder abuse, neglect, and exploitation shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long-term care ombudsman/advocacy programs, and legal assistance programs operating in the service area.

HOME INJURY CONTROL

Services Number: B3 – Service Category: In-home

Definition of Service

Providing adaptations to the home environment of an older adult in order to prevent or minimize the occurrence of injuries. Home injury control does not include any structural or restorative home repair, chore or homemaker activities. Allowable tasks include installation or maintenance of:

- enhanced lighting
- ramps for improved and/or barrier-free access
- bathroom chairs and grab bars
- non-slip treatments
- vision or hearing adaptive devices
- stairway and/or hallway handrails
- smoke and/or gas alarms

Unit of Service

Installation or maintenance of one safety device in an older adult's residence.

Minimum Standards

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

2. Each program must develop working relationships with chore, homemaker, home care assistance and home repair service providers, as available within the program area, to ensure effective coordination of efforts.
3. Each program must utilize a home environment assessment tool to formally evaluate the
Circumstances and needs of each client. The program may utilize the MI Choice assessment for initiating service if the client is referred by either a care management or HCBS/ED program.
4. Each program must maintain a record of safety improvements made at each residence including dates, tasks performed, materials used and cost.
5. All safety devices installed must conform to local building codes and meet respective UL® safety standards.
6. Funds awarded for home injury control may be used for labor costs and to purchase safety devices to be installed. The program must establish a limit on the amount to be spent on any one residence in a 12-month period. Each program must seek contributions of labor and supplies from the private sector and volunteer organizations, as may be feasible. Equipment or tools needed to perform home injury control tasks may be purchased or rented with grant funds up to an aggregate amount equal to 10% of total grant funds.

INFORMATION & ASSISTANCE

Service Number: A-4- Service Category: Access

Definition of Service

Assistance to individuals in finding and working with appropriate human service providers that can meet their needs which may include; information-giving (e.g., listing the providers of a particular service category so an individual may make their own contact directly); group presentations; referral (making contact with a particular provider on behalf of an individual); advocacy intervention (negotiating with a service provider on behalf of a client); and, follow-up contacts with clients to ensure services have been provided and have met the respective service need.

Unit of Service

Provision of one hour of component information and referral (I&A) functions (Note: newsletters and media spots are encouraged but are not to be counted as information-giving units of service).

Minimum Standards

1. Each I&A program shall have a resource file, which is current that includes a listing of human service agencies, services available, pertinent information as to resources and ability to accept new clients and eligibility requirements. The program shall be able to

provide adequate information about community resources and agencies to all callers so they may make their own contact directly.

2. Each program located in areas where non-English or limited English speaking older persons are concentrated shall have bilingual personnel available or have the capacity to acquire interpretation services as necessary. In addition, each program must have the capacity to serve hearing impaired persons and visually impaired persons in a manner appropriate to their needs, such as through the Michigan Relay Center.

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

4. Each program shall maintain records (for three years or until audit has been closed) of the nature of calls received, the agencies and/or organizations to which referrals are made and the service for which referrals are made, the results of follow-up contacts, and any client files maintained. Such information regarding service transactions shall be reported to the AAA upon request for monitoring and/or planning purposes.

5. A follow-up contact shall be made on all referrals, whether services are negotiated or not, within ten working days to determine whether services were received, the identified need met, and client satisfaction. Follow-up contacts are not required for information-giving only contacts.

6. Each program must determine the quality of I&A services provided, through a sampling of no less than 10% of clients, at least annually.

IN-HOME SERVICES – HOMEMAKER

Service Number: B4 – Service Category – In-home

Definition of Service

Performance of routine household tasks to maintain an adequate living environment for older individuals with functional limitations. Homemaking does not include provision of chore or personal care tasks. Allowable homemaking tasks are limited to one or more of the following: laundry, ironing, meal preparation, shopping for necessities (including groceries) and errand running, light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, maintaining safe, environment) observing, reporting, and recording any change in client's condition and home environment. Note: Social/emotional support of client may be offered in conjunction with other allowable tasks.

Unit of Service

One hour spent performing allowable homemaking activities.

Minimum Standards

1. Each program must have written eligibility criteria.
2. Individuals employed as homemakers must have previous relevant experience or training and skills in housekeeping, household management, meal

preparation, good health practices, observation, reporting and recording information.

3. Required in-service training topics include safety, sanitation, household management, and nutrition and meal preparation. Allowable homemaking tasks are limited to the following:

- Laundry
- Ironing
- Meal preparation
- Shopping for necessities, including groceries
- Light housekeeping tasks (dusting, vacuuming, mopping floors, cleaning bathroom and kitchen, making beds, and maintaining a safe home environment)
- Observing, reporting, and recording any change in the participant's condition and the home environment.

IN-HOME SERVICES – PERSONAL CARE

Service Number: B8- Service Category: In-home

Definition of Service

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

Unit of Service

One hour spent performing personal care activities.

Minimum Standards

1. Each provider must have written policies and procedures compatible with the General Minimum Standards for All Service Specifications.
2. All workers performing personal care services must be directly supervised by a registered nurse licensed to practice nursing in the State of Michigan. At the State's discretion, other qualified individuals may supervise personal care providers.
3. The plan of care will indicate the frequency or intensity of supervision.
4. The provider agency must train each worker to properly perform each task required for each participant the worker serves. The supervisor must approve tasks each worker performs. Completion of a recognized nurse's aid training course by each worker is strongly recommended.
5. Providers must develop in-service training plans for personal care service workers which include the following topics in addition to those required under the general minimum standards:
 - Safety
 - Sanitation
 - Body mechanics
 - Universal precautions
 - Household management
 - Food preparation including safe/sanitary food handling procedures
 - Identifying and reporting abuse and neglect
6. Personal care providers may perform higher level, non-invasive tasks such as maintenance of catheters and feeding tubes, minor dressing changes, and wound care if the direct care worker has been individually trained and supervised by an RN for each participant who requires such care.

7. Each provider which chooses to allow staff to assist participants with self-medication shall establish written procedures that govern the assistance given by staff to participants with self-medication. These procedures shall be reviewed by a consulting pharmacist, physician, or registered nurse, and shall include, at a minimum:
- The provider staff authorized to assist participants with taking their own prescription or over-the-counter medications and under what conditions such assistance may take place. This must include a review of the type of medication the participant takes and its impact upon the participant. Volunteer respite care workers shall not assist participants, in any way, in taking either prescription or over-the-counter medications.
 - Verification of prescription medications and their dosages: the provider shall maintain all medications in their original, labeled containers.
 - Instructions for entering medication information in participant files.
 - A clear statement of the participant's and participant's family responsibilities regarding medications taken by the participant and the provision for informing the participant and the participant's family of the providers procedures and responsibilities regarding assisted self administration of medications.

LEGAL ASSISTANCE

Service Number: C-10 – Service Category: Community

Definition of Service

Provision of legal assistance through cases, projects, community collaborations and other services that provide the most impact whether for an individual client or group of older adults. Such assistance may be provided by an attorney, paralegal or student under the supervision of an attorney. Legal Services is priority service under the Older Americans Act (OAA).

Units of Service

Equal to provision of one hour of an allowable service component.

