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IDAPA 15 - OFFICE OF THE GOVERNOR

IDAHO COMMISSION ON AGING

15.01.01 - RULES GOVERNING SENIOR SERVICES PROGRAM

000. LEGAL AUTHORITY.
Under authority of Section 67-5003, Idaho Code, 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 Sections 67-5005 through 5008, Idaho Code, 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 Administrator. (5-3-03)

003. ADMINISTRATIVE APPEALS.
Appeals hereunder are governed by the provisions set forth in IDAPA 15.01.20, "Rules Governing Area Agency on Aging (AAA) Operations," Section 003. (4-6-05)

004. -- 009. (RESERVED).

010. DEFINITIONS.

01. Act. The Idaho Senior Services Act. Programs and services established in Sections 67-5001 through 67-5011, Idaho Code. (4-6-05)

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, the AAAs, and other providers. (5-3-03)

05. Advance Directive. A Living Will or Durable Power of Attorney for Healthcare executed under the Natural Death Act, Section 39-4501, Idaho Code. (5-3-03)

06. Area Agency on Aging (AAA). Separate organizational unit within a multipurpose agency which functions only for purposes of serving as the area agency on aging that plans, develops, and implements services for older persons within a specified geographic area. (4-5-00)

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. Assessment Instrument. A comprehensive instrument utilizing uniform criteria to assess a client's needs. (5-3-03)

09. Case Manager. A licensed social worker, licensed professional nurse (RN), or Certified Case Manager, or an individual with a BA or BS in a human services field or equivalent and at least one (1) year's experience in service delivery to the service population. (3-30-01)

10. Case Management. Case management is a service provided to older individuals and disabled adults, at the direction of the individual or a family member of the individual, to assess the needs of the person and to arrange, coordinate, and monitor an optimum package of services to meet those needs. Activities of case management include: comprehensive assessment of the individual; development and implementation of a service plan with the individual to mobilize formal and informal resources and services; coordination and monitoring of formal and informal service delivery; and periodic reassessment. (3-30-01)

11. Case Management 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. (4-5-00)

12. Certified Case Manager. A Case Manager who has met the requirements for certification as established by the National Academy of Care/Case Managers or other professional association recognized by the Idaho Commission on Aging. (5-3-03)

13. Chore Services. Providing assistance with routine yard work, sidewalk maintenance, heavy cleaning, or minor household maintenance to persons who have functional limitations that prohibit them from performing these tasks. (5-3-03)

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

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

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

17. Cost Sharing Payment. An established payment required from individuals receiving services under the Act. The cost sharing payment varies according to client's current annual household income. (4-6-05)

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

19. 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)

20. Eligible Clients. Residents of the state of Idaho who are sixty (60) years or older. (5-3-03)

21. 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)

22. Formal Services. Services provided to clients by a formally organized entity, including, but not limited to, Medicaid HCBS. (5-3-03)

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

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

25. Homemaker. A person who has successfully completed a basic prescribed training, who, under the supervision of a provider, supplies homemaker services. (4-6-05)

26. 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)

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

28. 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)

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

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

31. Legal Representative. A person who carries a Power of Attorney or who is appointed Guardian or Conservator with legal authority to speak for a client. (5-3-03)

32. Medicaid HCBS. Services approved under the Medicaid Waiver for the aged and disabled. (3-30-01)

33. 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 AAA staffing profiles, and identifies major program accomplishments; and (4-5-00)

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

34. 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)

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

36. 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. (5-3-03)

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

38. Planning and Service Area (PSA). Substate geographical area designated by the ICOA for which an AAA is responsible. (4-5-00)

39. Provider. An AAA or another entity under contract with the AAA to provide a specific service. (5-3-03)

40. Respite. Short-term, intermittent relief provided to caregivers (individuals or families) of a

functionally-impaired relative or custodial charge. (4-5-00)

41. 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)

42. 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)

43. 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 or to reduce risks and meet the care needs of a vulnerable adult. (4-6-05)

