Chapter 2

Intake, Screening, Prioritization, Assessment, and Case Management

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Section I: Screening and Assessment Forms

A. Screening and assessment forms are used to complete an initial assessment to place clients on the Department's statewide priority consumer list, or annual reassessment of clients enrolled in Department funded case-managed programs. The assessment forms are also used for current clients who have requested to update their assessment information when a significant change takes place. Assessment information then evolves into the development of profiles on client impairments and service needs which are useful in planning and budgeting for those needs.

The assessment helps to identify areas of need where services and/or informal networks should be developed in relation to the following:

- Mental Health/Behavior/Cognition;
- Physical Health;
- Activities of Daily Living (ADLs);
- Instrumental Activities of Daily Living (IADLs);
- Nutrition Status;
- Health Conditions/Special Services/Medications;
- Caregiver Status;
- Social Resources; and
- Environmental Risks.

B. Screening and Assessment Forms:

- DOEA Form 701S: Initial and Annual Reassessment
- DOEA Form 701B: Comprehensive Assessment
- DOEA Form 701C: Congregate Meals Assessment
- DOEA Form 701A: Condensed Assessment

Section II: Administration of Client Screening and Assessment Forms

A. Assessment Instructions (DOEA 701D): Specific and detailed instructions for completing the assessment forms are included in the Assessment Instructions (DOEA 701D) at elderaffairs.org.

B. DOEA Screening Form 701S:

- Primarily used for screening and re-screening individuals for enrollment and maintenance on the Assessed Prioritized Consumer List (APCL) for both the Statewide Medicaid Managed Long-Term Care (SMMC LTC) Program and Department funded programs. Completion of the form automatically generates a priority score and rank in eCIRTS. This priority score is indicated as part of a range of 1-5, with the lowest value being 1.

It is used to prioritize persons so that those in the greatest need and with the least assistance available will receive services first. If the applicant is determined to have a low priority and is not served, they may be placed on the APCL.

- The 701S is to be completed over the phone by ADRC staff who:
    - Meet the minimum education and experience requirements set forth by FAC 58B-1.003.
    - Have completed the Long-Term Care Program Education (LTCPE) training and received notification of a passing score on the required test.

- The ADRC must have policies and procedures that document quality assurance activities to include use of the Assessment Instructions (DOEA 701D), direct observation, coaching, and training of screening staff to ensure the accuracy and quality of the screenings being conducted. This includes the accuracy of the 701S data entry into eCIRTS.

- Attempts to contact the individual with the goal of completing a 701S are made within three (3) business days after receipt of a referral. If the screening cannot be performed at the time of the contact, appointments must be scheduled as promptly as possible, but no longer than 14 business days from the initial contact. Extenuating circumstances must be documented in eCIRTS. Documentation of such circumstances must include the date of the referral, attempted/successful contacts, and the date the 701s is completed, if applicable.

- If the 701S is used for OAA, the screener will be directed to the nutrition risk section of Form 701S only if “YES” is answered to the question, “Do you need other assistance for food?” The nutrition risk score is generated when the nutrition risk section of the screening is completed.

- The Contractor shall complete an Annual Rescreening DOEA Form 701S for all individuals on the SMMC LTC APCL maintained by the ADRC except for individuals who are active in another program and have a current (within one year) 701B in eCIRTS.

C. DOEA Assessment Form 701B

- Used to complete initial comprehensive client assessments and annual client reassessments for all clients enrolled in SMMC LTC as well as the Department funded case managed programs listed below.
    - ADI: Alzheimer’s Disease Initiative.
    - CCE: Community Care for the Elderly.

  - HCE: Home Care for the Elderly.
  - LSP: Local Services Program (if case management provided).
  - OAA: Older Americans Act (if case management provided).

- The 701B is completed face-to-face in the person's home.

D. Assessment Scores:

Two scores are produced when the completed DOEA 701B is entered in eCIRTS.

1. Risk Score: This score indicates the likelihood that the individual will go into a nursing home.

- There are questions within the Assessment Instrument, which add value to the risk score, measuring the client's frailty.
- The risk score can change after the client begins to receive services due to changes in the client's medical and physiological condition. Nevertheless, as frailty normally increases with age, the risk score tends to increase over time.
- This score has values that range from 0-100.

2. Priority Score: This score indicates the client's need for services.

- Both the client's frailty and the resources available to meet his/her needs are calculated.
- Greater frailty adds to the score, while the available resources subtract from the score.
- The priority score tends to decrease as the client receives services.
- This priority score is indicated as part of a range of 1-5, with the lowest value being Rank 1.

E. DOEA Assessment Form 701C

- Used to complete initial assessments and annual reassessments for individuals in need of congregate meals and nutrition counseling services in the OAA Title III C1 program. A nutrition risk score is generated.
- The 701C is to be completed face-to-face at a meal site.

F. DOEA Assessment Form 701A

- A shortened assessment based upon the 701B that generates a priority score, rank, and nutrition risk score and is used to complete initial assessments and annual client reassessments for the following: OAA Registered Services including Adult Day Care, Adult Day Health Care, Chore, Congregate Meals, Escort, Home-Delivered Meals, Home Health

Aide, Homemaker, Nutrition Counseling, Personal Care, and Respite.

- It is administered face-to- face for non-case managed clients in LSP and OAA programs.

- The service "Screening and Assessment" is the OAA service that is billed in eCIRTS to conduct initial and annual reassessments.

- OAA Title IIIE Caregiver Support Program services require client specific reporting in eCIRTS. The 701A collects the required federal report data and establishes the required frailty level of elder recipients (60 or older) to receive OAA Title IIIE Respite (Adult Day Health Care, Adult Day Care, Direct Pay Respite, In-Home Respite, or Facility-Based Respite) or OAA Title IIIES, supplemental services. The 701A documents the required frailty level for eligibility with "two (2) or more ADL deficits" or "Yes" to the question, "Does client need supervision?".

- OAA Title IIIEG Caregiver Support Program services require data for the annual federal report and eligibility for the OAA Title IIIEG program.

- LSP services that are operated under OAA standards.

G. All forms

- The appropriate DOEA Forms, 701B, 701A, or 701C must be completed before or on the date of client enrollment to determine the client's eligibility for the program.

- The reason for the screening must be identified when entered into eCIRTS as initial, annual, or significant change.

- The 701B, 701A, and 701C are to be completed by CARES Assessors and Lead Agency Case Managers who have completed the Department's web-based training:
    - Assessors and case managers must complete the online training and retain a certificate to demonstrate they successfully passed the final examination.
    - The web-based training is hosted by the Department of Management Service (DMS). To register for the training please send your First Name, Last Name, and email address to trainingadministrator@elderaffairs.org. A learner account will be created, then further instruction will be sent to the email address provided.

- Annual reassessments mean 365 days after the prior assessment through the end of the month. Reassessments may be completed up to 30 days

prior to clients' annual reassessment due date.

- Historical data, including certification of completion, for 701B Assessment training completed prior to August 30, 2020, in the previous training system is not available. To obtain a new certificate of completion follow the steps above to register for and then complete the 701B training course in DMS Learning Management System.

- To document the significant change in the client's condition, the appropriate form is completed in its entirety. Examples of significant changes include the following:
    - Change in health status after an accident or illness;
    - Change in living situation;
    - Change in the caregiver relationship;
    - Loss, damage, or deterioration of the home environment;
    - Loss of spouse, family member or close friend; or
    - Loss of income.

The following client scenarios are provided as examples to illustrate the screening and assessment requirements: See below on next page ↓

Screening and Assessment Summaries		
eCIRTS Program Status Codes	**Initial Screening/ Assessment**	**Annual Rescreening/ Reassessment/Significant Change**
APCL ADI, CCE, HCE and LSP (CCE criteria)	701S	701S
SMMC LTC	701S	701S or 701B by lead agency or local provider
APCL OAA (IIIB, IIIC IIIC1, IIIC2, IIIE, IIIEG, and IIIES), LSP (OAA criteria) Note: The 701S will generate a nutrition risk score when the nutrition section is completed. Completion of the nutrition section is required if the response to the question, "Do you need other assistance for food?" is "Yes." Completion of the nutrition section is optional if the response to the question "Do you need other assistance for food?" is "No."	Follow OAA targeting criteria. 701S (except for IIIB transportation and IIIC1 services).	Follow OAA targeting criteria. 701S (except for IIIB transportation and IIIC1 services). Completed annually to maintain the APCL status.
ACTV ADI, CCE, and HCE	701B	701B by case manager
APCL ADI, CCE, HCE, OAA registered services and ACTV OAA C1	701C and 701S (except for IIIB transportation)	701C and 701S (except for IIIB transportation)
eCIRTS Program Status Code	Initial Screening/Assessment	Annual Rescreening/Reassessment
APCL for any program, and ACTV in ADI, CCE, or HCE	701B	701B by case manager
APCL for any program except SMMC LTC, and ACTV in OAA receiving a registered service	701A	701A
APCL for any program except SMMC LTC, or ACTV OAE3G and ACTV in OA3E receiving at least one service that requires client specific reporting	701A	701A
ACTV ADI, CCE, HCE, SMMC LTC	701B	701B
ACTV any Department funded program (including OAA or LSP) and receiving Case Management	701B	701B
ACTV OAA receiving registered service(s)	701A	701A
ACTV O3C2	701A	701A
ACTV OAA C1 only	701C	701C
ACTV OAA receiving registered service and ACTV OA3E	701A	701A
ACTV OAA receiving registered service and ACTV OAA C1	701A	701A
ACTV OA3E receiving at least one service that requires client specific reporting only	701A	701A
ACTV OA3EG and OA3ES	701A	701A
ACTV LSP, if case managed	701B	701B
ACTV LSP, not case managed	Follow OAA criteria	Follow OAA criteria

Section III: Intake and Screening

The following information addresses the ADRC and provider agency responsibilities as they pertain to the intake and screening process.