Minimum Standards

1. Allowable service components:
 - a. Intake – the initial interview to collect demographic data and identification of the client’s legal difficulties and questions.
 - b. Advice and Counsel – where the client is offered an informed opinion, possible courses of action, and clarification of his/her rights under the law.
 - c. Referral – if a legal assistance program is unable to assist a client with the course of action that he/she wishes to take, an appropriate referral should be made. Referral may also be necessary when legal services providers observe individual needs which they are unable to resolve, such as income maintenance, social service, or health service needs.
 - d. Representation – if the client’s problem requires more than advice and counsel and the case is not referred to another source, the program may represent the person in order to achieve a solution to the legal problem. Representation may include legal research, negotiation, preparation of legal documents, correspondence, appearance at administrative hearings or courts of law, and legal appeals where appropriate.
 - e. Legal Research – the gathering of information about laws, rights, or interpretation of laws that may be performed at any point after intake has occurred, to resolve an individual’s legal problems. Such information will be used to assist providers of legal services in counseling individuals, in representing them in hearings and a court of law or in negotiations with potential legal adversaries.

- f. Preparation of Legal Documents – writing documents that serve to protect individual rights, such as contracts, wills, or leases, which might later be used in a court of law.
 - g. Negotiation – as the client’s representative, program staff may contact other persons concerned with the client’s legal problem in order to clarify factual or legal contentions and possibly reach an agreement to settle legal claims.
 - h. Legal Education – preparation and presentation of programs to inform elderly persons of their rights, the legal system, and alternative courses of legal action.
- 2. Each legal assistance program shall have an established system for targeting and serving older adults in greatest social and economic need within the OAA defined program target areas of income, healthcare, long term care, nutrition, housing, utilities, and protective services, defense of guardianship, abuse, neglect and discrimination. Each program shall complete and re-evaluate annually a program priority report and plan for targeting services to the most socially and economically vulnerable. This report shall be provided to the AAA and the Michigan Office of Services to the Aging (OSA).
- 3. Each legal assistance program shall work to develop outcome measures to reflect the impact of legal services intervention on individual clients and older adults in the greatest social and economic need in the service area. These outcomes shall be used for program development.
- 4. Services may be provided by an attorney licensed to practice law in the State of Michigan or a paralegal or student under the supervision and guidance of an attorney licensed to practice law in the State of Michigan.
- 5. Legal assistance programs may engage in and support client impact work, including but not limited to class action suits where a large group of older adults are affected by a legal inequity. For client impact work, programs are encouraged to utilize technical assistance resources such as the Michigan Poverty Law Program (MPLP).
- 6. Each legal assistance program shall demonstrate coordination with local long term care advocacy programs, aging services programs, Aging and Disability Resource Centers (ADRCs), elder abuse prevention programs and service planning efforts operating within the project area.
- 7. When a legal assistance program identifies issues affecting clients that may be remedied by legislative action, such issues shall be brought to the attention of the AAA, OSA, MPLP and other programs offering technical assistance to legal providers.

8. Each legal assistance program shall provide assurance that it operates in compliance with the OAA, as set forth in 45 CFR Section 1321.71.
9. As part of an integrated legal services delivery system, each legal assistance program that is not part of a Legal Services Corporation (LSC) project grantee shall have a system to coordinate its services with the existing LSC projects in the planning and service area in order to concentrate the use of funds provided under this definition to individuals with the greatest social and economic need. Each program shall also coordinate with the Legal Hotline for Michigan Seniors (LHMS) and the Counsel and Advocacy Law Line (CALL). Where feasible, each program should also coordinate with other low cost legal service delivery mechanisms, the private bar, law schools, and community programs in the service area to develop the targeting and program priority plan.
10. Each program shall make reasonable efforts to maintain existing levels of legal assistance for older individuals being furnished with funds from sources other than Title III Part B of the OAA.
11. A legal assistance program may not be required to reveal any information that is protected by attorney/client privilege. Each program shall make available non-privileged, non-confidential, and unprotected information which will enable the AAA to perform monitoring of the provider's performance, under contract, with regard to these operating standards.
12. Each legal assistance program should participate in statewide and local legal service planning groups including MPLP's Elder Law Task Force. Each legal assistance program is expected to participate in at least two (2) Task Force meetings per year. Participation by conference call/webinar is acceptable..
13. Each legal assistance program should participate in elder law training and technical assistance activities.
14. Each legal assistance program shall report program data through the Legal Services Information System (LSI) application of OSA's Aging Information System (AIS). Legal assistance programs will submit/post data in the LSI quarterly. Data shall be submitted no later than 30 days after the end of the quarter. AAAs will utilize the LSI to retrieve needed legal services program data and will consult with OSA prior to requiring additional reports or data from the legal program. The requirement for legal assistance programs to report data through the LSI shall be included in AAA/legal assistance program contracts.

LONG-TERM CARE OMBUDSMAN/ADVOCACY

Service Number: C-11 – Service Category: Community

Definition of Service

Provision of assistance and advocacy services to residents of long term care facilities to resolve complaints through problem identification and definition, education regarding rights, provision of information on appropriate rules, and referrals to appropriate community resources. The service also involves assistance to prospective long term care facility residents and their families regarding placement, financing and other long term care options. Identification and sharing of best practices in long term care service delivery, with an emphasis on promotion of culture change, is also part of the service. Each program must provide the following elements:

***Consultation/Family Support.** Provision of assistance to older adults and their families in understanding, identifying, locating, evaluating and/or obtaining long term care services.

***Complaint Investigation/Advocacy.** Receipt, investigation, verification and attempted resolution of individual complaints from residents or others acting on their behalf regarding any action which may adversely affect the health, safety, welfare and rights of a long term care facility resident. Complaint resolution processes include negotiation, mediation, and conflict resolution skills. This component also includes activities related to identifying obstacles and deficiencies in long term care delivery systems and developing recommendations for addressing identified problems.

***Non-Complaint Related Facility Visits.** Quarterly visits to each long term care facility in the project area. More frequent visits may occur where problems exist.

***Community Education.** Provision of information to the public including long term care facility residents, regarding all aspects of the long term care system elder abuse, neglect and exploitation. This component includes formal presentations, licensed facility and agency consultation, activities with the print and electronic media, development of consumer information materials.

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

Unit of Service

Each hour of family support, complaint investigation/advocacy, community education or volunteer support activities, including travel time to and from long term care facilities.

Minimum Standards

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

2. Each entity desiring to operate a local Ombudsman program shall be designated by the State Long Term Care Ombudsman (SLTCO) to provide services in the State of Michigan. Individuals employed by local Ombudsman providers must be certified as local ombudsman by the SLTCO.
3. Each designated local ombudsman program will adhere to program directions, instructions, guidelines, and Ombudsmanager reporting requirements issued by the SLTCO in the following areas:
 - a. Recruiting, interviewing and selection, initial training, apprenticeship and assessment of job readiness and credentialing of new local ombudsman staff and ombudsman volunteers;
 - b. Ongoing education, professional development, performance evaluation, as related to the annual certification and designation process;
 - c. Assignment to workgroups, task forces, special projects, meetings, both internal and external;
 - d. Conduct of local ombudsman work and activities;
 - e. Attendance at training/professional development events, staff meetings, quarterly training sessions and other educational events, or attendance as a presenter, as necessary;
 - f. Implementation and operation of the ombudsman volunteer program.
4. Each program shall maintain the confidentiality of client identity and client records in accordance with policies issued by the SLTCO
5. Each program shall establish linkage with Legal Assistance and Medicare/Medicaid Assistance Programs (MMAP) operating in the project service area and be able to assist clients in gaining access to available services, as necessary.
6. Each program shall maintain working relationships with OSA funded Care Management and Michigan Department of Community Health HCBS/ED Waiver projects operating in the project service area.
7. Each program shall work to prevent elder abuse, neglect and exploitation by conducting
 - a. professional/paraprofessional training, community outreach, public education, case consultation, and/or interdisciplinary teams shall be implemented through a coordinated, interagency approach.
8. Each program shall participate in coordinated, collaborative approaches to prevent elder abuse, neglect and exploitation which shall include the participation of, at a minimum, adult protective services staff of local Department of Human Services, long term care ombudsman/advocacy programs, and legal assistance programs operating in the project service area.
9. Each program shall develop and maintain, for the purposes of coordination, relationships with state and local law enforcement agencies and courts of competent jurisdiction.

