Table of Contents

IDAPA 15 - OFFICE OF THE GOVERNOR

15.01.01 - RULES GOVERNING SENIOR SERVICES PROGRAM

000. LEGAL AUTHORITY. 2
001. TITLE AND SCOPE. 2
002. WRITTEN INTERPRETATIONS. 2
003. ADMINISTRATIVE APPEALS. 2
004. -- 009. (RESERVED). 2
010. DEFINITIONS. 2
011. -- 019. (RESERVED). 5
020. PROGRAM OUTCOMES. 5
021. ELIGIBILITY. 5
022. CLIENT ASSESSMENT. 5
023. UNIT OF SERVICE. 5
024. FAMILY AND CAREGIVER SUPPORTS. 5
025. ACCOMMODATIONS. 6
026. FEES AND CLIENT CONTRIBUTIONS. 6
027. CLIENT WAITING LISTS. 6
028. DISCLOSURE OF INFORMATION. 7
029. DENIAL OF SERVICE. 7
030. -– 039. (RESERVED). 7
040. TERMINATION OF SERVICE. 7
041. HOMEMAKER. 8
042. CHORE. 11
043. ADULT DAY CARE. 12
044. RESPITE. 13
045. -– 055. (RESERVED). 14
056. CARE COORDINATION. 14
057. –- 999. (RESERVED). 17

IDAPA 15
TITLE 01
Chapter 01

IDAPA 15 - OFFICE OF THE GOVERNOR

15.01.01 - RULES GOVERNING SENIOR SERVICES PROGRAM

000. LEGAL AUTHORITY.
Under authority of Idaho Code, Section 67-5003, the Idaho Commission on Aging adopts the following rules. (7-1-98)

001. TITLE AND SCOPE.

01. Title. These rules shall be cited as IDAPA 15.01.01, "Rules Governing Senior Services Program". (7-1-98)

02. Scope. These rules constitute minimum requirements for aging services funded under authority of Idaho Code, Sections 67-5005 through 5008, and include a list of common terms and definitions related to Idaho's aging programs. (7-1-98)

002. WRITTEN INTERPRETATIONS.
This agency may have written statements which pertain to the interpretation of the rules in this chapter. To obtain copies, contact the Idaho Commission on Aging by writing to the Director. (7-1-98)

003. ADMINISTRATIVE APPEALS.
The ICOA shall provide AAAs with opportunity to appeal administrative decisions related to these rules in accordance with IDAPA 04.11.01, "Idaho Rules of Administrative Procedure of the Attorney General". (7-1-98)

004. -- 009. (RESERVED).

010. DEFINITIONS.

01. Act. The Idaho Senior Services Act. Programs and services established in Idaho Code, Section 67-5001, et. seq., Idaho Code. (7-1-98)

02. Activities Of Daily Living (ADL). Bathing, dressing, toileting, transferring, eating, walking. (7-1-98)

03. Adult Day Care. A structured day program which provides individually planned care, supervision, social interaction, and supportive services for frail older persons in a protective group setting, and provides relief and support for caregivers. (7-1-98)

04. Aging Network. The ICOA, it's AAAs and providers. (7-1-98)

05. Advance Directive. A Living Will or Durable Power of Attorney for healthcare executed under the Natural Death Act, 39-4501, Idaho Code. (7-1-98)

06. Area Agency On Aging (AAA). Local agency designated by the Idaho Commission on Aging, pursuant to the OAA (OAA) of 1965, as amended, that plans, develops, and implements services for older persons within a specified geographic area. (7-1-98)

07. Area Plan. Plan for aging programs and services which an AAA is required to submit to the Idaho Commission on Aging, in accordance with the OAA, in order to receive OAA funding. (7-1-98)

08. Care Coordinator. A licensed social worker, or licensed professional nurse (RN), or an individual with a BA or BS in a human services field and at least one (1) year's experience in service delivery to the service population. (7-1-98)

09. Care Coordination. Case management assistance in circumstances where the older person, their caregivers, or both, are experiencing diminished functioning capacities, personal conditions, or other characteristics which require the provision of services by formal service providers. Activities of care coordination include assessing needs, developing care plans, authorizing services among providers, follow-up and reassessment, as required. (7-1-98)

10. Care Coordination Supervisor. An individual who has at least a BA or BS degree and is a licensed social worker, psychologist or licensed professional nurse (registered nurse/RN) with at least two (2) years' experience in service delivery to the service population. (7-1-98)

11. Chore Services. Providing assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy housework, yard work or sidewalk maintenance. (7-1-98)

12. Client. Person who has met program eligibility requirements for services addressed in this chapter. (7-1-98)

13. Cognitive Impairment. A disability or condition due to mental impairment. (7-1-98)

14. Congregate Meals. Meals that meet the requirements of the OAA, as amended, served in a group setting. (7-1-98)

15. Department. Department of Health and Welfare. (7-1-98)

16. Direct Costs. Costs incurred from the provision of direct services. These costs include, but are not limited to, salaries, fringe benefits, travel, equipment, and supplies directly involved in the provision of services. Salaries of program coordinators and first line supervisors are considered direct costs. (7-1-98)