44. Supportive Services Technician. AAA employee working under the supervision of a licensed social worker or case manager assisting with investigation of Adult Protection reports, completion of the ICOA approved assessment instrument for services of clients of ICOA funded in-home services, or development and initiation of SSPs. The employee shall have a High School diploma and at least two (2) years' experience delivering services to the elderly or at-risk populations. (5-3-03)

45. 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)

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. Avoid inappropriate institutionalization of a client; facilitate timely discharge of an institutionalized client; or prevent inappropriate or premature reinstitutionalization of a formerly discharged client. (5-3-03)

02. Enhance Ability to Accomplish Short-Term Rehabilitation. Facilitate rehabilitation at home by providing supportive services to those who are temporarily incapacitated due to short-term illness or injury. (5-3-03)

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 under age sixty (60) 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. (4-5-00)

022. CLIENT ASSESSMENT.
Applicants for services under this chapter shall be assessed utilizing the ICOA approved assessment instrument. (4-6-05)

023. 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 cost sharing requirements, AAAs shall support family caregiver efforts by making program services available to such families. (4-6-05)

024. 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 shall make reasonable accommodations to work with persons who speak a language other than English. (5-3-03)

03. Cultural Accommodations. All providers shall make reasonable accommodations for cultural differences and take them into account when delivering services. (5-3-03)

04. Accommodations for Disabilities. All providers shall make reasonable accommodations to work with persons who have vision or hearing impairments or other disabilities. (5-3-03)

025. COST SHARING PAYMENTS 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 make a cost sharing payment for services according to a variable fee schedule established by the ICOA. (4-6-05)

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. (5-3-03)

04. Cost Sharing Payment Based on Actual Cost. Assessed cost sharing payment shall be a percentage of the provider's actual unit cost. (4-6-05)

05. Cost Sharing Payment Required. Cost sharing payments are required from clients receiving either Chore or Homemaker Services. (4-6-05)

06. Cost Sharing Payment Waived. The cost sharing payment may be waived for clients who refuse to make such payment if there is documented evidence that not providing the service would increase risk or harm to the client. (4-6-05)

07. Client Contributions. All clients from whom a cost sharing payment is not required shall be given the opportunity to make voluntary contributions. (4-6-05)

08. Use of Cost Sharing Payments and Contributions. Providers shall maintain accounting records of all cost sharing payments and contributions collected and of all monies expended from these sources. All monies derived from cost sharing payments, contributions, or both, shall be used to offset the costs of providing the service for which they were collected. (4-6-05)

026. DISCLOSURE OF INFORMATION.

Providers' 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: (5-3-03)

01. Disclosure. A provider 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 may: (5-3-03)

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 as approved in writing by the ICOA. (5-3-03)

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, if required, the Department. Disclosure to individuals outside that group shall not be authorized without prior written approval from the ICOA. (5-3-03)

027. 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 reasons listed below, or at the discretion of the AAA director: (5-3-03)

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 available formal or informal supports are adequate to meet applicant's current needs. (4-6-05)

03. Other Care Required. The applicant's needs are of such magnitude that more intensive supports, such as Medicaid HCBS, attendant care, or referral for residential or nursing home placement are indicated. In such instances, alternatives shall be explored with the applicant and the applicant's legal representative and family, if available. Referrals shall be made by the provider, as appropriate. (5-3-03)

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 AAA determines that the applicant's home is geographically inaccessible from the nearest point of service provision of home-delivered meals, homemaker, chore, or respite and the provider can document efforts to locate a worker or volunteer to fill the service need have been unsuccessful. (5-3-03)

06. Lack of Personnel or Funding. Services are unavailable based on a lack of available service personnel or funding. When an eligible applicant is denied service based on a lack of available service personnel or funding, the applicant shall be placed on a waiting list. For services other than Case Management, the applicant shall receive an in-home assessment prior to placement on a waiting list. Applicants on a waiting list for services shall be prioritized according to IDAPA 15.01.20, "Rules Governing Area Agency on Aging Operations," Section 053. All applicants placed on a waiting list shall be notified of this action in writing. (4-6-05)

028. 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, "Rules Governing Area Agency on Aging Operations," Section 053. (4-6-05)

03. AAA Services. AAA authorized services may be discontinued by the provider for any of the reasons listed below, or at the discretion of the AAA director: (5-3-03)