10. Each program shall develop and maintain an effective working relationship with the local nursing home closure team for their area as designated by the Department of Community Health, Bureau of Health Systems.

11. Each program shall be able to demonstrate working relationships with local offices of the Department of Human Services, and local county public health agencies.

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

13. Program staff shall receive training in the following areas: common characteristics, conditions and treatments of long term care residents; long term care facility operations; long term care facility licensing and certification requirements; Titles XVIII and XIX of the Social Security Act; interviewing, investigating, mediation and negotiation skills; culture change, management of volunteer programs, and other areas as designated by the SLTCO.

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

15. Each program shall maintain a financial management system that fully and accurately tracks, and accounts for the use of, all funds received from OSA and area agencies on aging.

16. Each program shall comply with Long Term Care Ombudsman/Advocacy Operating Standards and SLTCO program policy standards

MEDICATION MANAGEMENT

Service Number: B-7 – Service Category: In-home

Definition of Service

Direct assistance in managing the use of both prescription and over the counter (OTC) medication. Allowable program components include:

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

Unit of Service

Equal to each 15 minutes (.25 hours) of component activities performed.

Minimum Standards

1. Each program shall employ a registered nurse (RN) who supervises program staff and is available to staff when they are in a client's home or making telephone reminder calls. Each program shall employ program staff who are appropriately licensed, certified, trained, oriented and supervised.

2. The supervising nurse shall review and evaluate the medication management care plan and the complete medication regimen, including prescription and OTC medications, dietary supplements and herbal remedies, with each client and appropriate caregiver. Each program shall implement a procedure for notifying the client's physician(s) of all medications being managed.

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

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

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

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

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

- a. Each medication being taken.

- b. The dosage for each medication.
- c. Label instructions for use for each medication.
- d. Level of service provided and initials of person providing service.
- e. Date and time for each time services are provided.

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

NUTRITION SERVICES – CONGREGATE MEALS

Service Number: C-3 – Service Category: Community

Definition of Service

The provision of nutritious meals to older individuals in congregate settings. The service includes provision of nutrition education services and other appropriate nutrition services for older persons.

Unit of Service

Each meal served to an eligible participant

Minimum Standards

1. Each program shall have written eligibility criteria that places emphasis on serving older individuals in greatest need and includes, at a minimum:
 - a. That the eligible person must be 60 years of age or older, or be the spouse or partner of a person 60 years of age or older.
 - b. That individuals living with disabilities who have not attained 60 years of age but who reside in housing facilities occupied primarily by older adults at which congregate nutrition services are provided, may receive such services.
 - c. That non-older adult individuals living with disabilities who reside in a noninstitutional household may accompany an eligible older individual and may participate on the same basis as the elderly participants.
 - d. Whether, at the provider's discretion, a non-senior volunteer who directly supports meal site and/or food service operations may be provided a meal. Such meals may be provided only after all eligible participants have been served and meals are available. A fee is not required for non-senior volunteer meals and such meals are to be included in National Aging Programs Information System (NAPIS) meal counts.
2. At the provider's discretion, persons not otherwise eligible may be served, if meals are available, and they pay the full cost of the meal. The full cost includes raw food, preparation costs, and any administrative and/or supporting services costs. Documentation that full payment has been made shall be maintained.
3. Each congregate nutrition provider shall be able to provide information relative to eligibility for home delivered meals and be prepared to make referrals for persons unable to participate in the congregate program and who appear eligible for a home delivered meals program.
4. Each congregate meal site shall be able to document:
 - a. That it is operated within an accessible facility. Accessibility is defined as a

participant living with a disability being able to enter the facility, use the rest room, and receive service that is at least equal in quality to that received by a participant not living with a disability. Documentation from a local building official or licensed architect is preferred. A program may also conduct accessibility assessments of its meal sites when utilizing written guidelines approved by the respective Area Agency on Aging (AAA).

b. That it complies with local fire safety standards. Each meal site must be inspected, by a local fire official, no less frequently than every three years. For circumstances where a local fire official is unavailable after a formal (written) request, a program may conduct fire safety assessments of its meal sites when utilizing written guidelines approved by the respective AAA.

c. Compliance with Michigan Food Code and local public health codes regulating food service establishments. Each meal site and kitchen operated by a congregate meal provider shall be licensed, as appropriate, by the local health department. The local health department is responsible for periodic inspections and for determining when a facility is to be closed for failure to meet Michigan Food Code standards. The program shall submit copies of inspection reports on all facilities to the respective AAA within ten days of receipt. It is the responsibility of the program to address noted violations promptly.

5. Each program, through a combination of its meal sites, must provide meals at least once a day, five or more days per week. Programs may serve up to three meals per day at each meal site.

6. Each site shall serve meals at least three days per week with a minimum annual average of 10 eligible participants per serving day. If the service provider also operates a home delivered meals program, home delivered meals sent from a site may be counted towards the 10 meals per day service level. Waivers to this requirement may be granted by the respective AAA only when the following can be demonstrated:

a. Two facilities must be utilized to effectively serve a defined geographic area for three days per week.

b. Due to a rural or isolated location, it is not possible to operate a meal site three days per week.

c. Seventy-five percent or more of participants at a meal site with less than 10 participants per day are in great economic or social need. Such meal sites must operate at least three days per week.

7. Congregate meal sites currently in operation by the program may continue to operate unless the respective AAA determines relocation is necessary in order to more effectively serve socially or economically disadvantaged older persons. New and/or relocated meal sites shall be located in an area which has a significant concentration of the over aged 60 population living at or below the poverty level or with an older minority or ethnic population comprising a significant concentration of the total over-60 population. The Michigan Office of Services to the Aging (OSA) must approve, in writing,

the opening of any new and/or relocated meal site prior to the provision of any meals at that site and receive service that is at least equal in quality to that received by able-bodied participants.

8. When a meal site is to be permanently closed, the following procedures shall be followed:

a. The program shall notify the respective AAA in writing of the intent to close a meal site.

b. The program shall present a rationale for closing the meal site which is based on

lack of attendance, inability to meet minimum standards and/or other requirements, loss of resources, or other justifiable reason.

c. The respective AAA shall review the rationale and determine that all options for keeping the site open or being relocated have been exhausted. If there remains a need for service in the area that was served by the meal site, efforts should be made to develop a new meal site and/or assist participants to attend another existing meal site.

d. The respective AAA shall approve in writing the closing of all meal sites operating with funds awarded from OSA and notify OSA of all meal site closings. If a meal site to be closed is located in an area where low-income and/or minority persons constitute 25% or more of the population, or if low-income and/or minority persons constituted more than 25% of meal participants served over the past 12 months, OSA must also approve in writing the closing of the meal site.

e. The program shall notify participants at a meal site to be closed of the intent to close the site at least 30 days prior to the last day of meal service.