17. Eligible Clients. Residents of the state of Idaho who are sixty (60) years or older and their spouses. (7-1-98)

18. Fee For Services. An established payment required from individuals receiving services under the Act. The fee varies according to client's current annual household income. (7-1-98)

19. Fiscal Effectiveness. A financial record of the cost of all formal services provided to insure that maintenance of an individual at home is more cost effective than placement of that individual in an institutional long-term care setting. (7-1-98)

20. Formal Services. Services provided to clients by a formally organized entity. (7-1-98)

21. Functional Impairment. A condition that limits an individual's ability to perform ADLs and IADLs. (7-1-98)

22. Home-Delivered Meals. Meals delivered to eligible clients in private homes. These meals shall meet the requirements of the OAA. (7-1-98)

23. Homemaker. A person who has successfully completed a basic prescribed training, who, with additional supervision, provides homemaker services. (7-1-98)

24. Homemaker Service. Assistance with housekeeping, meal planning and preparation, essential shopping and personal errands, banking and bill paying, medication management, and, with restrictions, bathing and washing hair. (7-1-98)

25. Household. For sliding fee purposes, a "household" includes a client and any other person(s) permanently resident in the same dwelling who share accommodations and expenses with the client. (7-1-98)

26. Idaho Commission On Aging (ICOA). Commission designated by the Governor to plan, set priorities, coordinate, develop policy, and evaluate state activities relative to the objectives of the OAA. (7-1-98)

27. Informal Supports. Those supports provided by church, family, friends, and neighbors, usually at no cost to the client. (7-1-98)

28. Instrumental Activities Of Daily Living (IADL). Meal preparation, money management, transportation, shopping, using the telephone, medication management, heavy housework, light housework. (7-1-98)

29. Legal Representative. A person who carries a Durable Power of Attorney or who is appointed Guardian or Conservator with legal authority to speak for a client. (7-1-98)

30. National Aging Program Information System. (NAPIS) Standardized Nationwide reporting system that tracks: (7-1-98)

a. Service levels by individual service, identifies client characteristics, State and area agency staffing profiles, and identifies major program accomplishments; and (7-1-98)

b. Complaints received against long term care facilities and family members or complaints related to rights, benefits and entitlements. (7-1-98)

31. Non-Institutional. Living arrangements which do not provide medical oversight or organized supervision of residents' activities of daily living. Non-institutional residences include congregate housing units, board and room facilities, private residential houses, apartments, condominiums, duplexes and multiplexes, hotel/motel rooms, and group homes in which residents are typically unrelated to individuals. Non-institutional does not include skilled nursing homes, residential care facilities, homes providing adult foster care, hospitals, or residential schools/hospitals for the severely developmentally disabled or the chronically mentally ill. (7-1-98)

32. Older Americans Act (OAA). Federal law which authorizes funding to states to provide supportive and nutrition services for the elderly. (7-1-98)

33. Ombudsman. An individual or program providing a mechanism to receive, investigate, and resolve complaints made by, or on behalf of, residents of long-term care facilities, or persons aged sixty (60) and older living in the community. (7-1-98)

34. Performance-Based Agreements. A written agreement between the ICOA and area agencies which establishes output and outcome measures. (7-1-98)

35. Personal Care Services (PCS). Services which include personal and medically-oriented procedures required to meet the physical needs of a patient convalescing at home or to provide for a long-term care client's on-going maintenance/support, in accordance with Section 39-5602 (f), Idaho Code. (7-1-98)

36. Program. The Idaho Senior Services Program. (7-1-98)

37. Planning And Service Area (PSA). Substate geographical area designated by the ICOA for which an area agency is responsible. (7-1-98)

38. Provider. An AAA that provides services directly or another entity under contract with the AAA to provide a specific service(s). (7-1-98)

39. Respite. Short-term, intermittent relief provided to full-time caregivers (individuals or families) of a functionally-impaired relative. (7-1-98)

40. Shopping Assistance. Accompaniment and provision of assistance to an elderly individual for the purpose of purchasing food, medicine and other necessities for an elderly individual who is disabled or homebound. (7-1-98)

41. Sliding Fee Scale. A fee scale ranging from zero percent (0%) to one hundred percent (100%) of the cost of services. Cost of services shall be based on the contractor's or provider's actual unit costs. A client's

percentage (payment) shall be determined by ranking the client's annual household income against the federally determined poverty guidelines for that year. (3-19-99)

42. Supportive Service Plan (SSP). An individual support plan outlining an array of services or the components of an individual service required to maintain a client at home. For Adult Protection purposes the SSP shall address the available remedial, social, legal, medical, educational, mental health, or other services available to reduce risks and meet the care needs of a vulnerable adult. (7-1-98)

43. Supportive Services Technician. AAA employee who is a paraprofessional working under the supervision of a licensed social worker or care coordinator assisting in the performance of specified tasks associated with investigation of Adult Protection reports or development and initiation of a SSP. The employee shall have a degree in a related field or a high school diploma and at least two (2) years' experience working with elderly or at-risk populations. (7-1-98)

44. Transportation Services. Services designed to transport eligible clients to and from community facilities/resources for the purposes of applying for and receiving services, reducing isolation, or otherwise promoting independence. (7-1-98)

45. Uniform Assessment Instrument (UAI). A comprehensive assessment instrument utilizing uniform criteria. The ICOA mandates use of a UAI in determining an applicant's need for care and services. (7-1-98)

011. -- 019. (RESERVED).