A. Entrance to Community Care Service System: Individuals seeking services may enter the community care service system by direct contact with an ADRC or an access point. An access point is a service provider or other entity that performs one or more ADRC functions under an agreement with the ADRC. If the access point has a direct monetary funding agreement, the ADRC must have a process for monitoring and sanctioning the access point in accordance with Section 58B-1.005, F.A.C., including routine observation. Access points may not perform any ADRC service functions for SMMC LTC applicants.

B. Intake Process:

1. Process Commencement: The intake process begins when an individual seeks assistance by contacting the Elder Helpline or other access point.

2. Necessary Information: Essential information about the nature of the person's physical, mental, and functional abilities, concerns, limitations, or problems, as well as general background information, is obtained during the intake process to assist in screening for eligibility and appropriate program and service referrals.

3. 701S Screening is administered for APCL.

C. APCL Maintenance and Prioritizing Enrollment of New Consumers

1. Assessed Priority Consumer List (APCL): APCL is maintained in eCIRTS when SMMC LTC services or services funded by Department are not available.

2. Potential consumers or referring parties must:

- Be informed about SMMC LTC, the eligibility process, and the waitlist, including the individual's potential for Medicaid eligibility, if the individual appears to be eligible.
- Be provided suggestions regarding additional sources of assistance, including PACE, other Medicaid programs, Older Americans Act services, General Revenue programs, Supplemental Nutrition Assistance Program (SNAP, formerly known as Food Stamps), and private pay options; and
- Be provided ADRC contact encouragement to call for a significant change rescreening if the individual's situation changes.

- Have their demographic information updated by the AAA when moving out of County or service area or the person has passed away.

3. If there is a significant change in a consumer's condition between annual comprehensive assessments, then the purpose of the assessment will indicate changes in one or more of the following client conditions: Health, Living Situation, Caregiver, Environment, or Income. The new assessment will automatically reflect an updated priority score and rank in eCIRTS.

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

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

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

7. An individual whose inclusion on the waitlist is terminated must initiate a new request for placement on the wait list, and any previous priority considerations must be disregarded.

8. For SMMC, refer to EMS procedures for exceptions.

D. Consumer Enrollment in DOEA-Funded Programs to Receive Services: Consumer enrollment in DOEA-funded programs is based on availability of funding, program-specific eligibility, targeting, and prioritization criteria as stated in law, rule and DOEA contracts.

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

2. CCE: Pursuant to Section 430.205(5), F.S. Adult Protective Services referrals in need of immediate services to prevent further harm will be given primary consideration for receiving services in the CCE program. APS high-risk clients (Rank 8) must receive case management and crisis-resolution services within 72 hours of the APS referral per DOEA policy.

3. ADI, CCE, HCE, LSP, and SMMC LTC: Approval to begin the eligibility process for ADI, CCE, HCE, LSP, and SMMC LTC is determined by the

availability of funds and the priority score or rank of individuals. The order of priority is as follows:

a. Individuals designated as Adult Protective Services High-Risk (Rank 8);

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

c. Individuals designated as Aging Out (Rank 6); and

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

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

5. Regarding consumers who are released from the pre-enrollment list and assessed using the 701B:

- ADI, CCE, and HCE applicants may continue with program enrollment regardless of the 701B priority score or rank.
  - Only after completing the 701B assessment is a determination of an individual's functional impairment made for eligibility determination. If the individual is determined by the case manager to be functionally impaired, he or she is eligible to receive ADI, CCE, or HCE services. The case manager also determines the individual's risk of institutionalization without ADI, CCE, or HCE services. Priority is given to the individual most at risk. Therefore, it is up to the provider to determine if a client shall continue with program enrollment or be placed back on the pre-enrollment list.

- SMMC LTC potential clients are placed on APPL status in accordance with the Statewide Medicaid Managed Care Long-Term Care Program Enrollment Management System (EMS) procedures.

6. SMMC LTC: Refer to the SMMC LTC Enrollment Management System (EMS) Procedures for monthly release procedures and impact on 5, 6, 7, and 8 rank. Approval to begin the eligibility process for SMMC LTC is authorized by the Department’s notification of an EMS release to the ADRCs.

7. Once the client becomes active in SMMC LTC, CCE services may continue for 30 days after the client’s SMMC LTC start date. The CCE ACTIVE span must be closed in eCIRTS once the 30 days have elapsed.

Section IV: Case Management Requirement

A. Case management is a required service for clients with an active enrollment in the Alzheimer's Disease Initiative (ADI), Community Care for the Elderly (CCE), and Home Care for the Elderly (HCE) state funded programs.

Case management is not a required service for clients with an active enrollment in Older Americans Act or Local Services Programs that follow OAA guidelines. If case management is provided under OAA Title IIIB for clients enrolled to receive OAA registered services or LSP, then all case management requirements apply.

The purpose of case management is to coordinate the delivery of community care services in accordance with the following principles:

1. Gatekeeper: The case manager is the community care service system "gatekeeper" with the knowledge and responsibility to link clients' needs to the most beneficial and least restrictive array of community services and resources.

2. Client Centered: Case management is client centered. Case managers shall make every effort to link clients with appropriate formal and informal support, regardless of the agency or organization offering the services and advocate on the client's behalf to help the client to receive the assistance needed.

3. Limiting Services: Case managers should not limit services only to those services offered by their agency.

4. Coordination: Case managers should ensure full coordination of services provided by various agencies and individuals and pay attention to the scheduling of services in the home of the client.

5. Linking Services: Case management is the link between social services programs, home and community-based service providers and health care delivery systems, such as physicians, hospitals, health maintenance organizations (HMOs), and nursing homes.

6. Informal Support Systems: Case management provides the contact through which the family, caregivers, neighborhood help organizations and volunteer services assist the client. The case manager is a developer of informal support systems, one of the most necessary and productive components of long-term care. Case managers should actively pursue informal resource development.

7. Assistance to Families: Case managers assist clients' families as well as clients. Allowing for legally competent clients to choose who participates in decisions about their care, case managers will encourage families to be involved and link them with respite care resources as needed.

8. Family Training: Case managers should encourage family members to receive training in caregiving methods.

B. Goals of Case Management are the following:

1. Self-Sufficiency*:* To coordinate services that assist clients in becoming more independent, remaining in the least restrictive environment, and attaining or maintaining the highest level of physical, mental, and psychosocial well-being.

2. Quality Assurance: To ensure effective and efficient client care through the following activities:

- Initiating or terminating services;
- Increasing or decreasing services;
- Assessing client needs in a comprehensive manner;
- Determining client satisfaction with services;
- Planning and arranging for appropriate services (duration, scope, frequency) provided to clients within a reasonable time and that produce effective results;
- Coordinating services through community care service systems and eliminating unnecessary overlap of services, as possible; and
- Documenting gaps between services that are needed and those presently being received for planning and budgeting purposes.

3. Continuum of Care: To provide access to holistic care, ranging from services in the home to institutional care.

C. Role of the Case Manager: Functions and responsibilities of the case manager include the following:

1. Investigating Community Resources: The case manager is responsible for knowledge about all formal and informal community resources to coordinate client services.

2. Receiving and Documenting Referrals: The case manager is assigned referrals for case management services.

- The case manager shall complete an initial comprehensive assessment using the 701B.

- The 701B is entered in eCIRTS and any handwritten notes on the paper assessment form must be entered in the appropriate eCIRTS field, and a priority score and rank are generated. Referrals to other agencies shall be documented.

3. Networking with other Agencies: The case management agency shall develop a network with other agencies to assist clients in obtaining needed services.

- This network will provide valuable information, save valuable time coordinating client services, and prevent service duplication.

- The case manager is responsible for making referrals when appropriate. This may include such agencies or offices as the Department of Children and Families (Supplemental Nutrition Assistance Program), Social Security Administration, or Veterans Administration.

4. Completing the Client Assessment: The case manager shall complete the Comprehensive Assessment (DOEA 701B). The assessment will determine the client's level of functioning, existing resources, and gaps in service.

5. Developing a Care Plan: If the client is determined eligible for services after the comprehensive assessment is completed, a care plan and confidential file must be developed for each client. The case manager shall use the uniform care plan (DOEA 203A and additional pages DOEA 203B) to develop with the client, caregiver and/or designee, ways to address service needs.

The care plan can also be completed and printed from eCIRTS pulling data from the Services page. All services the client is to receive will be entered on the Services tab of the client's record. See the Services section of the eCIRTS Training Manual for more information.

6. Arranging Needed Services: The case manager shall complete the care plan within 14 days after completion of the client assessment. The case manager must arrange needed services offered by agencies in the community care service system and organize informal sources.

7. Referring to Other Sources: Services not arranged through agency contracts should be obtained through referrals to other community resources. Referrals may be made to volunteer agencies, informal networks and proprietary agencies that charge fees.

8. Providing Follow-up: The case manager or case aide must conduct a follow-up contact on service arrangements and referrals within 14 days following such arrangements to ensure that services have begun.

9. Communicating with Other Agencies:

- Agency Involvement: It is very important for all agencies involved to know when a client's needs change or when an agency, for whatever reason, modifies its services.

- Assistance: Some agencies may be able to assist or know of other resources to help the client.
- Staffing: One way to ensure communication and coordination of services is to meet on a regular basis with other agencies for case staffing.

10. Documenting Case Activities: A good case record serves as an invaluable aid in rendering services to the client and documenting the outcomes. The record serves as the tool for relevant information regarding the client's progress. The case manager has the responsibility for the following:

- Initiating and maintaining the case record.

- Documenting pertinent information in the case record and updating the record when conditions change or following periodic contacts with the client; and

- Writing in a fashion to enable an independent reviewer to fully understand the client's status and services and obtain a good overview of case management. Legibility of handwriting or use of word processing, along with a legend of abbreviations used, is vital to a good case record. (See the Case Record Section of this chapter for required documentation.)

11. Contacting the Client to Review and Monitor the Care Plan: The case manager must make a home visit to review the care plan at least every six months, or more frequently, based upon the individual client's needs and program requirements.