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

b. Other resources, including, but not limited to, formal and informal supports, became available. (5-3-03)

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

d. Family or other available formal or informal support to client increased. (5-3-03)

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. At least two (2) weeks prior to termination, the client shall be informed in writing of the reasons for provider initiated service termination and the right to appeal in accordance with IDAPA 15.10.20, "Rules Governing Area Agency on Aging Operations," Section 053. 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. (4-6-05)

029. SERVICE WORKERS.

01. Training and Supervision. All service workers shall receive an employee orientation from the provider before performing any services. Orientation shall include the purpose and philosophy of the services, review of pertinent skills, program regulations, policies and procedures, proper conduct in relating to clients, and handling of confidential and emergency situations involving a client. (4-6-05)

a. CPR. Service workers shall complete CPR training within three (3) months of hire and shall maintain certification thereafter. (4-6-05)

b. In-Service Training. Providers shall annually provide service workers with a minimum of ten (10) hours training, including CPR, for the purpose of upgrading their skills and knowledge. (4-6-05)

c. Providers shall assure that service workers who assist clients with bathing or hair washing receive

specific training in performing these services prior to being assigned to a client. (4-6-05)

d. Supervision. All providers shall maintain written job descriptions for service workers and shall have written personnel policies. All service workers shall receive an annual performance evaluation. Supervisors of service workers shall be available to service workers during work hours to discuss changes in client's circumstances, to resolve problems with schedules, or to respond to emergencies. (4-6-05)

02. Medical Emergencies. In case of medical emergency, the service worker shall immediately call 911 or the available local emergency medical service and, if appropriate, shall initiate CPR. (4-6-05)

03. Restrictions. Providers shall ensure, through personnel policies, orientation procedures, signed service workers' agreements, and supervision, that the service worker's conduct is governed by the following restrictions. A copy of these restrictions, signed by the service worker, shall be placed in each service worker's personnel file. (4-6-05)

a. Service workers shall not accept money or a loan, in any form, from a client. (4-6-05)

b. Service workers shall not solicit the purchase of goods, materials or services. (4-6-05)

c. Service workers shall not provide a personal telephone number or home address to clients. (4-6-05)

d. Service workers shall not work privately for a client. (4-6-05)

e. Service workers 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. (4-6-05)

f. Service workers shall not engage in religious proselytizing during the course of employment. (4-6-05)

g. Service workers shall not administer medications. A service worker 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. (4-6-05)

h. Service workers shall regard all client communications and information about clients' circumstances as confidential. (4-6-05)

i. Service workers shall not smoke in the home of a client. (4-6-05)

030. -- 039. (RESERVED).

040. 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. AAAs may reserve funds to support the expenditure of up to a maximum of ten percent (10%) of their annual Act Homemaker Service funding to support emergency service requests and response to Adult Protection referrals of individuals aged sixty (60) years or older. (4-6-05)

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 prevent them from maintaining a clean and safe home environment. (4-6-05)

b. Clients aged sixty (60) years or older, 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. (4-6-05)

c. They are Adult Protection referrals for whom homemaker service is being requested as a component of an SSP to remediate or resolve an adult protection complaint. (4-6-05)

d. They are home health service or hospice clients who may be eligible for emergency homemaker service. (5-3-03)

03. Medicaid HCBS. When clients are determined by the Department to be eligible for Medicaid HCBS, they are no longer eligible for homemaker services unless the services are determined to be needed on an interim, emergency basis until Medicaid HCBS is initiated. (4-6-05)

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 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. (4-6-05)

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. Providers shall obtain adequate and appropriate insurance coverage prior to assigning their homemakers to assist clients with bathing or washing hair, or both. (5-3-03)

06. Service Priority. Once approved, clients shall be prioritized to receive homemaker services based on their needs, as determined through the completion of the ICOA approved assessment instrument as follows: (5-3-03)

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 other formal or informal supports, or both; then (5-3-03)

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

07. Program Intake. (4-6-05)

a. If homemaker services are to be provided, the income declaration and Supportive Services Plan shall be completed prior to any work being performed. (4-6-05)

b. If the client is not eligible for services, appropriate referrals shall be made. (4-6-05)