020. PROGRAM OUTCOMES.

State Senior Services are designed to provide older individuals with assistance they need to compensate for functional or cognitive limitations. Individuals qualifying for these services are those who require personal assistance, stand-by assistance, supervision or cueing to accomplish ADLs, IADLs, or both. The program aims to help clients: (7-1-98)

01. Avoid Inappropriate Or Premature Institutional Placement. Facilitate earlier discharge of an institutionalized client; or prevent reinstitutionalization of a formerly discharged client. (7-1-98)

02. Enhance Ability To Accomplish Short-Term Rehabilitation. Provide the opportunity for rehabilitation at home by providing services to those who are temporarily incapacitated due to short-term illness or injury.
(7-1-98)

03. Assist In Crisis Intervention. Maintain older individuals in their own homes, on a short-term basis, during a crisis when the primary caregiver is incapacitated or absent. (7-1-98)

04. Provide Protection. Enable individuals to remain in their own homes during a crisis through coordination with Adult Protection Services. (7-1-98)

021. ELIGIBILITY.

Persons eligible to receive services under the Act shall be sixty (60) years of age or older and residents of the state of Idaho. Functionally- or cognitively-impaired adults living in the home of a caregiver who is age sixty (60) or older are exempted from this requirement. In those instances the caregiver is considered to be the client. (7-1-98)

022. CLIENT ASSESSMENT.

All applicants for services under this chapter shall be assessed utilizing the ICOA standardized UAI. (7-1-98)

023. UNIT OF SERVICE.

One (1) hour, or fraction thereof, providing Adult Day Care, Care Coordination, Chore, Homemaker, or Respite Service. (7-1-98)

024. FAMILY AND CAREGIVER SUPPORTS.

01. Intent Of ICOA. It is the intent of ICOA to support efforts of family caregivers to maintain

functionally or cognitively-impaired elderly relatives in the household. (7-1-98)

02. Eligibility. Based on eligibility and fee for service requirements, AAAs shall support family caregiver efforts by making program services available to such families. (7-1-98)

025. ACCOMMODATIONS.

01. Accommodations For Geographic Inaccessibility. All providers shall make and document efforts to locate and hire a part-time worker or generate a volunteer to meet the client service need. (7-1-98)

02. Accommodations For Language. All providers providing services under these rules shall make accommodations to work with persons who speak a language other than English. (7-1-98)

03. Cultural Accommodations. All providers shall accommodate cultural differences and take them into account when delivering services. (7-1-98)

04. Accommodations For Disabilities. All providers shall make accommodations to work with persons who have vision or hearing impairments or other disabilities. (7-1-98)

026. FEES AND CLIENT CONTRIBUTIONS.

01. Poverty Guidelines. Clients whose income exceeds one hundred percent (100%) of poverty (as established by the United States Department of Health and Human Services) shall be required to pay a fee for service according to a variable fee schedules established by the ICOA. (7-1-98)

02. Income Declaration. Income shall be determined by an annual client self-declaration. When a client's income increases or decreases, the client shall notify the provider for a redetermination of income. (7-1-98)

03. Determining Income. For this purpose, income means gross household income from all sources, less the cost of medical insurance and expenditures for non-covered medical services and prescription drugs. Payments the client receives from owned property currently being leased shall be counted as income after expenses are deducted if paid by the client, i.e., insurance, taxes, water, sewer, and trash collection. In determining income for respite clients, income means the gross income of the client as specified above but shall not include the income of any other person(s) who reside in the household. (3-19-99)

04. Fee Based On Actual Cost. Assessed fee shall be a percentage of the provider's actual unit cost. (7-1-98)

05. Fee Waived. The fee may be waived for clients who refuse to pay a fee if there is documented evidence that not providing the service would increase risk or harm to the client. (3-19-99)

06. Fee Required. Fees are required from clients receiving either Chore or Homemaker Services. (3-19-99)

07. Client Contributions. Clients whose annual income falls below poverty shall be given the opportunity to make voluntary contributions. (7-1-98)

08. Use Of Fees And Contributions. Providers shall maintain accounting records of all fees and contributions collected and of all monies expended from these sources. All monies derived from fees, contributions, or both, shall be used to offset the costs of providing the service(s) for which they were collected. (7-1-98)

027. CLIENT WAITING LISTS.

When an eligible applicant is denied service based on lack of available service personnel or funding, the applicant shall be placed on a waiting list. The applicant shall receive an in-home assessment prior to placement on a waiting list. Applicants on the waiting list for service shall be prioritized according to IDAPA 15.01.20, Section 053, "Rules Governing Area Agency on Aging Operations". All applicants placed on a waiting list shall be notified of this action in writing. (7-1-98)