- Continuity of Care: The case manager will oversee the care plan for continuity of services and changes in the client's functioning that warrant increases, decreases, or other changes in the recommended care plan.

- Care Plan Review: The review is not a complete reassessment, but a review of service goals and changes in the client's status that may warrant modification to the care plan. The case manager will discuss any changes in the care plan with the client, caregiver and/or designee for acceptance prior to changes in service provision. The case manager will verify service quality and client satisfaction.

12. Client Reassessment: For case management, as well as planning and coordination purposes, the case manager must perform a face-to-face client reassessment at least once every year.

- Reassessment Form: The case manager shall complete the Comprehensive Assessment (DOEA 701B) in accordance with the instructions in the Client Assessment section of this chapter.

- Reassessment Results: Reassessment results are to be used to evaluate and modify the care plan, if needed.

13. Discontinuing or Modifying Services: The decision to discontinue or modify services shall include the client, family members or caregiver, after a review and update of the client's situation.

- Improvement of Condition: If the client's health or functional status improves, then the case manager shall modify the care plan, accordingly, accommodating assistance from family members or other community supports. If formal services are no longer needed, the case manager shall terminate services.

- Deterioration of Condition: If the client's health deteriorates to the extent that more extensive care is needed, then the case manager shall assist the person in locating the most appropriate, least restrictive, and most cost-effective alternate living arrangement.

- Client Behavior Problems: The case manager may close the case when the client exhibits any of the following behaviors:

    - Refuses to continue services; or
    - Is uncontrollable, uncooperative, or combative.

- The case manager shall document in the case narrative circumstances of the situation and the progression of the behavior problems.

- Documentation: The case record must reflect adequate documentation for service modification or termination. The client must be notified in writing 10 calendar days in advance of the termination of services, except in the case of death, the client moving out of the service area, the client moving to an assisted living facility or nursing home, or the client requesting the termination.

14. Referrals to Protective Services (Florida Abuse Hotline): Agency staff or their subcontractors must report any suspicions of abuse, neglect, or exploitation to the Florida Abuse Hotline.

- Florida Statutes: The Florida Abuse Hotline was established by Section 415, F.S., to record all such incidences.

- Hotline: On-call coverage for reporting of abuse, neglect, or exploitation of disabled or infirmed, aged adults is provided 24 hours a day, seven days a week by the Florida Abuse Hotline staff at a toll-free number: 1-800-96 ABUSE (1-800-962-2873).

- Investigation*:* Each complaint of alleged abuse, neglect or exploitation accepted by the hotline is phoned to the designated Adult Protective Services investigator in the respective district for contact and action.

D. Recommended Staffing, Caseload Standards and Case Manager Supervision:

1. Caseload: A caseload consists of those clients determined eligible and receiving case management services.

- Average Caseload: DOEA suggests maintaining a caseload of 60-70 clients per case manager full-time equivalent (FTE).

- Over Average Caseloads: Caseloads exceeding 100 clients per case manager require a waiver from the Area Agency on Aging (AAA).

2. Case Manager Supervisor: Case manager supervisors may be established in agencies employing five or more case managers.

- Supervisor's Caseload: The case manager supervisor may handle a small number of cases, not to exceed half of the size of a case manager's caseload (30-35 clients).

- Alternate Supervision: In smaller projects, supervision may be provided by the project director or other project staff with direct service experience.

E. Job Description Inclusion Requirements

1. Case Manager Major Duties and Responsibilities

a. Referral and Assessment: Receives referrals and completes initial assessments and annual reassessment. After the new client is released and it is determined that funding is available to provide services, the case manager will schedule a face-to-face visit with the client to complete the Comprehensive Assessment (DOEA 701B). The form will generate a priority score and rank to prioritize the client in comparison with all other clients waiting for services. If the applicant can be served, the

Comprehensive Assessment will be completed within 14 business days after receiving the referral. In all cases, the Comprehensive Assessment (701B) will be completed face-to-face with the client before services have begun.

- Information: Provides information as needed to involve the client, caregiver and/or designee in the care plan.

b. Care Plan: Develops a care plan in conjunction with the client, caregiver and/or designee, obtaining the client's concurrence and signature or that of the client's representative, if the client is unable to sign the care plan. If the client is legally incompetent, his/her guardian must sign the care plan.

- Follow-up: Arranges for, and follows up on services provided; and reviews care plans with other professionals involved with service provision

- Home Visits: Makes home visits.

- Case Records: Maintains individual case records.

- Informal Support Network: Develops informal support network (relatives, volunteers, friends, etc.) when there is no caregiver or when additional help is needed.

- Expanded Support Network: Builds an expanded support network with members of the client's immediate community.

- Care Plan Review: Reviews care plan with supervisor at initial development. This may be a team activity for subsequent reviews.

- Services: Arranges services and coordinates service delivery.

- Respite Care: Arranges respite care for caregivers as needed. Refers caregivers to, or arranges for, counseling/support groups to relieve the stresses of the caregiver role.

- Training: Encourages and may arrange for caregivers, family members or friends to attend training where possible.

- Client Reassessment: Completes written client reassessment at least annually and more frequently if conditions warrant.

- Client Record: Completes and maintains a client record with

progress reports and forms related to service provision and ongoing documentation.

- Supervisory Role: May supervise other personnel.

- Other Duties: Performs other duties, as necessary.

2. Minimum Qualifications: A case manager must meet one of the following qualifications:
- A bachelor's degree in social work, sociology, psychology, nursing, gerontology, or a related social services field; or

- Year for year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA.

F. Case Aide Major Duties and Responsibilities

1. Case aides are paraprofessionals who complement or supplement the work of case managers. The case aide service is not a stand- alone service and is only provided in conjunction with the provision of case management. Case aide activities are billed as case aide services and not case management services.

- Assist with the implementation of care plans.

- Assist with accessing medical and other appointments.

- Perform follow-up contacts. This may include the monthly contact with the HCE caregiver.

- Oversee quality of provider services.

- Deliver supplies and equipment.

- Assist with paying bills.

- Assist the client or caregiver in compiling information and completing applications for other services and public assistance.

- Facilitate linkages of providers with recipients via telephone contacts and visits.

- Determine client satisfaction with services provided.

- Arrange, schedule, and maintain scheduled services.
- Document activities in the case record.
- Reconcile and voucher activities.
- Assist with HCE monthly contact to confirm caregiver eligibility; and
- Record telephone and travel time associated with billable case aide activities.
- Provider Qualifications:

2. Provider Qualifications: Minimum qualifications for case aides include a high school diploma or General Educational Development (GED) diploma. Job related experience may be substituted for a high school diploma or GED diploma upon approval of the AAA.

G. Case Manager Supervisor Major Duties:

- Supervision: Supervises case managers and case aides.
- Care Plans: Reviews care plans at initial development, and as necessary, ensures follow-up on all care plans.
- Reviews, Reassessments, Case Records: Ensures completion of semiannual reviews and annual reassessments for clients and that appropriate case records are maintained.
- Service Delivery: Ensures that providers deliver services as scheduled, within specified time frames and without negative incident.
- Coordination: Resolves service delivery problems and ensures coordination among community care providers.
- Problem Resolution: Resolves problems between the case manager and client or caregivers.
- Quality Assurance: Reviews service provision to ensure effective and efficient client care.
- Home Visits: Makes random client home visits for the following objectives:
    - To ensure that service plans are followed;

- To become familiar with the client's environment; and
- To ensure accuracy of case recordings.

- Respite Care: Ensures that respite care is arranged for caregivers as needed.
- In-Service Training: Arranges for in-service case manager training.
- Informal Support Systems: Ensures that case managers are actively developing informal support systems among clients' neighbors and community volunteers.
- Caregiver Training: Ensures that caregivers, family members or friends receive training where possible.

H. In-Service Training Program:

1. Program Development: Each provider agency shall develop a preservice and annual in-service training program for case management staff.
2. Minimum Standards: Each provider agency shall conduct, at a minimum, an annual in-service training of six hours and will document the duration and content in case management staff records.
3. Description and Allocation of Funds: Each provider agency shall describe and allocate budget funds for training in the provider application.
4. Minimum Standards: Training will include, at a minimum, the following topics:
    - Overview: Overview of community care services.
    - Relationship: Relationship of case management to the community care services system.
    - Completion of Forms: Use and completion of assessment instruments and care plans.
    - Interviewing: Interviewing skills and techniques.
    - Record Keeping: Record-keeping procedures.
    - eCIRTS: Client Information and Registration Tracking System (eCIRTS) procedures.

- Aging Network Overview: Overview of the aging network (AAA, AHCA, DCF, DOEA and other agencies) and the agency's relationship to the community care service system;

- Caregiver Training: Caregiver training regarding responsibilities and resource development techniques.

- Coordination Training: Interagency coordination and informal network development training; and

- Adult Protective Services (APS) Training: Training on the Abuse Registry Tracking Tool (ARTT) and the APS Referrals Operations Manual.

I. Conducting the Interview

1. Interviewing Techniques

a. Establishing Rapport:

- Interview Relationship: The assessor must make every effort to establish a good interviewing relationship and environment by providing warmth, genuineness, and empathy.

- Respect and Dignity: The assessor must treat the applicant/client with dignity and respect.

- Hints: The assessor should refer to "Assessor/Case Manager Skills" in the Assessment Instructions (DOEA 701D) for hints in establishing rapport.

b. Applicant/Client Involvement:

- Privacy: In most cases the applicant should be interviewed alone.