9. Each program shall document that appropriate preparation has taken place at each meal site for procedures to be followed in case of an emergency including:

a. An annual fire drill.

b. Staff and volunteers shall be trained on procedures to be followed in the event of a severe weather storm or natural disaster and the county emergency plan.

c. Posting and training of staff and regular volunteers on procedures to be followed

in the event of a medical emergency.

10. Each program shall have written agreements with the owners of all leased facilities used as meal sites. Written agreements are recommended for donated facilities, but not required. The agreements shall address at a minimum:

a. Responsibility for care and maintenance of facility, specifically including restrooms, equipment, kitchen, storage areas and areas of common use.

b. Responsibility for snow removal.

c. Agreement on utility costs.

d. Responsibility for safety inspections.

e. Responsibility for appropriate licensing by the Public Health Department.

f. Responsibility for insurance coverage.

- g. Security procedures.
- h. Responsibility for approval of outside programs, activities and speakers.
- i. Other issues as desired or required.

11. A program may enter into an agreement with an organization operating a congregate meal site in order for that organization to receive Nutrition Services Incentive Program (NSIP) funding for meals served to persons aged 60 and over, upon approval of the respective AAA. Any meal site receiving NSIP-only funding must operate in compliance with all federal requirements and state operating standards pertaining to the congregate meal program and assure the availability of adequate resources to finance the operation of the meal site without charge to program participants. The program shall have a written agreement with each organization operating NSIP-only meal sites. This agreement shall be either OSA's standardized "Agreement for Receipt of Supplemental NSIP Cash Payment" or one that contains the same components.

12. Each program shall display, at a prominent location in each meal site, the OSA Community Nutrition Services poster. The program may use its own poster as long as all required information is included and clearly presented. The poster shall contain the following information for each program: the name of the nutrition project director; the nutrition project director's telephone number; the suggested donation for eligible participants; the guest fee to be charged non-eligible participants; and, a statement of non-discrimination identical to the language on the OSA poster. Additional information pertaining to the program shall not be displayed so as to avoid any misunderstanding or confusion with information presented on the poster.

13. Each program shall make available, upon request, food containers and utensils for participants who are living with disabilities.

14. Congregate meal programs receiving funds through OSA may not contribute towards, provide staff time, or otherwise support potluck dining activities.

15. Each program shall have a project council, comprised of program participants, to advise program administrators about services being provided. Program staff shall not be members of the project council.

16. Temporary Meal Site Closings. If a meal site must be closed, or moved temporarily, the nutrition provider must notify the AAA and in turn, the AAA must notify the OSA field representative via facsimile or email, including information on why the closing occurred, how long it will last, how participants will be notified. Refer to Transmittal Letter #2009-175.

17. Food Taken Out of Meal Site (leftovers). Nutrition providers may allow leftovers (food served to participants and not eaten) to be taken out of the site if the following

conditions are met:

- a. A sign shall be posted near the congregate meal sign informing the meal participants that all food removed from the site becomes the responsibility of the individual.
- b. All new congregate participants receive written material about food safety and preventing food-borne illness when they sign up.
- c. All participants receive written material about food safety and preventing foodborne illness annually.
- d. The individual is required to sign a waiver statement that should be added to the National Aging Program Information System form that states the individual understands that they are responsible for food taken out of the site.
- e. Containers are not provided for the leftovers

18. If a regular congregate meal participant is unable to come to the site due to illness, the meal may be taken out of the site to the individual for no more than seven days. If needed for more than seven days, the participant should be evaluated for home delivered meals. If the person taking out the meal is also a regular congregate participant, they may also take their meal out.

19. Off-Site Meals. Off-site meals that are part of an organized older adult activity are allowed if the following conditions are met:

- a. The activity must be sponsored by an aging network agency/group. (For example, Council/Commission on Aging, senior center, etc.)
- b. The sponsoring agency has worked with the nutrition provider to meet the standards.
- c. The activity, including the meal, must be open to all eligible participants.
- d. The take away meal must meet all the requirements of food safety, and be foods that are low-risk for food borne illness.
- e. Local health department rules and regulations, if any, supersede this standard and must be followed.
- f. The meal site must provide written notification to the AAA nutrition program staff person prior to the event.
- g. AAA nutrition program staff person must inform their OSA field representative of the date, time, and sponsoring agency of the activity prior to the event.
- h. Covered under Transmittal Letter #2008-167.

20. Second Meal Option. Nutrition providers may elect to offer second meals at specified dining sites. A second meal is defined as a shelf-stable meal, a frozen meal, or a meal that is low-risk for food borne illness. A congregate meal participant may qualify for a second meal if:

- a. The participant eats a regularly scheduled meal at the meal site;

b. The participant has requested a second meal following the nutrition provider's process; (i.e. phone request). The second meal must meet the OSA nutrition standards. Donations may be accepted for second meals. The second meal is given to the participant when they leave the congregate site. It must be stored properly until the participant is ready to leave for the day. The second meal is to be counted as a congregate meal in all record keeping. The second meal option does not apply to NSIP-only sites. Refer to Transmittal Letter #2009-191

21. Participant Choice. Person-Centered Planning involves participant choice. Participants in this program are allowed to participate in both home delivered and congregate programs at the same time. Proper documentation must be kept as to the home-delivered meal schedule and the congregate schedule. An agreement between the AAA and the nutrition provider regarding participants who may be in both programs is encouraged.

22. Voucher Meals. Nutrition providers may develop a program using vouchers for meals to be eaten at a restaurant, café, or other food service establishment. The program must meet the following standards:

a. The restaurant, café, or other food service establishment must be licensed, and

follow the Michigan Food Code, and is inspected regularly by the local health jurisdiction.

b. The restaurant, café, or other food service establishment agrees to provide at least one meal that meets Association on Aging and OSA nutrition standards for meals.

c. The restaurant, café, or other food establishment must be barrier-free and Americans with Disabilities Act (ADA) compliant.

d. The nutrition provider and restaurant, café, or other food establishment must have a written agreement that includes: 1) how food choices will be determined: 2) how food choices will be advertised/offered to voucher holder: 3) how billing will be handled (will a tip be included in the unit price, i.e. if the meal reimbursement is \$6.25, will \$.25 be used toward the tip?); 4) How reporting takes place (frequency and what is reported): 5) evaluation procedures: and 6) a statement that voucher holders may take leftovers home, and that they may purchase additional beverages and food with their own money.

e. A copy of the written agreement shall be given to the AAA nutrition program coordinator.

f. A written plan must be developed and kept on file that includes consideration of the following items: 1) location of the restaurant, café, or other food service establishment in regard to congregate meal site locations; 2) establishment of criteria for program participation – how restaurant, café, or other food service establishments are selected to participate and how new establishments can apply to participate; 3) how older adults qualify for and obtain their vouchers, i.e. senior centers, nutrition provider office, nutrition program representative meets with older adults and the restaurant, café, or other food service establishment to issue vouchers and collect donations; and, 4) how frequently menu choices will

be reviewed and revised by the AAA Dietitian or equivalent.

g. Nutrition providers must allow older adults to use congregate meal sites and voucher programs interchangeably. If a nutrition provider chooses to do so, the plan described in item f. above must detail how this will be done.