028. DISCLOSURE OF INFORMATION.
AAA employees' and contractors' disclosure of information about clients is limited by law. All information obtained from a client, whether verbal or written, and any records created from that information, shall be treated as confidential. The OAA requires that confidentiality regarding clients shall be followed thus: (7-1-98)

01. Disclosure. An AAA provider or contractor may disclose to anyone the content of a client's communication only with the client's prior, informed consent. Without the client's prior, informed consent, the provider or contractor may: (7-1-98)

a. Only disclose information for purposes directly related to the administration of the program under which the client is applying for or receiving benefits; or (7-1-98)

b. Disclose client information to auditors and to persons conducting research within certain defined circumstances. (7-1-98)

02. Client's Expectation Of Privacy. Disclosure of information to others does not abrogate a client's expectation of privacy as protected by law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. (7-1-98)

03. Disclosure Required. The disclosure of information required for a coordinated assessment of a client and for coordinating delivery of services to a client is allowed between aging network providers and contractors and, if required, the Department. Disclosure to individuals outside that group shall not be authorized. (7-1-98)

029. DENIAL OF SERVICE.
An applicant shall be notified in writing of a denial of service and the right to appeal in accordance with IDAPA 15.01.20, Section 003, "Rules Governing Area Agency on Aging Operations". The request for services may be denied for any of the following reason(s): (3-19-99)

01. Applicant Not In Need Of Service. The applicant's functional or cognitive deficits are not severe enough to require services. (7-1-98)

02. Family Or Other Supports Adequate. Family, or other informal supports are adequate to meet applicants current needs. (7-1-98)

03. Other Care Required. The client's needs are of such magnitude that more intensive supports, such as Medicaid PCS, attendant care, or referral for residential or nursing home placement are indicated. In such instances, alternatives shall be explored with the client and the client's legal representative and family, if available. Referrals shall be made by the provider, as appropriate. (7-1-98)

04. Barriers To Service Delivery Exist. The applicant's home is hazardous to the health or safety of service workers. (7-1-98)

05. Geographical Inaccessibility. The applicant's home is more than twenty (20) miles from the nearest point of service provision of homemaker, chore, or respite and the provider can document efforts to locate a worker or volunteer to fill the service need have been unsuccessful. (7-1-98)

030. -– 039. (RESERVED).

040. TERMINATION OF SERVICE.

01. Documentation. Documentation of notice of termination shall be placed in the client's case record, signed, and dated by the provider. (7-1-98)

02. Appeals Process. The client shall be informed of the appeals process, in accordance with IDAPA 15.01.20, Section 003, "Rules Governing Area Agency on Aging Operations". (3-19-99)

03. AAA Services. AAA authorized services may be discontinued by the provider for any of the reasons listed below, or at the discretion of a program director or AAA director: (7-1-98)

a. Services proved ineffective, insufficient, or inappropriate to meet client needs. (7-1-98)

b. Other resources were utilized. (7-1-98)

c. Client withdrew from the program or moved. (7-1-98)

d. Family or other support to client increased. (7-1-98)

e. Client placed in a long-term care facility. (7-1-98)

f. Client died (no notification of termination required). (7-1-98)

g. Client's functioning improved. (7-1-98)

h. Client refused service. (7-1-98)

i. Client's home is hazardous to the service provider (requires prior notification of the AAA Director with final approval being at the discretion of the AAA Director). (7-1-98)

j. Client's home is not reasonably accessible. (7-1-98)

k. Client's behavior is a threat to the safety of the provider (requires prior notification of the AAA Director with final approval being at the discretion of the AAA Director.) (7-1-98)

l. Client verbally abuses or sexually harasses service provider. (7-1-98)

m. Client refuses to pay fee determined for service. (7-1-98)

n. Service provider is not available in locale. (7-1-98)

o. Services are no longer cost effective. (7-1-98)

04. Notification Of Termination And Right To Appeal. Client shall be informed in writing of the reasons for provider initiated service termination and the right to appeal at least two (2) weeks prior to termination. Exceptions to the two (2) week advance notification of termination will be justified to the AAA Director with final approval being at the discretion of the AAA Director. Appeal actions are the responsibility of the AAA. The client shall be referred to other services as appropriate. (7-1-98)

041. HOMEMAKER.

01. Policy. Homemaker service is designed to provide assistance required to compensate for functional or cognitive limitations. Homemaker services provide assistance to eligible individuals in their own homes, or, based on an adult protection referral, in a caregivers home; to restore, enhance, or maintain their capabilities for self-care and independent living. Available family shall be involved in developing a supportive services plan for the client to ensure the formal services provided shall enhance any available informal supports provided. A client or legal representative shall have the right to accept or refuse services at any time. Homemaker providers shall reserve funds to support the expenditure of up to a maximum of ten percent (10%) of their annual Act funding to support emergency service requests and response to adult protection referrals. (7-1-98)