- Involvement of Others: A caregiver and/or designee may need to be present to provide the assessment information if the applicant/client is confused, very ill or otherwise unable to provide the necessary information. However, the assessor must make an effort to involve the client as much as possible in the interview.

c. Statement of Interview Intent: The assessor will state that the intent of the interview is to obtain specific information to:

- Determine what type of assistance the person may need; and

- Ensure that all eligibility criteria are met.

d. Confidentiality: The assessor will inform the client that the data collected will be kept confidential; however, with his/her written consent, there may be situations when information will need to be shared with another agency to obtain services that will be of assistance. It should be understood by clients that failure to provide informed consent may preclude referral to another service agency. However, the client's refusal to consent to sharing his/her information with another agency does not prohibit the client's receipt of services from the interviewing agency. All HIPAA regulations (the federal Health Insurance Portability and Accountability Act of 1996) will be followed always. (Case Management Requirements —Case Record for more information on confidentiality).

J. Care Planning and Service Arrangement

1. Case Manager: The case manager uses the care plan for the following tasks:

- Information Organization: To organize service information related to client problems/gaps; and

- Documentation: To document the plan of action to address client problems and needs through the development of service solutions that meet the client's needs.

2. Care Plan Inclusions: The care plan should prescribe the following services:

- DOEA Funded: Services provided through DOEA-funded programs; and

- Non-DOEA Funded: Services funded outside of DOEA, or informal services provided by the caregiver and/or designee.

3. Development of Care Plan: The case manager utilizes the information gathered through the assessment in the development of a client-centered care plan. The final notes and summary section of the Comprehensive Assessment is a summary of all assessment information and will assist the case manager in developing the client's care plan.

a. The care plan development is:

- Mutual Endeavor: A mutual endeavor between the case manager, the client, caregiver and/or designee, and the caregiver and other family members; and

- Roles: Recognition of the roles and contributions of family members.

4. Client or Caregiver/Case Manager Expectations: The following applies to the client, caregiver and/or designee and case manager:

a. Written Consent: The client, caregiver and/or designee, if the client is unable, must be involved in the care plan development and must provide written consent to the plan.

b. Expectations: To avoid possible false expectations on the part of the client, caregiver and/or designee, the case manager shall explain, during the initial interview, that services will be planned and provided as feasible, in keeping with the care plan goals.

5. Time Frame: The case manager must complete the care plan within 14 business days after completion of the client assessment. The client shall receive a copy of the care plan.

6. Care Plan Consultation: The case manager may consult with individuals, such as the client's physician, nurse, hospital discharge planner or other specialized medical staff, as possible, to ensure appropriate care planning.

7. Client-Centered Care Planning: Case managers shall perform the following client-centered tasks regarding care planning and concentrate on assisting clients to identify:

- What the client identifies as problems.
- What solutions are available to alleviate the problems; and
- Whether the solutions are possible or feasible.

a. Commitment: The client's commitment to the plan is crucial as well as the commitment of the caregiver and/or designee.

b. Case Manager Role: The case manager should use communication skills to enable the client to perform the following care planning tasks (or the caregiver and/or designee in the absence of client capability):

- Understand goals;
- Appraise resources; and
- Decide on a course of action.

c. Case Manager Identification of Goals: In some instances, case managers may

identify additional goals that they should discuss with the client and, if agreeable, add to the care plan.

9. Consideration of Most Appropriate Resources The case manager shall consider the most appropriate resources to provide the services outlined in the care plan. The client must be given the opportunity to participate in the selection of service providers.

b. Non-DOEA Services: Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/employee assistance programs, private insurance, association, religious/other and local government.

- Service Development: These services shall be developed to effectively address client needs as an alternative to purchased services from providers of DOEA funded services.

- Preservation of Funds: Case managers shall emphasize using informal resources, whenever possible, to preserve program funds for clients with the most critical needs.

- Other Resources: The case manager and client shall consider informal resources, such as faith-based organizations and civic groups, in the development of the care plan.

- Examples:

    - A concerned friend or family member can sometimes arrange to provide homemaker or personal care assistance.
    - A faith-based organization can sometimes provide meals or transportation services.

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

d. Resource Directory: The case manager should have access to a local community care service system directory, and the statewide aging resource center database to assist individuals in selecting and arranging for services.

e. Client Refusal: If a client refuses a service(s) recommended by the case manager, the case manager must document the refusal in the case narrative notes in the client's case file. The case manager may periodically suggest adding the needed service.

K. Review and Evaluation of Services

1. 14-Day Follow-Up Contact: The case manager or case aide must telephone or visit the client within 14 business days following the ordering of services to determine the following:

a. Service Satisfaction: Is the client satisfied with the services? If not, why?

b. Quality of Service: Is the client satisfied with the quality of the services performed? If not, why?

c. Interviewer: The individual conducting the interview is not required to observe the service being performed but is encouraged to observe services being performed and conduct discussions with the service worker, if there is any indication that this action would be beneficial in determining the quality of services (e.g., the client expresses dissatisfaction with the way the service is performed).

2. Quality Assurance (QA) Interviews: Quality assurance interviews should rate the following subject areas at a minimum:

a. Rapport: Service worker's rapport with the client. Does the service worker communicate effectively with the client (no language barriers)?

b. Service Worker Attitude: Service worker's attitude towards job performance. How does the service worker approach the job? Is he/she positive, negative, enthusiastic? Other observations.

c. Service Worker Compliance: Service worker's compliance with assigned duties. Are all services being completed as assigned?

d. Service Worker Dependability: Service worker's dependability regarding the work schedule. Does the service worker arrive timely; arrive when expected by the client; stay as planned in the care plan?

e. Client Evaluation: Client's evaluation and assessment of the service provided. Is the client satisfied with the services received?

f. QA Interview Format: Agencies may devise their own formats for the quality assurance interview.

L. Review and Update of the Care Plan

1. Care Plan Review: Case manager responsibilities are as follows:

a. Semiannual Review: The case manager shall conduct a care plan review and home visit at least semiannually or more frequently, if necessary, depending upon the changes in the client's condition.

- Definition of Semiannual: 180 calendar days after the initial service delivery through the end of the month.

- Example: If the initial service date is July 23, 2014, then the case manager must complete the semiannual review by January 31, 2015.
- Sample Review: The case manager shall review a sample of service delivery logs during the semi-annual review to ensure services were delivered per the care plan, and that the service delivery logs indicate all tasks performed during the service period.

b. Review Schedule: The case manager shall establish a care plan review schedule for home visits and face-to-face contact with each client based on this standard.

Note: *eCIRTS Training Manual- 6 Month and Annual Care Plan Review: The Case Manager will be reminded by a tickler in eCIRTS to complete a 6-month care plan review and an annual care plan review. The 6-month tickler is due 6 months after the Care Plan Date on the General Information page. 1. The Case Manager will monitor his/her My Work > Ticklers queue daily and work the ticklers due that day/week. Closer to when the 6-month review is due, the Case Manager will open the tickler from My Work > Ticklers queue and locate the tickler.*

c. Continuity of Services/Changes in Client Status: The case manager will monitor for continuity of services and changes in the client's functional status, which warrant the following changes in the recommended care plan:

- Additional services;

- Reduction in services; and

- Any other changes.

d. Review Parameters: The review is not a complete reassessment but a review of problems/gaps and changes in the client's functional status that warrant modification of the care plan.

e. Review Date: The review date will be posted on the care plan form along with the case manager's initials.

2. Care Plan Update to Case Narrative: The case manager's responsibilities for

case narrative are as follows:

a. Address Goals: Address each service need listed on the care plan in the case narrative after the semiannual visit.

b. Progress/Barriers: The case narrative shall describe progress, regress, or barriers encountered.

2. Review Outline: The care plan review must comply with the following guidelines:

a. Review Date: The case manager shall visit the client and review the care plan at least semiannually and review the care plan.

b. Service Needs: The case manager and client will discuss the following:

- Continuation of current services in relation to the client's identified needs; and/or
- Need for additional services due to changes in condition; and/or
- Acknowledgement of improvements and the corresponding modification or termination of specific services.

c. Plan for Services: The case manager will perform the following tasks regarding client services:

- Review services provided;
- Discuss any changes that need to be made with the client, caregiver and/or designee; and
- Revise the care plan, as needed.

M. Case Closure/Service Termination

1. Procedures: Procedures shall be developed to discontinue services to clients when their condition has either improved or declined sufficiently that services are no longer effective or appropriate.

2. Case Closure: An individual's case may be closed for services for any of the following reasons:

a. Change in Condition: The client's condition has declined to the extent that he/she can no longer be safely maintained in the home.

- Hospitalization: In the case of hospitalization, the case manager shall maintain contact with the client and hospital social services worker to assist in planning for the client's discharge.

- Other Placements: If the client is discharged to a location other than home (e.g., nursing home, assisted living facility, adult family care home or other placement), the case manager shall maintain contact with the client for a three-month period or until it is evident that return to the home is no longer possible. Follow-up with the placement facility staff may be completed by correspondence or telephone.

b. Move Out of County/Service Area: The case manager shall arrange to transfer client records upon request and communicate with service providers in the client's new area.

c. Client Death: The case manager shall close a case upon the death of a client.

d. Client Ineligibility: The case manager shall close cases when clients become technically or financially ineligible for services.

e. Services No Longer Needed: The case manager shall close cases when services are no longer needed such as the following:

- Improved Condition: The client's functional status has improved so that services are no longer required.

- Other Sources Available: The client's family or other persons are available to assist the client.

- Transfer to Another Program: The client is transferred to another program.

- Client Request: The client requests that services be terminated.

3. Responsibilities in Case Closures:

a. Case Manager: The case manager shall record a brief explanation of the termination reason and the effective date in the case record.

b. Case Management Agency: The case management agency shall develop and implement the following:

- Written Notification: To provide advance written notification to clients when terminating services; and

- Grievance Rights: To provide information to clients regarding their right to appeal the decision except in the following situations:

    - The client has moved out of the service area;

    - The client requested termination;

    - The client has been placed in an assisted living facility or nursing home; or

    - The client has died.

- Notification Timeframe: The timeframe for notification shall be established in conjunction with the case management agency's grievance procedures.

N. Purpose of Case Record

1. The purpose of the case record is two-fold:

a. Single Location: To keep information about the client in a single location; and

b. Client Information Retrieval: To keep the information filed in an orderly fashion for retrieving all pertinent information on a client.