23. Adult Foster Care/other Residential Care. Adult Foster Care (AFC) or other residential providers that bring their residents to congregate meal sites shall be requested to pay the suggested donation amount for meals provided to residents and staff 60 years of age or older. For those AFC residents and staff under the age of 60, the guest charge must be paid as posted at each meal site. The congregate meal provider may request the AFC program to provide staff to assist the residents they bring with meals and other activities attended.

24. Complimentary Programs/Demonstration Projects. AAAs and nutrition providers are encouraged to work together to provide programming at the congregate meal sites that include activities and meals. AAAs and nutrition providers may conduct a demonstration project to assess the feasibility of alternate delivery systems for congregate meals, such as but not limited to, providing a sack meal for persons that participate in an activity at the site that is not immediately before or after a scheduled meal time. Demonstration projects must be approved by OSA prior to implementation.

NUTRITION SERVICES – HOME DELIVERED MEALS (HDM)

Service Number: B-5 –Service Category: In-Home

Definition of Service

Provision of low-cost, nutritionally-sound meals to persons who have been properly assessed as physically or mentally incapable of preparing their own meals.

Unit of Service

One meal served to an eligible participant

Minimum Standards

1. Each program shall have written eligibility criteria which includes, at a minimum:
 - a. That, to be eligible, a person must be 60 years of age or older, or be the spouse of a person 60 years of age or older, or be an individual with disabilities who resides in a non-institutional household with a person eligible for and receiving home delivered meals.
 - b. That the spouse, or unpaid caregiver, if over 60, of an eligible client, or an individual with disabilities residing with an eligible client, may receive a home delivered meal if the assessment indicates receipt of the meal is in the best interest of the client.
 - c. That to be eligible, a person must be homebound; i.e., does not leave his/her home under normal circumstances.
 - d. That to be eligible, a person must be unable to participate in the congregate nutrition program because of physical or emotional difficulties.
 - e. That to be eligible, a person must be unable to obtain food or prepare complete meals.

- f. That there is no adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
- g. That the person's special dietary needs can be appropriately met by the program; i.e., the meals available would not jeopardize the health of the individual.
- h. That to be eligible, a person must be able to feed him/herself.
- i. That to be eligible, a person must agree to be home when meals are delivered, or contact the program when absence is unavoidable.

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

2. Each home delivered meal program must demonstrate cooperation with congregate and other home delivered meal programs in the project area. If the same provider operates both congregate and home delivered meal programs for an area, it must be able to demonstrate effective utilization of existing congregate meal sites and personnel for the home delivered meal program. If the home delivered meal provider is not a congregate provider, Minimum Standards 8, 12, 13, 15, 16, 21, 22, 23, 24, 26, 27 and 34, as detailed under Congregate Meals, must also be complied with.
3. Each home delivered meal program will use volunteers, as feasible, in program operations.
4. Each program may provide up to three meals per day to an eligible client based on his/her need for meal service as determined by assessment. Providers are expected to vary the level of meal service for an individual in response to varying availability of help from family and friends and changes in the participant's status or condition. Where meal services are provided less than seven (7) days per week, the program shall identify and/or document the usual source of all meals for the client not provided by the program. Providers must provide seven (7) day meal service to all eligible clients.
5. Each home delivered meal provider must have the capacity to provide three meals per day, which together contain at least all of the daily recommended dietary allowances as established by the Food and Nutrition Board of the National Academy of Sciences – National Research Council. Meals must be available at least five days per week.

At least one meal must be served hot, unless a variance is approved by the area agency dietitian. For any meal delivered in a frozen state and to be heated by the client, the dietitian must approve the menu as appropriate for meal preparation method. Meal pattern can be altered based on client choice. Effort should be made to use high fiber foods. Meal patterns are to comply with the USDA food pyramid. Meals, whether delivered frozen or hot, must conform to the following meal pattern.

a. IF ONLY ONE MEAL IS SERVED

<p>Meat or Meat Alternative Group</p>	<p>If the provider only serves one main meal, they shall offer no less than three ounces of cooked edible portion of meat, fish, fowl, eggs, or cheese. The provider may occasionally use meat alternates to supplement protein for variety and may include cooked dried beans or peas, seeds, nuts, or peanut butter. A protein source may contain a combination of meat, fish, fowl, eggs, or cheese.</p>
<p>Vegetables and Fruit Group</p>	<p>The provider shall offer two, one-half cup servings. The provider may use all vegetables and all fruits, including fruit packed in light syrup. The provider may make water packed or juice packed fruit available to participants upon request, if feasible. The provider may occasionally use full strength vegetable and fruit juices, particularly when needed to meet Vitamin C requirements.</p>
<p>NOTE: Rice, spaghetti, macaroni, and noodles are not vegetables. The provider shall not consider tater-tots and hash browns vegetables due to their low vitamin content. The provider shall not consider fruit used as dessert toward the two servings of vegetables and fruits.</p>	
<p>Bread or Cereal, Rice and Pasta Group</p>	<p>The provider shall offer two servings. The provider may use enriched or whole-grain bread, biscuits, muffins, dinner rolls, sandwich buns, cornbread, and other hot breads. Alternates may include enriched or whole-grain cereals or cereal products such as spaghetti, macaroni, rice, dumplings, pancakes, and waffles.</p>
<p>Fat Exchange</p>	<p>The provider shall offer one serving.</p>
<p>Dessert Group</p>	<p>The provider shall offer one one-half cup serving. The dessert is in addition to other menu requirements. All fruit and simple desserts such as puddings, gelatin desserts, ice cream, ice milk, and sherbet are included. Fruit may be fresh or packed in light syrup. If feasible, the provider may make water packed or juice packed fruit available to participants upon request. The provider shall make fruit available as a dessert in two out of five meals a week.</p>

Milk Group	The provider shall offer eight (8) ounces or equivalent of vitamin A and D fortified skim or low fat milk. The provider may also use low fat buttermilk. The provider may substitute yogurt for milk.
Optional Beverages	The provider may use coffee, tea, decaffeinated beverages, and fruit flavored drinks.

b. The second meal, which is to be delivered cold, must conform to the following meal pattern:

Meat or Meat Alternative Group	The provider shall offer two ounces of cooked edible portion of meat, fish, fowl, eggs, or cheese. The provider may occasionally use meat alternates for variety. The provider shall avoid luncheon meats because of their high salt and fat content.
Vegetables And Fruit Group	The provider shall offer two one-half cup servings. If the provider serves juices, they shall be full-strength.
Bread or Cereal, Rice and Pasta Group	The provider shall offer two slices of bread or equivalent. Alternates may include biscuits, bread, muffins, dinner rolls, sandwich buns, cornbread, and unsweetened cereal products such as macaroni, rice, pancakes, or waffles. The provider shall use whole grain products whenever possible.
Milk Group	The provider shall offer one half pint of vitamin A and D fortified skim or low fat milk. The provider may substitute yogurt for milk.
Butter, Margarine, Fat or Oil	The provider shall offer one teaspoon. The provider may serve as a spread for butter or in food preparation, including seasoning for vegetables. The provider may substitute salad dressings or mayonnaise.

c. An optional meal (breakfast) can be provided. The meal pattern is the same as the second, except no protein source is required.