02. Service Eligibility. Individuals are eligible for homemaker services if they meet any of the following requirements: (7-1-98)

a. They have been assessed to have ADL deficits, IADL deficits, or both, which prohibit their ability to maintain a clean and safe home environment. (7-1-98)

b. Clients over age sixty (60), who have been assessed to need homemaker service, may be living in the household of a family member (of any age) who is the primary caregiver. (7-1-98)

c. They are Adult Protection referrals for whom homemaker service is being requested as a component of a SSP to remediate or resolve an adult protection complaint. (7-1-98)

d. Vulnerable adults under age sixty (60), who have been assessed to need homemaker service are eligible to receive the service a maximum of three (3) consecutive months within a program year. (7-1-98)

e. They are home health service clients who may be eligible for emergency homemaker service. (7-1-98)

03. PCS. Clients eligible to receive PCS through the Department are not eligible for homemaker services unless the services are determined to be needed on an interim, emergency basis until PCS is initiated. Interim emergency services shall not exceed two (2) months' duration. (7-1-98)

04. Purpose Of Service. (7-1-98)

a. Maintain Independence And Dignity. To secure and maintain in a home environment the independence and dignity of clients who are capable of self-care with appropriate supportive services. (7-1-98)

b. Prevent Institutionalization. To avoid or delay placement into long-term care institutions. (7-1-98)

c. Remedy Harmful Living Arrangements. To promote the health and safety of the client. (7-1-98)

d. Crisis Intervention. To assist the client through a crisis situation, if the homemaker service(s) required meet the client's needs and can be provided within the guidelines set forth in these rules. (7-1-98)

05. Exclusions. (7-1-98)

a. Meal Preparation. Homemakers shall not prepare meals for a client if home-delivered meals are available. (7-1-98)

b. Transportation. Homemakers shall not transport a client unless the provider carries liability insurance. (7-1-98)

c. Medical Judgments. Homemakers shall not make medical judgments nor any determinations regarding the application of advance directives. (7-1-98)

d. Bathing and Washing Hair. Contractors shall obtain adequate and appropriate insurance coverage prior to assigning homemakers to assist clients with bathing and (or) washing hair. (3-19-99)

06. Service Priority. Once approved, clients shall be prioritized to receive homemaker services based on their needs, as determined through the completion of the UAI as follows: (7-1-98)

a. Highest priority shall be given to clients with the greatest degree of functional or cognitive impairment; then (7-1-98)

b. To clients lacking informal supports; then (7-1-98)

c. To clients whose homes are in poor condition with respect to those circumstances which the homemaker service can remedy. (7-1-98)

07. Homemaker Training And Supervision. All homemakers shall receive an employee orientation from the provider before performing homemaker services. Orientation shall include the purpose and philosophy of homemaker services, review of homemaking skills, program regulations, policies and procedures, proper conduct in

relating to clients, and handling of confidential and emergency situations involving a client. (7-1-98)

a. CPR. Homemakers shall complete CPR training within three (3) months of hire and shall maintain certification thereafter. (7-1-98)

b. In-Service Training. Providers shall annually provide homemakers with a minimum of ten (10) hours training, including CPR, for the purpose of upgrading their skills and knowledge. (7-1-98)

c. Providers shall assure that homemakers who assist clients with bathing or hair washing receive specific training in performing these services prior to being assigned to a client. (7-1-98)

d. Homemaker Supervision. All providers shall maintain written job descriptions for homemakers and shall have written personnel policies. All homemakers shall receive an annual performance evaluation. Homemaker supervisors shall be available to homemakers during work hours to discuss changes in client's circumstances, to resolve problems with schedules, or to respond to emergencies. (7-1-98)

08. Medical Emergencies. In case of medical emergency, the homemaker shall immediately call 911 or the available local emergency medical service and, if appropriate, shall initiate CPR. (7-1-98)

09. Conduct Of Homemakers. Contractors shall insure, through personnel policies, orientation procedures, signed homemaker agreements, and supervision, that homemaker conduct is governed by the following restrictions. A copy of these restrictions, signed by the homemaker, shall be placed in each homemaker's personnel file. (7-1-98)

a. Accepting Money or Loans. A homemaker shall not accept money or a loan, in any form, from a client. (7-1-98)

b. Sale of Goods. A homemaker shall not solicit the purchase of goods, materials, or services. (7-1-98)

c. Addresses and Telephone Numbers. A homemaker shall not provide a personal telephone number or home address to clients. (7-1-98)

d. Private Work. A homemaker shall not work privately for a client of homemaker services. (7-1-98)

e. Client's Residence. A homemaker shall not enter a client's residence in the absence of the client unless the client has given permission to enter to accomplish scheduled work and the permission is documented in the client file. (7-1-98)

f. Proselytizing. A homemaker shall not engage in religious proselytizing during the course of employment. (7-1-98)

g. Medication Administration. A homemaker shall not administer medications. The homemaker may remind a client to take medications, assist with removing the cap from a multi-dose or bubble pack container, and may observe the client taking medications. (7-1-98)

h. Confidentiality. A homemaker shall regard all client communications and information about clients' circumstances as confidential. (7-1-98)

i. Smoking. A homemaker shall not smoke in the home of a client. (7-1-98)