2. Case Record Information: The case record contains current client information. This information is the basis for continuing or adjusting the client's care plan and the basis for review. The case record contains the following:

a. Prioritization Screening (DOEA Screening Form 701S): A completed prioritization form for clients released from an assessed priority consumer list prior to receiving services in a case managed program.

b. Comprehensive Assessment (DOEA 701B): A completed 701B, as well as at least one prior year assessment.

c. Care Plan Form: Current and accurate care plan form(s), covering at least the past two years. The form(s) should be signed and dated annually and should reflect the initials and dates of semiannual or more frequent care plan reviews.

d. Grievance Procedures: A current notice of grievance procedures signed and dated by the client, applicable to terminations, suspensions, or reductions in service.

e. Case Narrative: A current and accurate case narrative. A current detailed case narrative showing all contacts with the client, and the caregiver, and notes regarding the client's progress toward achieving care plan outcomes.

f. HCE Financial Worksheet: A financial worksheet for HCE clients. A current and correct form should be included.

g. Co-pay Assessment Form: A co-pay assessment form for CCE and ADI clients. A current and correct form should be included.

h. Specific Forms: Program specific forms for CCE, ADI, HCE or OAA. Forms for individual programs should be included.

i. Other Information: Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.

j. Choice & Options: Documentation of the choices and options given to the client.

3. Case Record Information: When clients request service from an agency, they give the agency the right to receive information about their condition. This information enables the case manager to perform the following tasks:

a. Service Planning/Provision: Plan for and provide appropriate and timely services; and

b. Update Client Information: Update information for current and future delivery of services.

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

5. Care Plan: The case record is the basis for the following regarding care plans:

a. Continuance/Adjustment: Continuance or adjustment of the client's care plan; and

b. Quality Assurance: The basis for reviewing the client's situation.

O. Content of the Case Record: The case record shall contain the following items:

1. Assessment: Completed client assessment form(s):

a. A completed prioritization form for clients released from an assessed priority consumer list prior to receiving services in a case managed program (DOEA 701S, 701A, 701B and/or 701C, as appropriate);

b. Any assessments completed to document a significant change in the client's condition; and

c. Annual Reassessments.

2. Care Plan: Completed care plan - DOEA Forms 203A and 203B - with updates and review dates indicated.

3. Case Narrative:

a. All Case Narratives: Each narrative entry shall be signed and dated by the case manager who performed the activity. Case narrative entries made by a case aide shall be signed and dated by the aide.

- Case management or case aide services are documented with the actual units of services provided, as well as the time spent on the activity. For billing of case management or case aide services, the time spent in direct service with or on behalf of a client is accumulated daily. The cumulative amount of time per service is totaled for the day and minutes are rounded up to the nearest quarter of a unit.

- Service logs documenting the delivery of other services provided may be kept in the client file or may be kept in separate files.

b. The case narratives for Adult Protective Services High-Risk Referrals require the following additional documentation:

- The specific services authorized and the specific service dates for services provided during the 72 hours following the referral must be recorded. This includes non-DOEA services. If services were delayed or not provided, the reason why must be stated, and all actions taken to provide service must be recorded.

4. Co-pay Assessment Form: Copy of the co-pay form for CCE and ADI clients.

5. Home Care for the Elderly (HCE) Financial Worksheet: Copy of the HCE financial

worksheet shall be included for HCE clients.

6. Physician's Assessment/Order: Copies of the physician's assessment and order if the following services are provided:

- Home Health Aide;
- Skilled Nursing;
- Occupational Therapy;
- Physical Therapy; and
- Speech Therapy.

The original physician's order shall be filed at the provider location with a notation of the physician's order in the case narrative.

7. Specific Forms: Program specific forms for CCE, ADI, HCE or OAA. Forms for individual programs should be included.

8. Grievance Procedures: If necessary, a current notice of grievance procedures signed and dated by the client, applicable to terminations, suspensions, or reductions in service.

9. Other Information: Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.

10. Choice and Options: Documentation of the choices and options given to the client.

P. Standards for Security and Privacy of Case Records

1. Locked Files: Client records shall be kept in a locked file within the agency.

2. Client Informed Consent: The case manager must inform clients of the following:

- Purpose for which the information is collected; and
- How it will be utilized, maintained, and disseminated.

3. Information Obtained: The case manager shall inform applicants/clients that information obtained about them is:

- Required to provide services;
- Confidential and protected from loss, defacement, and unauthorized access, and

- available for review by applicants/clients and/or their representatives.

g. Case Record Review: The client and representative/guardian have the right to review the client's case record.

a. Case Manager Responsibility: The case manager shall review and update the case record before releasing it for the client's review.

b. Case Manager Availability: The case manager shall be available to discuss the contents of the case record with the client, if requested.

c. Method of Case Record Review: Active case records shall not be mailed to clients. The client may review the record in the case manager's office or, if homebound, request that an authorized staff person bring it to the client's residence for review.

d. Case Record Copy: The case manager may provide one copy of the case record to the client.

5. Electronic Records: The 21st Century Cures Act, Section 12006 requires an Electronic Visit Verification (EVV) system for Medicaid-funded personal care services. The EVV system must verify the following:

- Type of service performed,
- Individual receiving service,
- Date of service,
- Location of service delivery,
- Individual providing service, and
- Time the service begins and ends.
- Verification of attendance

The Department authorizes, but does not require, the contractor to create and retain electronic records and to use electronic signatures to conduct transactions necessary to carry out the terms of its agreement. A contractor that creates and retains electronic records and uses electronic signatures to conduct transactions shall comply with the requirements contained in the *Uniform Electronic Transaction Act*, s. 668.50, Fla. Stat.

Vendor systems must be able to provide a verification method that produces an audit trail confirming the client service was performed. For example, an electronic time stamp

initiated by the client (i.e., telephonic or via service app) can verify attendance of an individual providing the service in lieu of a "wet" signature.

Electronic records must be fully auditable; are subject to Florida's Public Records Law, Chapter 119, F.S.; must comply with Section 29, Data Integrity, and Safeguarding Information; must maintain all confidentiality, as applicable; must be retained and maintained to the same extent as non-electronic records are retained and maintained; and must be provided to clients in non-electronic format, upon request.

Q. Case Narrative Guidelines

1. General Guidelines:

a. Reflection of Activity: Case narratives are completed to reflect activity that relates either directly or indirectly to the implementation of the care plan.

b. Framework: The reviewer should be able to determine the following as it relates to the care plan:

- Is the care plan valid?
- Are the services appropriate?
- Are the services responsive to the client's needs in both duration and intensity?

2. Case Narrative:

a. Record the status of all active care plan problems in the case narrative after each contact with the client.

- If no changes are identified, enter a statement covering multiple problems such as, "The client's needs remain the same and all services are continued."
- Make sure the problem number on the most recent care plan corresponds with the problem number entry which updates the case narrative. There is no need to rewrite the problem statement in the narrative. See the example below:
  - Problem Statement Entry from Care Plan: Client is unable to get in and out of the bathtub safely.
  - Case Narrative Entry Indicating Status of the Problem:

- Through home modification services, Ms. Smith could retrofit her bathroom so that she can safely get in and out of the bathtub. She can take a bath daily and her caregiver helps her to wash her hair and back. The modifications to her bathroom and assistance from her caregiver are appropriate now.

b. The case narrative describes the client's progress and challenges or barriers that hinder the desired outcomes in the care plan.

- The narrative reflects services consistent with the needs and service gaps identified in the care plan and provides reasons for variances.
- The case narrative entries may reference specific care plan and assessment summary entries.
- Case narrative entries should document the date of the contact, the type of contact (Office Visit - OV, Telephone Call - TC, Field Visit - FV), and the person making the contact.

c. Case Narrative Sections: Case narratives shall consist of the following two sections:

- Section 1—Contact Summary: The following information shall be included in the contact summary:
  - Date of Contact
  - Type of Contact:
  - Office Visit-OV
  - Telephone Call-TC
  - Field Visit-FV
  - Home Visit-HV
  - Staff Name: Name of staff making the contact and person contacted.
- Section 2—Narrative: A summary of data shall include the following:
  - Client's Progress: The client's progress towards goals.
  - Care Plan: Pertinent data related to the care plan and/or the client's

overall situation.

- Follow-Up Activity: Documentation of contacts and other action performed for the client. This includes contacts with external entities and persons as well as agency staffing, or other activities performed within the agency that relate directly to the client. Dates of follow-up activity must be documented.

- Service Barriers: Problems encountered in service delivery.

- Special Circumstances: Unique circumstances affecting the case.

- Care Plan Semiannual Review Contacts: Each active problem listed in the care plan addressed for each client semiannual care plan review contact.

- Initial Entries: Initial entries should reflect the following elements:

- Available Resources: Available resources are explored, including involvement of client's family and friends.

- Client Goals: Provider is advised of the client's goals (for arranged or referred service only).

- Consistency: Service provision is consistent with the care plan.

- Variances: Variances from the care plan are addressed including reasons for the change.

- Other Data: Any other appropriate data is included.

- Assessment Case Notes: The following applies to case notes taken during the assessment process:

  - Assessment Notes: Notes taken on the assessment form at the annual assessment or reassessment shall generally serve as case notes for the assessment visit. Any specific information about the client, his/her needs, surroundings, the assessor's observations of the situation, or other information not captured on the assessment form, should be noted in the narrative for the visit, along with the date and the purpose of the visit.

  - Case Note File Entry: Notes written about the client's problems and needs on the assessment form do not have to be rewritten in the case narrative.