In addition to the above meal patterns, menus must meet the following specifications:

- a. A variety of foods shall be included in a 20-day menu cycle. Recipes within the meat, vegetable and fruit, and dessert groups should be different for the same days of each week.
- b. Each week's menus must include, at a minimum, three foods which are rich in sources of Vitamin A and a daily source rich in Vitamin C. A

combination of foods may be used to meet vitamin requirements. A rich source is defined as one which provides at least 33% of the current Adult Male Recommended Dietary Allowance as published by the National Research Council of the National Academy of Science.

- c. Each day's menu must include a variety of colors, textures and flavors.
 - d. Foods must be under-salted in cooking. Each meal should contain less than 1,500 mg sodium total. A meal containing more than 1,500 mg of sodium may be served only once in a 20-day menu cycle.
 - e. Protein can come from more than one source, though not from the bread and milk groups.
 - f. High fiber foods shall be used.
 - g. Relish trays and raw vegetables may be counted toward the required fruit/vegetable serving once a week. While coleslaw, lettuce, spinach, or tomatoes may be used at any time, they do not constitute a relish tray.
 - h. Modified diets (diabetic, low-sodium, low-fat, texture modified, and dietary supplements), where feasible and appropriate, shall be provided for meeting the particular dietary need arising from health requirements of participants. The provider must assure that a current physician's written diet order is on file for participants consuming any modified diet.
 - i. Programs should modify serving sizes and menu ideas to provide client choice.
6. The program must also make liquid meals available. The following requirements apply to those clients certified by their physician as using liquid meals as the sole source of nutrition.
- a. Such meals must individually meet one-third RDA and be at least 440 calories.
 - b. Diet orders, and renewals, for liquid meals must include client weight, calorie counts, protein, carbohydrates, and fat levels or the specific brand name.
 - c. The expected duration must be on file at the beginning of service provision.
 - d. Liquid meal diet orders must be renewed every six months.
 - e. If the program does not provide the full daily diet for liquid meal recipients, documentation must be made as to the provision of the balance of the daily diet.
 - f. The care plan for clients receiving liquid meals must be developed in consultation with a Registered Nurse available through the Care Management program or the client's physician. The area agency nutritionist should review liquid diet orders that are in place for one year or longer if the client is not on Care Management or Waiver.
 - g. The program must provide instruction to the client, client's caregiver, and client's family in proper administration and storage of liquid meals.
 - h. Liquid meals as a part of HDM of supplement – liquid nutritional supplements that are ordered by the care managers may be provided.

7. The time period between the end of preparation of either hot or cold food and delivery to the client in their home must not exceed four (4) hours. Products which do not need to be held above 140°F or below 45°F are exempt. Frozen food must be delivered to the client in the frozen state, 32°F or below.
8. The program must also make specialized meals available. Specialized meals include: Heart friendly, (Low sodium, low fat); Diabetic, Renal (low sodium, low potassium), Vegetarian and Liquid Nutrition. Specialized meal must meet the following requirements:
 - a. Be approved by a dietitian;
 - b. Must be identified as a specialized meal on the quarterly menu submission;
 - c. Must have a corresponding diagnosis (i.e. high cholesterol, heart disease, obesity for Heart friendly meals, Renal Failure for Renal meals, etc). Note: Vegetarian meals do not require a diagnosis.
 - d. A doctor's order/prescription must be obtained for the above mentioned specialized meals; and
 - e. Specialized meals orders/prescriptions must be renewed every six months.
9. Food must be delivered at safe temperatures.
 - a. Hot foods not maintained at 140°F or above upon delivery shall not be served. Temperature logs should be maintained by meal sites.
 - b. Cold foods not maintained at 45°F or below upon delivery shall not be served.
 - c. Frozen meals, when feasible and appropriate, can be provided.
 - i. Frozen foods not maintained at 32°F or below shall not be left with the client.
 - ii. Clients without appropriate appliances to maintain frozen food in a frozen state and to heat it to a proper serving temperature shall not receive frozen meals.
 - iii. The program must verify and maintain records that indicate each client has and maintains the ability to handle frozen meals.
 - iv. Frozen meals may only be provided in situations where it is not logistically feasible to provide the client with hot meals, with the exception of holidays, weekends, or emergency situations.
10. Each program must develop and have available written plans for continuing services in emergency situations such as short-term natural disasters (i.e., snow and/or ice storms), loss of power, physical plant malfunctions, etc. Staff and volunteers are to be trained on procedures to be followed in the event of severe weather or natural disasters and the county emergency plan.

11. Each program must develop and utilize a system for documenting meals served for purposes of receiving reimbursements from USDA. Meals eligible for USDA reimbursement are those served to eligible clients which meet the meal pattern requirements specified above.

Acceptable methods for documenting meals served include:

- a. Obtaining signatures daily from clients receiving meals.
- b. Maintaining a daily or weekly route sheet signed by the driver which identifies the client's name, address, and number of meals served to them each day.

12. The program may provide meals to a person under age 60, other than the spouse, if that person meets all other eligibility criteria and pays the full cost of the meal. The full cost includes raw food, preparation costs, and any administrative and/or supporting services cost. Documentation that full payment has been made must be maintained. All revenues from such meals are to be considered program income.

13. Each program must provide monthly nutrition education appropriate to home delivered meals clients. Topics should include food, nutrition, behavior patterns, consumerism and health.

14. The area agency may adjust the number of nutrition grantees to meet the needs of the region.

15. The provider shall use food cost and inventory systems, as prescribed by OSA minimum standards.

16. Each program must complete a care management prescreen and nutrition screening initiative checklist for each individual placed on a waiting list for home delivered meals. This information is in addition to that required by the General Requirements for In-Home Service Programs.

17. The provider shall ensure that meal production meets minimum standards.

18. The provider shall maintain a system for the confidential collection of contributions.

19. The provider shall provide a system to securely collect all donations.

20. The program shall accept food stamps as a donation/contribution for the home delivered meal program.

21. Meal preparation site must be licensed by the Department of Health, in accordance with the Public Health Code of Michigan.

22. Each meal served must meet minimum standards, defined by state and/or federal policies, which are designed to ensure that meals provide, at a minimum, one-third of the current Adult Recommended Daily Allowance, as defined by the Food and Nutrition Board of the National Research Council.
23. Applicant agency must have the capacity to provide two meals per day per client. These meals must be available seven (7) days per week.
24. Grantee must assure the number of meals a person receives per day and per week is based on his/her need for service, as determined by the assessment of the individual.
25. Menus must be approved by an area agency dietitian/nutritionist.
26. Project director must be qualified, by training or experience, to administer the program.
27. Staff or volunteers preparing and serving meals must be trained in proper food service practices.
28. Applicant shall have insurance to cover any indemnity loss of federal, state and local resources due to casualty or fraud. All property purchased, in whole or in part, with funds awarded by the Valley Area Agency on Aging (VAAA) are to be covered with sufficient insurance. The following insurances are required for each program:
 - Worker's compensation
 - Unemployment
 - Property and theft
 - Fidelity bonding (for persons handling cash)
 - Facility insurance (for facilities purchased with federal and/or state funds)
 - No-fault vehicle insurance (for agency owned vehicles)
 - General liability
29. Applicant is to provide at least one meal for major holidays (Easter, Christmas, New Year's Day, 4th of July and Thanksgiving Day); and one meal for a minor holiday (Columbus Day, Memorial Day, Labor Day, Martin Luther King Birthday or President's Day.)
30. Applicant must comply with the minimum standards for nutrition services, as approved by the Michigan Office of Services to the Aging.
31. Each nutrition provider must submit a copy of current Health Department Inspections and Fire Safety Inspections to VAAA within 10 days of receipt.