10. Intake And Assessment. (7-1-98)

a. Normal Intake. Client contact shall be initiated within five (5) days of receipt of the referral, and an assessment shall be conducted within two (2) weeks of referral. (7-1-98)

b. Emergency Intake. Referrals indicating a crisis or potential crisis such as a marked decline in health

or functional status, hospital discharge, or adult protection referral require a home visit be conducted to assess service need within one (1) working day of receipt of referral. If appropriate and available, a homemaker shall be assigned and service shall be initiated immediately. Such emergency homemaker service shall not exceed two (2) weeks' duration. Referrals assessed to need emergency service shall take precedence over applicants carried on a waiting list. (7-1-98)

c. Client Assessment. To determine the level of need and the type of service needed, the provider shall conduct an in-home assessment using the ICOA UAI. Service alternatives shall be discussed and referrals initiated as appropriate. (7-1-98)

d. Assessment Coordination. A client need not be re-assessed if an assessment completed within the past ninety (90) days by another human services agency provides the same information as the ICOA's UAI and the client signs a Release of Information form. A client assessment shall be completed if no current assessment from another agency is available. In either case, a home visit shall be included in the process of developing the client's individual SSP. (7-1-98)

11. Individual Supportive Service Plan (SSP). A supportive service plan shall be signed by the client or legal representative prior to initiation of service. (7-1-98)

a. An approved plan shall reflect needed services to be provided by available family or others. (7-1-98)

b. Revision of the SSP. After services have been in place for one (1) month, the homemaker shall inform the supervisor of any modifications needed in the SSP, such as changes in hours of service or tasks to be performed. (7-1-98)

c. Reassessments of SSP. The SSP shall be updated at least annually. Any revisions to an SSP shall be initialed by the client prior to being put into effect. An SSP may be updated more often than annually if changes in a client's circumstances (i.e., functional or cognitive ability, living conditions, availability of supports) indicate a necessity for re-assessment. (7-1-98)

042. CHORE.

01. Policy. Chore service is designed to be provided to individuals who reside in their own homes or who occupy individual rental units. Chore services for those individuals who rent housing shall not provide repairs or maintenance that are contractually the responsibility of the property owner. (7-1-98)

02. Service Eligibility. Clients qualify to receive chore service if: (7-1-98)

a. They have been assessed to have ADL or IADL deficits which inhibit their ability to maintain their homes or yards; (7-1-98)

b. There are no available informal supports; (7-1-98)

c. Chore service is needed to improve the client's safety at home or to enhance the client's use of existing facilities in the home. These objectives shall be accomplished through one-time or intermittent service to the client. (3-19-99)

03. Service Priority. Service provision shall be prioritized based on client's degree of functional impairment. (7-1-98)

04. Program Intake And Eligibility Determination. (7-1-98)

a. A home visit shall be made within five (5) work days of the referral. (7-1-98)

b. Client assessment shall be conducted utilizing the UAI. (7-1-98)

c. If chore services are to be provided, the income declaration, service determination and work plan shall be completed prior to any work being done. The work plan shall be signed by both the client and the service provider. The work plan shall include a description of the work to be accomplished, the start and completion dates for such work, and a summary of any cost to the client (for labor or materials) the work shall incur. (7-1-98)

d. If the client is not eligible for services, appropriate referrals shall be made. (7-1-98)

043. ADULT DAY CARE.

01. Policy. Adult Day Care is designed to meet the needs of eligible participants whose functional or cognitive abilities have deteriorated. It is intended to provide relief for care providing family members. It is a comprehensive program which provides a variety of social and other related support services in a protective setting during any part of a day, but for a duration of less than twenty-four (24) hours. (7-1-98)

02. Eligibility. Individuals eligible for adult day care include: (7-1-98)

a. Those who have physical or cognitive disabilities affecting ADL or IADL functioning; (7-1-98)

b. Those capable of being transported; (7-1-98)

c. Those capable of benefiting from socialization, structured and supervised group-oriented programs; and (7-1-98)

d. Those capable of self-care with supervision or cueing. (7-1-98)

03. Enrollment Agreement. A signed enrollment agreement shall be completed to include: (7-1-98)

a. Scheduled days of attendance; (7-1-98)

b. Services and goals of the center; (7-1-98)

c. Amount of fees and when due; (7-1-98)

d. Transportation agreement, if appropriate; (7-1-98)

e. Emergency procedures; (7-1-98)

f. Release from liability (for field trips, etc.); (7-1-98)

g. Conditions for service termination; (7-1-98)

h. A copy of the center's policy; and (7-1-98)

i. A SSP. (7-1-98)

04. Staffing. Staff shall be adequate in number and skills to provide essential services. (7-1-98)

a. There shall be at least two (2) responsible persons at the center at all times when clients are in attendance. One (1) shall be a paid staff member. (7-1-98)

b. Staff to client ratio shall be increased appropriately if the number of clients in day care increases or if the degree of severity of clients' functional or cognitive impairment increases. (7-1-98)

c. Staff persons counted in the staff to client ratio shall be those who spend the major part of their work time in direct service to clients. (7-1-98)

d. If the administrator is responsible for more than one (1) site or has duties not directly related to

adult day care, a program manager shall be designated for each site. (7-1-98)

e. Volunteers shall be included in the staff ratio only when they conform to the same standards and requirements as paid staff. (7-1-98)