- Ongoing Narrative: Ongoing narrative must reflect the following:
    - Appropriateness: That services as well as the duration and intensity continue to be appropriate for meeting the client's ongoing needs.
    - Service Consistency: That services continue to be consistent with the care plan and are delivered in accordance with program policy.
    - Adjustments Needed: Adjustments to be made to the plan based on new information received.
    - Problem Status: The status of each active problem listed on the care plan:
    - Care Plan Semiannual Review Standard: The case manager shall address each problem in case notes at least semiannually following initial client contact.
    - Tracking: For tracking ease, the problem number on the most recent care plan shall correspond with the problem number entry that updates the case note.
    - Progress/Barriers: Case notes shall describe progress or additional problems encountered in achieving desired outcomes stated on the care plan.
- Other Data: Include any other data appropriate to the client's situation.
- Client's Satisfaction: Include how satisfied the client or caregiver is with the services being provided.
- Termination: Circumstances for termination.

Section V - Grievance Proceedings

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

Section VI Developing the Care Plan

A. Guiding Principles:

- Every client must have a current care plan that addresses problems identified by the assessment.

- The care plan is based on an assessment as well as observations made between reassessments. It is a holistic evaluation of the client's situation, regarding transportation, finances, medication, mental health, substance abuse, etc.

- The care plan provides a clear picture of the client's needs and identifies services that will be provided to meet the identified needs. It specifies service interventions, frequency and intensity offered.

- The care plan will include DOEA-funded services, services provided by insurance companies, family caregivers, local United Way entities, health care taxing districts and non-DOEA funded services and activities provided by community resources, volunteers, friends, and family.

- The client's coping skills and adaptability are assets and should be considered in developing the care plan.

- Client choice and autonomy are important and should be considered in the care planning process.

B. Care Planning Concepts

1. Effective care planning is:

- Client-focused;

- Derived from the assessment;

- A team effort with the client, caregiver and/or designee and case manager; and

- Conscious of the cost of care and the safety of the client.

2. The resulting care plan will:

- Respond to the appropriate amount of care required by the client, caregiver and/or designee, allowing for choices;

- Be proactive when possible and preventive in nature;

- Commit a variety of providers to provide services; and

- Include DOEA and non-DOEA funded services and activities.

C. The Four Steps in Developing a Care Plan

1. Use the assessment information. Develop the care plan with the client, caregiver and/or designee within 14 business days after the completed assessment. Begin the care plan by reviewing the client's assessment and identifying the appropriate services required by the client. All issues identified should be addressed by the care plan, even if services/resources are not currently available to meet all needs. The following information should be gleaned from the assessment summary:

- Functional deficits, problems, and health conditions, including aspects of medication management and nutrition;
- Coping skills, adaptability, and preferences;
- Supports the client currently has in place, as well as current and potential service gaps;
- Caregiver issues, and
- Environmental issues.

2. Actively involve the client, caregiver and/or designee and existing support systems. The existing persons/resources providing help to the client will be supported by planned services, not replaced. DOEA and non-DOEA services/resources will fill in gaps in the client's present support system. Throughout the planning process and as service provision continues, the client, caregiver and/or designee will help to evaluate how effective the services/resources are and plan together for needed changes.

3. Apply Professional Knowledge and Judgment in Using Community Resources.

The goal is to help elders to age in place with security, purpose, and dignity in an elder- friendly environment. Thus, it is important to know what services and activities are available in the community to support elders.

a. Learn as much as possible about the client's situation, including caregivers, employee assistance programs, insurance, etc. With input from the client, caregiver and/or designee, the case manager can determine if the client can participate in his or her own care, including whether the client can pay for some of the services.

b. Find out what coping skills the client has and the client's adaptability. Then, decide how much care the client needs, the services the client will receive, and the client's choice in service providers.

c. The client should be empowered to choose the services that best meet his/her needs, from service providers of his/her choice. Services should be scheduled in a delivery method that complements the client's lifestyle. However, when clients need more assistance with managing their care and handling their activities of daily living, it is important to:

- Identify help to be provided by family, volunteers, and others;
- Consider which DOEA and non-DOEA funded services and activities are available to best meet the client's needs, and
- Consider all options, including insurance, employee assistance, and faith- based programs.

4. Become familiar with the services and community resources available. The following are suggested ways to learn what is available:

- Talk with veteran case managers;
- Use the resource directories produced by organizations and associations in the area, telephone directories, and web resources;
- Check with local employers and review insurance coverage;
- Contact health care taxing districts, (local government entities which collect funds for a specific cause, such as health care);
- Contact participants in the local service network, following agency protocols, such as Senior Centers, Area Agencies on Aging, Community Care for the Elderly provider agencies, Elder Helplines and FL Department of Children and Families, and
- Consider all sources of help including families, friends, and volunteers; churches, temples, synagogues, or other religious groups; local service clubs and civic organizations; and local taxing districts.

5. Develop a comprehensive list of possible resources. Learn the specifics of services offered by each provider and be aware of eligibility requirements for each.

6. Identify a key person and a backup contact with each provider. Write down phone numbers and when key persons are available.

a. Use available services, including services covered by insurance companies and employee assistance programs.

b. Consider how to enhance the client's quality of life within the context of his or her life situation.

7. Apply Client Choices and Reflect the Client's Preferences:

a. Client and caregiver directed options: Involving the client, the caregiver and/or designee allows for autonomy and choice. Autonomy is self-determination and freedom from unnecessary dependency and having choices in available services and providers. The following guidelines will help:

- Find out from the client, the caregiver and/or designee what amount of help is acceptable.
- Case management is a required service. Do not mandate other services as a condition for opening the case if a client does not want a service.
- Provide enough information about available services and provider options so that the client, the caregiver and/or designee can make an informed decision.
- Do not arrange for others to perform activities that the client, the caregiver and/or designee can do.
- Exhibit cultural and linguistic sensitivity when working with clients, the caregiver and/or designee and family members.
- Remember the client, the caregiver and/or designee have the right to accept or decline services, providers, or other care arrangements.

b. Discuss the following topics with the client, caregiver and/or designee:

- Assessment results: Explain the assessment result. The assessment results allow the case manager to assist the client to identify service needs and resources that help the client remain living safely in the least restrictive setting, appropriate to the individual's needs.
- Client goals: Document the client's preference in services, providers, and scheduling.
    - Discuss the client's coping skills and adaptability to determine how to fill in gaps.
    - Discuss the client's preference of care to determine desired results.

  - Understand what the client would like to achieve. What problems does the client currently communicate the need to overcome?

- Expectations about services: Inform the client, the caregiver and/or designee of both DOEA and non-DOEA services and resources available.
  - Inform the client, the caregiver and/or designee that programs have lists of service providers from which clients may choose.
  - Discuss the frequency and duration of services to be arranged and the alternatives.
  - Encourage the client, the caregiver and/or designee to participate in decisions and arrange services for those which are acceptable and appropriate.
  - Ask the client, the client's caregiver and/or designee to identify resources they would like to use.
  - Emphasize that priority is given to the frailest and that resources are limited.

- Cost of care: Discuss service costs, co-pay (CCE and ADI only), and the possibility of Medicaid eligibility.

- Quality assurance: Inform the client, the caregiver and/or designee that within 14 days following the start of services, a telephone call or visit will be made to determine if services are being provided as planned and if the client is satisfied with services, or if the client wishes to change providers.
  - Additional contacts may be made as needed, based upon the client's needs.
  - Explain to the client, caregiver and/or designee that there may be changes, reductions, or terminations in services at the time of the review, based upon the client's needs and achievement of specific goals.
  - Talk with the client, caregiver and/or designee to determine the effects of service delivery in meeting established needs.

- Document all telephone contacts and visits in the case narrative.

- Client rights: Give the client a copy of the grievance procedures. Explain the client's right to appeal care plan decisions, changes in services, or termination of services.

c. A well-developed care plan shall

- Address all aspects of the client's care. It represents the client, caregiver and/or designee, and professional worker's understanding of the situation, based upon the client's needs;

- Represent the case manager's best professional, objective, and independent judgment, based upon the client's needs;

- Reflect the client's health conditions, problems/services needed, challenges and barriers to problem resolution, outcomes to be attained, and DOEA and non-DOEA funded services and activities provided;

- Reflect the client's preferences and choice of providers in a document unique to the client;

- Serve as the information base to measure progress and revise services;

- Exhibit the caregiver's and/or designee's contributions, maximize other non-DOEA funded services and be used to estimate the cost of needed services and activities.

D. Completing the Care Plan Form

The Care Plan is a document that can be printed from eCIRTS, pulling data from the Services page. The Services page will be completed for all clients, whether they require a Care Plan or not. When a care plan is required, periodic follow-ups must also be completed. The Case Manager will be reminded of these by Workflow Wizards.

If the Care Plan is printed from eCIRTS, use the Service Record Data Report. The report will be run for one client at a time.

For instructions on printing the care plan from eCIRTS. See Care Plans in eCIRTS Training Manual.

If the Case Manager will use the Care Plan form 203A and additional

pages DOEA 203B:

1. Complete all sections of the care plan. The following information explains how each section is completed.

a. General Information:

- Client Name

b. Social Security Number (SSN)

- The nine-digit number is a unique identifier for each client and is used for tracking and comparing information.
- The client is not required to provide the SSN but is encouraged to do so for staff to screen for Medicaid eligibility and possible referral to the Department of Children and Families for services.
- The client must be informed that disclosure of the SSN is voluntary and will be used for referral and screening for Medicaid in accordance with Title XIX of the Social Security Act.
- If a pseudo identification number (ID) was used on the Assessment Form, the same number should be used on the Care Plan Form. Directions for creating a pseudo-ID are found in the DOEA Form 701D Assessment Instructions. eCIRTS Note: The pseudo-SSN does not populate on the 701B.

c. Case Manager Name

d. Provider: The provider code is unique for each individual provider within a PSA. The first digit of the provider code usually corresponds to the PSA code.

e. Care Plan Date: The date the care plan form is prepared is a reference point for determining care plan review dates. Each time the assessment is reviewed, the case manager shall review the care plan form and make necessary changes or begin a new form. The care plan must be updated annually in eCIRTS, at the time of reassessment.