NUTRITION SERVICES – HOME DELIVERED MEAL ASSESSMENTS (HDM)

Service Number: B-5 –Service Category: Access

Definition of Service

The provision of initial assessments and periodic reassessments of individuals' health and social status to determine eligibility for home delivered meals and other services.

Unit of Service

Equal to one assessment or reassessment.

Minimum Standards

1. In cooperation with the nutrition service provider and the VAAA, the program shall establish written eligibility criteria which include:
 - a. That, to be eligible, a person must be 60 years of age or older or be the spouse of a person 60 years of age or older.
 - b. That the spouse of an eligible client may receive a home delivered meal if the assessment indicates receipt of the meal is in the best interest of the client.
 - c. That, to be eligible, a person must be homebound (i.e., does not leave his/her home under normal circumstances.)
 - d. That, to be eligible, a person must be unable to participate in the congregate nutrition program because of physical or emotional difficulties.

- e. That, to be eligible, a person must be unable to obtain food or prepare complete meals.
 - f. That there is no adult living at the same residence or in the vicinity that is able and willing to prepare all meals.
 - g. That the person's special dietary needs can be appropriately met by the program (i.e., the meals available will not jeopardize the health of the individual.)
 - h. That, to be eligible, a person must be able to feed him/herself.
 - i. That, to be eligible, a person must agree to be home when meals are delivered, or contact the home delivered meal program when absence is unavoidable.
2. Eligibility criteria must be distributed to all potential referring agencies or organizations and be available to the general public upon request.
 3. Home delivered meals may be provided to persons under age 60, other than the spouse, if that person meets all other eligibility criteria and pays the full cost of the meal. Persons under age 60 who request an assessment must understand and agree to pay full cost of the meal, if found eligible, prior to the assessment visit.
 4. Eligibility criteria may be reviewed periodically with the nutrition service provider and VAAA, if necessary, to avoid a waiting list or to establish prioritization for a waiting list.
 5. Each program shall conduct an assessment of need for each participant within 14 days of initiating service. At a minimum, each participant shall receive two assessments per year, a yearly assessment and a six-month re-assessment. The initial assessment and yearly assessment must be conducted in-person. The six-month re-assessment may be either in-person or a telephone assessment.
 6. A telephone re-assessment may be used if the participant meets the following criteria:
 - 1) is able to complete a telephone assessment by themselves, or with the assistance of a family member, caregiver or friend;
 - 2) has no significant HDM delivery issues; and,
 - 3) the HDM driver, delivery person, and family and/or caregivers have no significant concerns for the participant's well-being. The nutrition provider may deem a participant not eligible for the telephone re-assessment at any time during their participation in the program. In-person assessments will then replace the telephone re-assessment.

7. The program should avoid duplicating assessments of individual participants to the extent possible. HDM programs may accept assessments and re-assessments of the participant conducted by case coordination and support programs, care management programs, other in-home service providers, home and community based Medicaid programs, other aging network home-care programs, and Medicare certified home health providers. Participants with multiple needs should be referred to case management programs as may be appropriate.
8. If the HDM program is the only program the participant will be currently enrolled in, the assessment and re-assessments must, at a minimum, include:
9. Agency will ensure the assessment of each potential home delivered meal recipient is conducted not more than four (4) days following the referral for services.
10. The assessment must be conducted in person prior to initiating the service.
11. Home delivered meals may be initiated prior to the assessment only in a documented emergency situation. In such special situations, the assessment must be conducted within four (4) days of initiating the service.
12. Each client must be reassessed every six months, unless circumstances require more frequent reassessments. Each assessment and reassessment should include a determination of when reassessment should take place.
13. Staff conducting assessments must be professionally qualified.
14. The program must have access to an RN for assistance in reviewing assessments and have linkages with appropriate health care program.
15. Preference will be given to the agency providing homemaker and personal care services in Genesee County, in order to avoid duplication of assessments.
16. Assessments and reassessments must include the identification of other service needs and referral to other needed services.
17. Assessors must attempt to acquire the information listed below, but must also recognize and accept the client's right to refuse to provide requested items. Changes in any item should be specifically noted during reassessments.
 - a. **Basic information –**
 1. Individual's name, address and phone number
 2. Source of referral
 3. Name and phone number of emergency contact
 4. Name and phone numbers of caregivers

5. Gender
6. Age, date of birth
7. Living arrangements
8. Whether or not the individual's income is below the poverty level and/or sources of income (particularly Supplemental Security Income).

b. Functional status –

1. Vision
2. Hearing
3. Speech
4. Changes in oral health
5. Prostheses
6. Current chronic illnesses or recent (within past 6 months) hospitalizations.

c. Support services –

1. Services currently receiving
2. Extent of family and/or informal support network

d. Participant Satisfaction (re-assessment only)

1. Participant's satisfaction with services received
2. Participant's satisfaction with program staff performance.

18. The agency must develop a specific working agreement with the nutrition service provider, specifying the methods of referral of eligible clients to the service provider and other procedures needed to ensure smooth delivery of service to clients.

19. A service plan must be developed for each client, specifying the number of meals served per day, days of service, and special diet orders or requests.

20. The agency must develop a written termination policy, in conjunction with the nutrition service provider and VAAA, which specifies acceptable reasons for termination and formal notification of client.

21. The program must have working agreements for coordination of services with the case management demonstration program and with other service programs which may be referral sources or to which clients may need referrals.

22. The program must require and thoroughly check references on paid staff prior to entering client's homes. In addition, each program must conduct an annual criminal background review through the Michigan State Police for each paid and/or volunteer staff per son who will be entering client homes. The costs for such background reviews may be charged against grant funds received under an area plan.

OUTREACH

Service Number: A-5 - Service Category: Access

Definition of Service

Efforts to identify and contact isolated older persons and/or older persons in greatest social and economic need who may have service needs and assisting them in gaining access to appropriate services. Outreach does not include comprehensive assessment of need, development of a service plan, or arranging for service provision.

Unit of Service

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

Minimum Standards

1. Each program shall have a uniform intake procedure which identifies and documents client needs. Persons who appear to have multiple needs shall be referred to a case coordination and support or care management program, where available.
2. Each program shall establish linkages with I&A programs in the project area and be able to assist clients in gaining access to available services, as necessary.
3. A follow-up contact shall be made on an annual basis with at least 15 percent of individuals served to determine whether needed services have been received.
4. Each program located in areas where non-English or limited English speaking older persons are concentrated shall have bilingual personnel available. Such interpreters do not have to be paid staff persons.
5. Each program shall specify annually how it intends to satisfy the service needs of low-income minority individuals in its respective service area.
6. Each program, to the maximum extent feasible, shall provide services to low-income minority individuals in accordance with their need for such services.
7. Each program must meet the specific objectives established by the AAA for providing services to low income minority individuals within the planning and service area.
8. Each program shall identify those eligible for assistance with a special emphasis on older individuals:
 - a. Residing in rural areas;

- b. With greatest economic need (with particular attention to low-income minority individuals);
 - c. With greatest social need (with particular attention to low-income minority individuals);
 - d. With severe disabilities;
 - e. Who are Native American;
 - f. With limited English speaking ability; and
 - g. With Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals).
9. Each program shall make efforts to inform older individuals identified in Minimum Standard 8 and the caretakers of such individuals, of the availability of assistance.