05. Services. Adult Day Care Programs shall, at a minimum, provide the following services: (7-1-98)

a. Assistance with transferring, walking, eating, toileting; (7-1-98)

b. Recreation; (7-1-98)

c. Nutrition and therapeutic diets; and (7-1-98)

d. Exercise. (7-1-98)

06. National Standards. Adult Day Care Programs shall operate under guidelines established by the ICOA in accordance with national standards developed by the National Council on Aging's National Institute on Adult Day Care. (7-1-98)

044. RESPITE.

01. Policy. Respite is a volunteer-based program designed to encourage and support efforts of family caregivers to maintain functionally or cognitively-impaired elderly relatives at home. The family may utilize respite care to meet emergency needs, to restore or maintain the physical and mental well being of family caregivers, and provide socialization for the client. Respite volunteers provide companionship for the homebound client so the caregiver can attend to personal business or recreational interests outside the home. This allows the caregiver intervals of needed relief. The Respite Care Service provides no hands-on care. (7-1-98)

02. Eligibility. (7-1-98)

a. The client shall be homebound or have physical or cognitive impairments affecting ADL or IADL functioning to the extent twenty-four (24) hour supervision is required. (7-1-98)

b. Functionally or cognitively-impaired persons under sixty (60) years of age living in the household of a person sixty (60) years of age or older are eligible to receive Respite. (7-1-98)

03. Exclusions. (7-1-98)

a. Respite care volunteers shall not perform housework, prepare meals, or provide any type of nursing or medical care. (7-1-98)

b. Respite care volunteers shall not transport clients. (7-1-98)

04. Service Priority. All approvals to receive respite services shall be based on an in-home visit and completion of the UAI. (7-1-98)

05. Volunteer Recruitment, Training, and Supervision. (7-1-98)

a. Job descriptions. All respite care programs shall have written job descriptions for volunteers. (7-1-98)

b. Volunteer screening. All respite care programs shall screen volunteers prior to placement. (7-1-98)

c. Orientation. All respite care volunteers shall receive a minimum of three (3) hours orientation and training prior to placement. (7-1-98)

d. Respite providers. Respite providers shall be available to volunteers to discuss changes in client

circumstances, resolve scheduling problems, and respond to emergency situations. (7-1-98)

06. Client Outreach. In coordination with Information & Assistance (I&A) and other referral sources, providers shall actively promote the program. (7-1-98)

045. -– 055. (RESERVED).

056. CARE COORDINATION.

01. Policy. Care coordination is a consumer-driven, social model case management service that empowers individuals and their families to make choices concerning in-home, community-based or institutional long-term care services. (7-1-98)

02. Qualifications. Any person hired to fill the position of care coordination supervisor or care coordinator on or after July 1, 1998, shall have the qualifications identified in Subsections 010.08 and 010.10 of this chapter. (7-1-98)

03. Service Priority. Service priority is based on the following criteria: (7-1-98)

a. Require minimal assistance with one or more ADLs or IADLs; and (7-1-98)

b. Require services from multiple health/social services providers, and (7-1-98)

c. Are unable to obtain the required health/social services for themselves, or, (7-1-98)

d. Lack available family or friends who can provide the needed assistance. (3-19-99)

04. Screening And Referral. (7-1-98)

a. The purpose of screening is to determine whether an older person needs service referral, assistance and client advocacy, or is a potential care coordination client who should receive a home visit and a comprehensive assessment. (7-1-98)

b. Screening shall be provided over the telephone. Screening may also be provided in the field, if appropriate. (7-1-98)

c. Screening shall usually be accomplished by the I&A component, Adult Protection, provider, or by a community agency. However, care coordination may receive a direct referral of a potential client who has not been screened. In such cases, care coordination shall conduct screening or refer the potential client to the I&A component for screening. (3-19-99)

d. All Care Coordination Programs shall utilize the pre-screen and referral component of the UAI to screen potential clients. (7-1-98)

e. Pre-referral screening shall be done to determine if a potential client meets the criteria for receipt of Care Coordination Services. If the potential client meets the criteria and agrees to the referral, the client shall be referred for a comprehensive assessment utilizing the UAI. (7-1-98)

f. Referrals who do not meet the criteria for Care Coordination Services shall be referred for other appropriate services. (7-1-98)

g. If notification was requested, the referral source shall be notified of case disposition following the screening. (7-1-98)

05. Referral For Care Coordination. Referrals shall be accepted from any source and may include eligible clients who are seeking or already receiving other services. (7-1-98)