041. 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 the contractual responsibility of the property owner. (4-6-05)

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 formal or informal supports; (5-3-03)

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. (4-6-05)

a. If chore services are to be provided, the income declaration and Supportive Service Plan shall be completed prior to any work being performed. (4-6-05)

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

042. 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 other than the participant's home during any part of a day, but for a duration of less than twenty-four (24) hours. (5-3-03)

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. Eligibility Determination. Highest priority shall be given to clients with the greatest degree of functional or cognitive impairment and then to clients lacking informal supports other than the regular caregiver. (4-6-05)

04. Enrollment Agreement. A signed enrollment agreement shall be completed by the provider and the client, or the client's legal representative, and shall include: (5-3-03)

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

b. Services and goals of the day care provider; (5-3-03)

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. An SSP. (5-3-03)

05. 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 site at all times when clients are in attendance. One (1) shall be a paid staff member. (4-6-05)

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 site 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. (5-3-03)

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)

06. 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)

07. 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)

043. RESPITE.

01. Policy. Respite is a Home and Community Based Service designed to encourage and support efforts of caregivers to maintain functionally or cognitively impaired persons at home. Paid respite staff and volunteers provide companionship or personal care services, or both, when needed and appropriate for the care recipient and the caregiver. Respite services may include, but are not limited to, the following: (4-6-05)

a. Meeting emergency needs; (4-6-05)

b. Restoring or maintaining the physical and mental well being of the caregivers; (4-6-05)

c. Providing socialization for the care recipient. (4-6-05)

02. Eligibility. (7-1-98)

a. The care recipient shall have physical or cognitive impairments affecting ADL or IADL functioning to the extent twenty-four (24) hour care or supervision is required. (4-6-05)

b. A caregiver sixty (60) years of age or older residing with an eligible care recipient who is under sixty (60) years of age is eligible to receive Respite. (4-6-05)

c. A caregiver under sixty (60) years of age residing with an eligible care recipient aged sixty (60) years or older is eligible to receive Respite. (4-6-05)

03. Service Limitations. (3-30-01)

a. When personal care services are a part of the SSP, those services shall be provided by trained Respite employees or trained Respite volunteers. (4-6-05)

b. Services requiring supervision of a registered nurse in accordance with the Nurse Practices Act shall not be performed by respite workers. (3-30-01)

c. The Respite provider shall provide adequate and appropriate insurance coverage prior to assigning its respite employees or volunteers to assist clients with personal care tasks. (4-6-05)

04. Eligibility Determination. Highest priority shall be given to caregivers of care recipients who have the greatest degree of physical or cognitive impairment and who are lacking informal supports other than the regular caregiver. (4-6-05)

044. -- 055. (RESERVED).

056. CASE MANAGEMENT.

01. Policy. Case management 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. (4-5-00)

02. Qualifications. Any person hired to fill the position of case manager or case management supervisor on or after July 1, 1998, shall have the qualifications identified in Subsections 010.09 and 010.11 of these rules. (4-6-05)

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; (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 formal or informal supports that can provide the needed assistance. (5-3-03)

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 case management client who should receive a home visit and a comprehensive assessment. (4-5-00)

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 Information and Assistance component, Adult Protection, provider, or by a community agency. However, case management may receive a direct referral of a potential client who has not been screened. In such cases, case management shall conduct screening or refer the potential client to the Information and Assistance component for screening. (5-3-03)

d. Pre-referral screening shall be performed to determine if a potential client meets the criteria for receipt of case management services. If the potential client meets the criteria and agrees to the referral, the client shall be referred for a comprehensive assessment utilizing the ICOA approved assessment instrument. (4-6-05)

e. Referrals who do not meet the criteria for Case Management Services shall be referred for other appropriate services. (4-5-00)

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

05. Referral for Case Management. Referrals shall be accepted from any source and may include eligible clients who are seeking or already receiving other services. (4-5-00)

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

a. The Case Management Program is encouraged to 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. (4-6-05)

b. Working agreements should address at least the following: (4-6-05)

i. How long each party will take to respond to a request for service; (4-6-05)