To update the Care Plan annually in eCIRTS, terminate all current service lines, effective the date of the annual reassessment. Enter a new service line for each service determined appropriate based on the annual reassessment using the following day's date. If it is

determined that the services will continue as they did the previous year, the same information regarding units, type, and frequency may be added in the corresponding columns.

f. Care Plan Review Dates:

- Review the care plan every six months or more frequently, if the case manager and supervisor deem it necessary to meet the needs of the client.

- Enter the date and reviewer's initials for each review.

g. Health Conditions and Service Impact.

- Identify the health conditions documented in the assessment and list them in the case narrative. If more than three conditions exist, list the three which are most problematic to the client.

- Conditions which affect the individual's ability to perform activities of daily living determine the degree of frailty and should be included in the care plan.

- Identify the most appropriate service impact for each health condition.

h. Problems and Gaps/Adaptability and Coping Skills/Challenges and Barriers:

- Review information provided in Sections D and E on the assessment to identify problems. Information will indicate the client's ability to functionally perform tasks or to complete moderately complex tasks necessary to maintain a healthy and independent life and the amount of assistance the client receives from others.

- List all problems, including medication management and nutritional considerations in the case narrative.

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

- Activities of daily living (ADL) and instrumental activities of daily living (IADL) the client cannot perform independently may cause problems unless the individual has developed methods of coping and adapting.

- Adaptability and coping skills are ways to compensate for deficits and are resources and assets.
    - Resources and assets documented on the assessment summary describe how the client overcomes deficits.
    - The use of assistive devices is one means of adapting and employing coping skills.
    - Doing activities of daily living in an unconventional or creative way or allowing others to do certain chores or parts of chores are methods of coping.
    - When the individual can use adaptability and coping skills to overcome challenges and barriers, problems may be alleviated or minimized.

i. Gaps (need for assistance) exist when problems have been identified, and challenges and barriers cannot be overcome through adaptability or coping skills. Gaps determine service needs.

2. Service/Activity:

a. Identify the specific service or activity to address the gap (assistance needed) related to each problem documented in Sections D and E of the assessment.

b. List both DOEA funded and non-DOEA funded services and activities on the care plan.

c. Services arranged by the case manager or case aide and provided by non-DOEA funded sources must be listed in the care plan.

d. In addition, services which exist at the time of the assessment, not arranged by a member of the case management staff, and provided by non-DOEA funded sources, must be listed in the care plan.

e. Document on the care plan and in the case narrative when a change in the client's service needs or a change in providers occurs.

f. Indicate the date of the change and any unit rate changes on the care plan. Also, notify service providers in writing when changes in service are needed.

g. Updates are based on changes in the client's health conditions and

other circumstances.

3. Frequency:

a. Record the frequency for services.

- Frequency is how often a service is planned. It is the number of hours, meals, or other units per week, month, and year.

b. Because of budget restraints and other barriers, services documented on the care plan as needed may not be the same as the services that are planned.

- Needed services represent the frequency of recommended services necessary to address the client's needs to obtain the desired outcomes stated in the care plan.

- Planned services represent the frequency of services which are planned to be provided.

- For the care plan to be an accurate reflection of the client's situation, it must be acknowledged that sometimes problems cannot be fully addressed.

    - Thus, recognize unmet needs/services needed on the care plan and document them in the case narrative.

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

    - Enter the beginning date and end date for the needed and planned services.

    - The beginning date for needed services must be equal to or prior to the beginning date of planned services.

c. When necessary, write "PRN "or "as needed" next to the amount of service noted on the care plan to indicate temporary changes may occur. ("PRN" is the abbreviation for the Latin "pro re nata," which means "as needed" or "when necessary").

- Note temporary changes in the case narrative and indicate when these temporary services are terminated.

- Record permanent changes to the care plan on the form and

enter them in eCIRTS.

d. Document in the case narrative the reason changes occur in the frequency or duration of planned services, indicating the date of the change. Notify the service providers in writing when changes in frequency are being made.

4. Non-DOEA Funded/DOEA Funded and Provider: Document the planned number of hours or other service units in the appropriate column.

a. Write “ND” for Non-DOEA funded and “D” for DOEA funded. Include the corresponding number for the source.

- Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.

- DOEA-funded sources include Older Americans Act (OAA), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Alzheimer’s Disease Initiative (ADI), and Serving Health Insurance Needs of Elders (SHINE). “Other” in this section of the form refers to:

    - Local Service Programs (LSP)
    - Respite for Elders Living in Everyday Families (RELIEF)
    - Long-Term Care Ombudsman Council (LTCOC).

The provider refers to the source and the funding method. The following listed below are some examples:

:

Non-DOEA Funded	Example
Family and friend	Child, granddaughter, niece, neighbor
Local Government	Board of County Commissioners, taxing entities, County Human Resources, City Government, County Taxing District (Health Care Taxing District in Palm Beach) Medicare, Medicaid
Associations/Religious/Other	American Diabetes Association, Lutheran Social Services, United Health Maintenance Organization, Volunteer, IBM Corporation, Employee Assistance Program, Private Insurance
Other Non-Profit	United Way, Habitat for Humanity, Food Bank
Long-term Insurance	Benefits covered under long term care
DOEA Funded Provider:	Funding Source:
Older Americans Act (OAA)	Federal
Community Care for the Elderly (CCE)	State
Alzheimer's Disease Initiative (ADI)	State
Home Care for the Elderly (HCE)	State
Local Services Program (LSP)	State
Respite for Elders Living in Everyday Families (RELIEF)	State
Serving Health Insurance Needs of Elders (SHINE)	Federal

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

6. Date Services Begin (B) and End (E):

a. Indicate the date each service began or ended in this column.

b. If a service or activity exists prior to DOEA involvement and is planned to continue, but the date the service began is not known, use the same entry as the problem date for the services begin date.

7. Date Problem Resolved (RS) or Revised (RV):

a. Document in the case narrative, the date and "RS" when the problem is resolved, and services are no longer needed.

- For example, if the client's problem was an inability to hear because of a lost hearing aid, then replacing the hearing aid resolves the problem and no further service is required.

- Once a resolved or revised date is posted, the problem need not be tracked in the case narrative unless the problem recurs.

b. Document in the case narrative the date and "RV" when a problem, frequency, service, or desired outcome is revised.

- If the client began receiving two hours a week of personal care services on 8/14/15 and this service was revised to three hours a week on 12/22/15, the care plan would be updated to show the date of the revision.

- Make a corresponding entry in the case narrative to describe the reason for the revision and any other details about the revision that occurred.

8. Unit Cost/Individual Purchase:

a. Enter the approved unit rate for the corresponding DOEA-funded service on a service cost calculation form.

- The approved rates are based upon those included and approved in the area plan.

- For an example of a non-DOEA service: If the daughter provides personal care, use the approved DOEA-funded rate for personal care as the non-DOEA funded resource value.

b. If the service is not a service provided by DOEA and the unit rate is not known, a fair market value will need to be computed. There are three suggested ways to figure the needed value:

- Call at least three sources of the service or activity in the area and average their cost. For example, if three sources of a service charged $5.00, $6.00, and $7.00 per unit, then the fair market value for the service would be $6.00, (5+6+7=18, divided by 3).

- Use eCIRTS average actual rates.

- Use market rate surveys as a basis for the determination that suggested rates are reasonable.

c. Enter the individual purchase cost of the item, service, or activity, if unit cost does not apply.

9. DOEA-Funded Monthly Care Plan Cost: Enter the total amount for all DOEA-funded care plan services documented.

10. Co-Pay Monthly Amount: Multiply the monthly co-pay amount by twelve, i.e., $27.00 X 12 = $324.00.

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

12. Signature:

a. Sign on the case manager line as the individual developing the care plan.

- The client is to sign the care plan when it is first done, and then once yearly, when reassessed.
  - Clients do not have to sign the plan each time there is a revision.

  - Clients must be made aware of and have an opportunity to discuss all revisions.

  - There must be documentation that the client agrees with the revisions.

- If the client is unable to sign the care plan, note that on the signature line.

b. The client's caregiver and/or designee should sign the form when it is first completed and once yearly, when the client is reassessed.

- Note "HCE" next to the caregiver's signature if the individual is an HCE caregiver.

- The caregiver and/or designee does not need to sign the care plan each time there is a revision, however, the caregiver and/or

designee must be informed of revisions.

c. By signing the care plan, the client acknowledges that he or she has participated in discussions about assessed needs, has helped to develop the care plan, has been given choices to address service needs, and agrees with the care plan provisions.

- Additionally, the client acknowledges that a grievance review can be requested if there is unacceptable change, reduction, or termination of services.

- Information must be provided to the client in a language the client can understand and articulate.

E. Organizing the Care Plan: List each problem (short or long-term) in chronological order, including information from the assessment summary related to its challenges and barriers, and the client's coping skills and adaptability in the client's case narrative.

1. Long-Term Problems:

a. These problems will likely not improve and may require services over a long period, i.e., more than 6 months, and may have to be changed or updated throughout the year.

Example: Long-Term Problem

- Health Condition: The client has emphysema and difficulty breathing when performing activities.

- Service Impact on Health Condition:

- Condition may be maintained with intervention.

- Problem: Challenges and barriers to problem resolution are the client's lack of stamina and strength to do more than light housekeeping.

- Service: Homemaker services are needed.

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

2. Short-Term Problems:

a. These problems will usually improve or be resolved over a short period

and will not require as many changes or updates during the year.

b. Thus, the "Date Service Began/Ended" column is used most.

Examples: Short-Term Problem

- Health Condition: The client has severe arthritis and is limited in her ability to perform physical activity.
- Service Impact on Health Condition:
- Condition may decline with intervention.
- Problem: Challenges and barriers to problem resolution are the client's inability to safely get in and out of the bathtub and the caregiver's frailty.
- Service: Home repair service is needed to make the bathtub accessible by installing grab bars

3. When revising a care plan:

a. Identify every new entry with the problem number of the original problem statement.

b. Record a date for each revision followed by "RV" in the "Date Problem Resolved or Revised" column.

c. If the problem is resolved, record the date of resolution and "RS."