06. Working Agreements. (7-1-98)

a. The Care Coordination Program shall enter into working agreements with primary community resources utilized by older persons. These resources may include AAA service providers, mental health centers, hospitals, home health agencies, legal services providers, and others. (7-1-98)

b. Working agreements shall address at least the following: (7-1-98)

i. How long each party shall take to respond to a request for service; (7-1-98)

ii Release of information procedures; (7-1-98)

iii. Referral and follow-up procedures; (7-1-98)

iv. How each party shall notify the other of program changes and non-availability of service; and (7-1-98)

v. Procedures for working out problems between the two (2) parties. (7-1-98)

07. Core Services. Care coordination provides responsible utilization of available informal (unpaid) supports before arranging for formal (paid) services. The care coordinator and client shall work together in determining the frequency and duration of needed services. Services shall be arranged subsequent to approval by the client or legal representative. Services provided shall be recorded and monitored to insure cost effectiveness and compliance with the SSP. (7-1-98)

a. Client assessment shall be conducted during a home visit and shall utilize the UAI. (7-1-98)

b. A client need not be re-assessed if an assessment completed within the past ninety (90) days by another human service agency provides the same information as the ICOA's UAI and the client signs a Release of Information form. (7-1-98)

c. SSP. Based on the information obtained during the client assessment and input obtained from family or professionals familiar with the client, the care coordinator shall develop a written SSP which shall include at least the following: (7-1-98)

i. Problems identified during the assessment; (7-1-98)

ii. Exploration of opportunities for family and other informal support involvement to be included in development of the SSP; (7-1-98)

iii. Overall goals to be achieved; (7-1-98)

iv. Reference to all services and contributions provided by informal supports including the actions, if any, taken by the care coordinator to develop the informal support services; (7-1-98)

v. Documentation of all those involved in the service planning, including the client's involvement (7-1-98)

vi. Schedules for care coordination monitoring and reassessment; (7-1-98)

vii. Documentation of unmet need and service gaps; and (7-1-98)

viii. References to any formal services arranged, including fees, specific providers, schedules of service initiation, and frequency or anticipated dates of delivery. (7-1-98)

d. The SSP shall be reevaluated and updated by the care coordinator at least annually or when significant changes in the client's status occur; (7-1-98)

e. A copy of the current SSP shall be provided to the client or legal representative. (7-1-98)

f. Case files shall be maintained for three (3) years following service termination. (7-1-98)

08. Other Supportive Services. (7-1-98)

a. Necessary Services. Care coordinators shall assist clients to obtain available benefits, services, medically related devices, assistive technology, necessary home modifications, or other services required to fulfill unmet needs. (3-19-99)

b. Social-Emotional Support. Care coordinators shall link clients and their families with available services which facilitate life adjustments and bolster informal supports. (7-1-98)

c. Unmet Needs. To assist the AAA in future planning, care coordinators shall identify and document unmet client needs. (7-1-98)

d. Other Informal Resources. In all cases, available informal supports shall be explored prior to utilization of formal services. (7-1-98)

09. Structure And Role. Care coordination is a centralized evaluator and arranger of services and provides those activities previously outlined under "Service Functions". AAAs shall be the direct provider for care coordination services. The AAA is responsible for the implementation of the care coordination program. (7-1-98)

a. Care coordinators shall coordinate service delivery between multiple agencies, individuals, and others. (3-19-99)

b. All providers of Care Coordination Services shall carry insurance in the types and amounts which meet acceptable business and professional standards. (7-1-98)

c. Providers shall conduct an orientation program for all new employees which covers, at least, local resources available, care coordination service delivery, confidentiality of information, and client rights. (7-1-98)

d. In addition to the development and maintenance of the SSP, program and client records shall be maintained to provide an information system which assures accountability to clients, the Care Coordination Program, and funding agencies, and which supplies data for AAA planning efforts. The information system established shall comply with the following ICOA requirements: (7-1-98)

i. NAPIS Registration Form; (7-1-98)

ii. Completed UAI; (7-1-98)

iii. Pertinent correspondence relating specifically to the client; (7-1-98)

iv. A narrative record of client and community contacts, including problems encountered and SSP modifications developed in response; (7-1-98)

v. Completed SSP, signed by the client; (7-1-98)

vi. Written consent and acceptance of Care Coordination Services and release of information forms; (7-1-98)

vii. Any other documentation necessary for systematic care coordination and SSP continuity. (7-1-98)

10. Standards Of Performance. AAAs shall assure care coordination meets the requirements for service neutrality. An agency providing care coordination shall not be a direct provider of other in-home services without proper written justification and approval by the Director of the ICOA. (7-1-98)

11. Evaluation. Evaluation is required to assure quality control. The AAA is responsible for monitoring care coordination activities for quality control and assurance. The AAA shall review client records to determine: (7-1-98)

a. Services are being provided as outlined in the SSP; (7-1-98)

b. Services are meeting the goals established in the SSP; (7-1-98)

c. The client is satisfied with the service(s) being provided; (7-1-98)

d. Changes in service have been authorized; (7-1-98)

e. The SSP continues to be cost-effective; (7-1-98)

f. Providers are noting observations and relating information about informal caregivers, additional actions required by the care coordinator, re-evaluations, amendments to the SSP, and client contacts. (7-1-98)

057. –- 999. (RESERVED).