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

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

iv. How each party will notify the other of program changes and non-availability of service; and (4-6-05)

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

07. Core Services. Case management provides responsible utilization of available informal (unpaid) supports before arranging for formal (paid) services. The case manager and client, or client's legal representative, shall work together in developing an SSP to establish 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 ensure cost effectiveness and compliance with the SSP. (5-3-03)

08. Program Intake. (4-6-05)

a. Normal Intake. Except under circumstances where a case management waiting list exists, 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. (4-6-05)

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 two (2) working days of receipt of referral. If appropriate and available, a homemaker shall be assigned and service shall be initiated immediately. Referrals assessed to need emergency service shall take precedence over applicants carried on a waiting list. (4-6-05)

c. Client Assessment. To determine the level of need and the type of service needed, an AAA Case Manager or SST shall conduct an in-home assessment using the ICOA approved assessment instrument. Service alternatives shall be discussed and referrals initiated as appropriate. (5-3-03)

d. Assessment Coordination. A client need not be re-assessed if an assessment completed within the past ninety (90) days by the Department provides the same information as the ICOA approved assessment instrument 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. (5-3-03)

09. Individual Supportive Service Plan (SSP). A supportive service plan shall be signed by the client or legal representative prior to initiation of services. (4-6-05)

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 provider shall inform the AAA of any modifications it suggests be made to the SSP, such as changes in hours of service or tasks to be performed. (4-6-05)

c. Reassessments of SSP. Case Management shall update the SSP 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. (4-6-05)

d. Client assessment shall be conducted during a home visit and shall utilize the ICOA approved assessment instrument. (5-3-03)

e. SSP. Based on the information obtained during the client assessment and input obtained from family or professionals familiar with the client, the case manager shall develop a written SSP which shall include at least the following: (4-5-00)

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 case manager to develop the informal support services; (4-5-00)

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

vi. Schedules for case management monitoring and reassessment; (4-5-00)

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)

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

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

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

a. Necessary Services. Case managers shall assist clients to obtain available benefits, services, medically related devices, assistive technology, necessary home modifications, or other services required to fulfill unmet needs. (4-5-00)

b. Social-Emotional Support. Case managers shall link clients and their families with available services which facilitate life adjustments and bolster informal supports. (4-5-00)

c. Unmet Needs. To assist the AAA in future planning, case managers shall identify and document unmet client needs. (4-5-00)

d. Other Resources. In all cases, other available formal and informal supports shall be explored prior to utilization of formal Aging Network services. (5-3-03)

11. Structure and Role. Case management is a centralized evaluator and arranger of services and provides those activities previously outlined under "Service Functions." AAAs shall be the direct provider for case management services. The AAA is responsible for the implementation of the case management program. (4-5-00)

a. Case managers shall coordinate service delivery between multiple agencies, individuals, and others. (4-5-00)

b. Each AAA shall carry insurance covering case management services in the types and amounts which meet acceptable business and professional standards. (5-3-03)

c. Each AAA shall conduct an orientation program for all new case management employees which covers, at least, local resources available, case management service delivery, confidentiality of information, and client rights. (4-6-05)

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 Case Management Program, and funding agencies, and which supplies data for AAA planning efforts. The information system established shall comply with the following ICOA requirements: (4-5-00)

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

ii. Completed ICOA approved assessment instrument; (5-3-03)

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 Case Management Services and release of information forms; (4-5-00)

vii. Any other documentation necessary for systematic case management and SSP continuity. (4-5-00)

12. Standards of Performance. AAAs shall assure case management meets the requirements for service neutrality. AAAs shall not be a direct provider of other in-home services, other than Adult Protection, without proper written justification and approval by the Administrator of the ICOA. (5-3-03)

13. Evaluation. Evaluation is required to assure quality control. The AAA is responsible for monitoring case management activities for quality control and assurance. The AAA shall review client records to determine: (4-5-00)

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 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 case manager, re-evaluations, amendments to the SSP, and client contacts. (4-5-00)

057. -- 999. (RESERVED).

Subject Index