Assistive Devices and Technologies

Service Number: B-9 – Service Category: In-Home

Service Definition

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

Unit of Service

One device, plus installation and training as appropriate, provided to a program participant.

Service Description

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

Minimum Standards

1. Each program must coordinate with other appropriate service providers in the community in order to avoid an unnecessary duplication of services.
2. All devices installed must conform to local building codes, as applicable, and meet respective UL® safety standards.
3. Funds awarded for assistive devices and technologies may be used for labor costs and to purchase devices to be installed.
4. With regard to Personal Emergency Response Systems (PERS), the following additional requirements must be met:
 - a. Equipment used must be approved by the Federal Communication Commission and must meet UL® safety standards specifications for Home Health Signaling Equipment.
 - b. Response center must be staffed 24 hours/day, 365 days/year with trained personnel. Response center will provide accommodations for persons with limited English proficiency.
 - c. Response center must maintain the monitoring capacity to respond to all incoming emergency signals.
 - d. Response center must be able to accept multiple signals simultaneously. Calls must not be disconnected for call-back or put in a first call, first serve basis.
 - e. Provider will furnish each responder with written instructions and provide training as appropriate.

f. Provider will verify responder and contact names semi-annually to assure current and continued participation.

g. Provider will assure at least monthly testing of the PERS unit to assure continued functioning.

h. Provider will furnish ongoing assistance, as necessary, to evaluate and adjust the PERS instrument or to instruct participants and responders in the use of the devices, as well as to provide for performance checks.

i. Provider will maintain individual participant records that include the following:

i. Service order.

ii. Record of service delivery, including documentation of delivery and installation of equipment, client/caregiver orientation, and monthly testing.

iii. List of emergency responders.

iv. Case log documenting client and responder contacts.

RESPITE CARE

Service Number: B-10 – Service Category: In-Home

Definition of Service

Provision of companionship, supervision and/or assistance with activities of daily living for persons with mental or physical disabilities and frail older persons in the absence of the primary care giver(s). Respite care may be provided at locations other than the client's residence.

Unit of Service

Each hour of respite care provided.

Minimum Standards

1. Each program must establish written eligibility criteria which include at a minimum:
 - a. That clients must require continual supervision in order to live in their own homes or the home of a primary care giver, or require a substitute care giver while their primary care giver is in need of relief or otherwise unavailable; and/or
 - b. That clients may have difficulty performing or be unable to perform activities of daily living (ADLs) without assistance as a result of physical or cognitive impairment.
2. Respite care services include:
 - a. Attendant care (client is not bed-bound) - companionship, supervision and/or assistance with toileting, eating and ambulation; and,
 - b. Basic care (client may or may not be bed-bound) - assistance with ADLs, routine exercise regimen, and assistance with self-medication.
 - c. Respite care may also include chore, homemaking, home care assistance, home health aide, meal preparation and personal care services. When provided as a form of respite care, these services must also meet the requirements of that respective service category.
3. Each program shall ensure that the skills and training of the respite care worker to be assigned coincides with the service plan of the client, client needs, and client preferences. Client needs may include, through are not limited to, cultural sensitivity, cognitive impairment, mental illness, and physical limitation.
4. An emergency notification plan shall be developed for each client, in conjunction with the client's primary caregiver.
5. Each program shall establish written procedures to govern the assistance to be given participants in taking medications, which includes at a minimum:
 - a. Who is authorized to assist participants in taking either prescription or over the counter medications and under what conditions such assistance may take place. This must include a review of the type of medication to be taken and its impact upon the client.

b. Verification of prescriptions and dosages. All medications shall be maintained in their original, labeled containers.

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

d. A clear statement of the client's and client's family responsibility regarding medications to be taken by the client while participating in the program and provision for informing the client and client's family of the program's procedures and responsibilities regarding assisted self-administration of medications.

KINSHIP SUPPORT SERVICES

Service Number: C19 – Service Category: Community

Definition of Service

Provision of support services (which include respite care, supplemental and education, support and training services) in kinship caregiver situations where an individual aged 60 or over is the primary caregiver for a child no more than 18 years old. Kinship support services may be provided at locations other than the client's residence.

Unit of Service

Each hour of supports services provided, or each activity session, as appropriate.

Minimum Standards

1. Each program must establish written eligibility criteria which includes, at a minimum:
 - a. That the child must require support services as a result of the kinship care relationship.
 - b. That the kinship caregiver must be a grandparent or relative caregiver who has a legal relationship to the child or is raising the child informally.
2. Each program shall conduct an evaluation of the care giving situation to ensure that the skills and training of the respite care worker to be assigned coincides with the situation. The program may utilize volunteer respite workers.
3. Each program must develop and maintain procedures to protect the safety and wellbeing of the children being serviced by the program. Each provider of Kinship Respite Care must be appropriately licensed or regulated and monitored to ensure the safety and wellbeing of the child in need of substitute care.
5. An emergency notification plan shall be developed for each care recipient and respective caregiver.
6. Supervision must be available to program staff at all times.
7. Kinship Respite Care may include, but is not limited to, services such as Karate Lessons, Day Care Services with licensed centers, memberships with local associations such as the YMCA and camps.

TRANSPORTATION

Service Number: A-6 – Service Category: Access

Service Definition

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

Unit of Service

One, one-way trip per person, or one educational session.

Minimum Standards

1. Older Americans Act funds may be used to fund all or part of the operational costs of transportation programs based on the following modes:

a. Demand/Response: Characterized by scheduling of small vehicles to provide door-to-door or curb-to-curb service on demand. The program may include a passenger assistance component.

(1) Route Deviation Variation--where a normally fixed-route vehicle leaves scheduled route upon request to pick up the client.

(2) Flexible Routing Variation--where routes are constantly modified to accommodate service requests.

b. Public Transit Reimbursement: Characterized by partial or full payment of the cost for an older person to use an available public transit system. (Either fixed route or demand/response). The program may include a passenger assistance component.

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

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

2. Older Americans Act funds may not be used for the purchase or lease of vehicles for providing transportation services, unless approved in writing by OSA.

3. All drivers and vehicles used for transportation programs supported all or in part by Older Americans Act funds must be appropriately licensed and inspected as required by the Secretary of State and all vehicles used must be covered by liability insurance.

4. All paid drivers for transportation programs supported entirely or in part by Older Americans Act funds shall be physically capable and willing to assist persons requiring help to and from and to get in and out of vehicles. Such assistance must

be available unless expressly prohibited by either a labor contract or insurance policy.

5. All paid drivers for transportation programs supported entirely or in part by Older Americans Act funds shall be trained to cope with medical emergencies, unless expressly prohibited by a labor contract or insurance policy.

6. Each program shall operate in compliance with P.A. 1 of 1985 regarding seat belt usage.

7. Each program shall attempt to receive reimbursement from other funding sources, as appropriate and available. Examples include the American Cancer Society, Veterans Administration, Human Services Agency, Department of Community Health, Medical Services Administration, United Way, Department of Transportation programs, etc. Within a respective PSA, an AAA may use an alternative unit of service (e.g., vehicle miles or passenger miles) when appropriate for consistency among funding sources. Such an alternative unit of service must be approved by the MCSA at the time of area plan approval