Examples: Long-Term Problem:

- Health Condition: The client has renal cancer, kidney and bladder failure, incontinence problems and is very weak from dialysis. In addition, the client has uncontrolled diabetes.
- Service Impact on Health Condition: Number "3" was selected as the condition may decline with intervention.
- Problem: Challenges and barriers to problem resolution are the client's inability to drive to the doctor or get around without assistance. The client is also unable to properly manage her healthcare needs.
- Service: Transportation and home health care are needed

services.

F. Care Plan Updates

1. Review and update the care plan semiannually.

a. The care plan may be updated more frequently depending upon the client's need for more frequent reviews, such as following a hospitalization, loss of a spouse or a physical move.

b. During the care plan review, discuss with the client the services provided and determine whether these services meet the client's needs or if changes are required.

c. Review the options and provide choices for the client.

- Are there new problems that need to be addressed?

- Additional problems identified should be added to the care plan.

2. Enter "same "or "no change" if some of the columns on the care plan are still accurate and do not need revising or updating, whichever method used. Only the initials of the case manager and review date are required.

3. The care plan for each active client will be updated in eCIRTS at least annually.

G. Case Narrative

Problem Statement Entry from Care Plan: Client is unable to get in and out of the bathtub safely.

Case Narrative Entry Indicating Status of the Problem Example:

Through home modification services, Ms. Smith could retrofit her bathroom so that she can safely get in and out of the bathtub. She can take a bath daily and her caregiver helps her to wash her hair and back. The modifications to her bathroom and assistance from her caregiver are appropriate now.

The case narrative describes the client's progress and challenges or barriers that hinder the desired outcomes in the care plan.

- The narrative reflects services consistent with the needs and service gaps identified in the care plan and provides reasons for variances.

- The case narrative entries may reference specific care plan and assessment summary entries.

- Case narrative entries should document the date of the contact, the type of contact (Office Visit - OV, Telephone Call - TC, Field Visit - FV), and the person making the contact.

1. Desired Outcomes:

a. Document in the case narrative the desired outcome established for the client based upon the individual's overall status, not select problems. In most situations, the desired outcome is either short-term or long- term.

b. Short-term outcomes address immediate concerns.

- The short-term outcome is that the individual's situation is stabilized, and acute episodes or nursing home placement can be delayed or prevented.

- For instance, after relocation, hospitalization, or incapacitation of a caregiver, a client may require temporary assistance to obtain necessary access to community resources.

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

c. Long-term outcomes address concerns that have long range implications and will exist into the future.

- The long-term outcome is that the individual's situation will be maintained or improved with assistance and that an acute episode or nursing home placement will be delayed or prevented.

- When a client's situation is stable, the goal is to help keep the individual as safe and healthy as possible. An example is an individual who has arthritis. Heavy chores may be difficult, but the person can manage small tasks, if paced appropriately throughout the day.

- Assistance should support the individual's abilities and offer relief from activities that might not be safe, such as cleaning the bathtub, but also allow the person to be as active as possible.

d. Both short-term and long-term outcomes address stabilization of a situation and concerns for the future.

- The overall outcome is that the individual's immediate concerns are addressed, and plans are made to address long-range implications.

- An example is an individual who has a recent hospital discharge and needs assistance with personal care needs. Personal care assistance will be required temporarily. However, due to health conditions, the individual is no longer able to drive. The need will be long-term for transportation.

Summary:

The essence of good care planning is the inclusion of the client at the center of the planning and selection process. All services and activities revolve around the client, and flexibility is the key to effective care planning. The role of the caregiver is paramount to the client's care and the planning process. The caregiver and/or designee must be included in the care planning process. The care planning process must be broad enough in scope to look at the abilities of the client, the support of the caregiver and/or designee, and the resources of the community.

Section VII: Incident Reporting Requirements

Incident Reporting Requirements for Alzheimer's Disease Initiative (ADI), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Local Service Programs (LSP), and Older Americans Act (OAA) service contracts.

The Contractor shall notify the Department immediately but no later than forty-eight (48) hours from the Contractor's awareness or discovery of conditions that may materially affect the Contractor's or Subcontractors ability to perform the services required to be performed. Such notice shall be made by phone and email to the Department's Contract Manager. The email *must include the Contractor's plan for provision of services.*

The Contractor shall immediately report knowledge or reasonable suspicion of abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96-ABUSE). As required by Chapters 39 and 415, F.S., this provision is binding upon the Contractor, Subcontractors, and their employees

The reporting requirements are associated with any conditions that may materially affect the Contractors or Subcontractors ability to perform the required services.

Such conditions include, but are not limited to the following:

- Meal site closure or suspension of services.

- Provider terminations; or
- Building or service site issues.

These incident reporting requirements are in addition to the requirements set forth by Chapters 39 and 415, F.S., related to “professionally mandatory reporters” and the required reporting of suspected abuse, neglect, or exploitation of a child, aged person, or disabled adult to the Florida Abuse Hotline.

Attachment 1: Case Management Program Comparison

PROGRAM	ELIGIBILITY	ASSESSMENT
ADI	**TECHNICAL CRITERIA:** Diagnosis or suspected diagnosis of a memory disorder which interferes with ADLs and IADLs **FINANCIAL CRITERIA:** None	**Screening Form (701S) and/or Comprehensive Assessment (701B)**
CCE	**TECHNICAL CRITERIA:** •Age: 60 + •Functional Impairment **FINANCIAL CRITERIA:** None	**Screening Form (701S) and/or Comprehensive Assessment (701B)**
HCE	**TECHNICAL CRITERIA:** •Age: 60 + •At risk of NH placement •Living with an adult caregiver who is: **1** 18 years or older; **2** Willing and able to provide and assist in arranging services; & **3** Willing to qualify as a caregiver. **FINANCIAL CRITERIA:** • Receiving the following benefits: **1** SSI; **2** Medicaid; **3** Medicaid Waiver; **4** QMB; or **5** SLMB. **OR** •Determined ICP eligible	**Screening Form (701S) and/or Comprehensive Assessment (701B)**
LSP	**Follow the criteria for CCE or OAA, as specified in the contract agreement**	**Follow the criteria for CCE or OAA, as specified in the contract agreement.**
OAA	**TECHNICAL CRITERIA:** •Age: 60 + •Assessed to be functionally impaired for in-home services •Emphasis placed on low-income minorities, older individuals residing in rural areas and individuals with limited English-speaking proficiency **FINANCIAL CRITERIA:** None	**Condensed Assessment (701A) or Congregate Meals Assessment (701C)**

	PROGRAM				
	ADI	**CCE**	**HCE**	**LSP**	**OAA**
CARE PLAN	**Uniform Care Plan:** **1** Indicate review date and initial. **2** Review semiannually. 3. List service(s) and provider(s): **A** DOEA funded; and **B** Non-DOEA funded. **3** State frequency of services. **4** State needed services and actual services available. **5** Indicate service(s): **A** Start date; **B** End date; **8** Include client, caregiver, and case manager signatures. **9** Update at next care plan semiannual review visit for changes. **10** List frequency of case management as a service.	**Uniform Care Plan:** **1** Indicate review date and initial. **2** Review semiannually. **3** List service(s) and provider(s): **A** DOEA funded; and **B** Non-DOEA funded. **4** State frequency of services. **5** State needed services and actual services available. **6** Indicate service(s): **A** **Start** date; **B** End date; **7** Include client and case manager signatures. **8** Update at next care plan semiannual review visit for changes. **9** List frequency of case management as a service.	**Uniform Care Plan:** **1** Indicate review date and initial. **2** Review semiannually. **3** List service(s) and provider(s): **A** DOEA funded; and **B** Non-DOEA funded. **4** State frequency of services. **5** State needed services and actual services available. **6** Indicate service(s): **A** Start date; **B** End date; **7** Include client, caregiver, and case manager signatures. **8** Update at next care plan semiannual review visit for changes. **9** List frequency of case management as a service.	**Follow the criteria for CCE or OAA, as specified in the contract agreement.**	**For case managed clients, follow the standards for CCE.**

PROGRAM	CASE NARRATIVE	FORMS	GRIEVANCE	HANDBOOK
ADI	Case narratives should include: **1** Telephone contacts. **2** Home visits. **3** Case staffing. **4** Client progress on identified problems. **5** Services are consistent with the care plan. **6** Care plan semi-annual reviews. 7. Units of service for provision of case management.	Forms utilized: **1** Intake and Assessment **2** Care Plan **3** Co-Pay Assessment Form	Grievance Procedures: **1** Apply to Provider Agency **2** Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
CCE	Case narratives should include: **1** Telephone contacts. **2** Home visits. **3** Case staffing. **4** Client progress on identified problems. **5** Services are consistent with the care plan. **6** Care plan semiannual reviews. **7** Units of service for provision of case management.	Forms utilized: **1** Intake and Assessment **2** Care Plan **3** Co-Pay Assessment Form	Grievance Procedures: **1** Apply to Provider Agency **2** Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
HCE	Case narratives should include: **1** Telephone contacts. **2** Home visits. **3** Case staffing. **4** Client progress on identified problems. **5** Services are consistent with the care plan. **6** Care plan semi-annual reviews. **7** Units of service for provision of case management	Forms utilized: **1** Intake and Assessment **2** Care Plan **3** HCE Financial Worksheet	Grievance Procedures: **1** Apply to Provider Agency **2** Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook
LSP	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Department of Elder Affairs Programs and Services Handbook
OAA	For case -managed clients, follow the standards for CCE.	Forms Utilized: **1** Intake and Assessment	Grievance Procedures: **1** Apply to Provider Agency **2** Final Determination with AAA if needed	Department of Elder Affairs Programs and Services Handbook

DOEA CARE PLAN

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Care Plan Date_____

Last Name	First Name	DOB	SSN
Case Manager			Provider / Worker ID

Program Enrollment: ADI _____ CCE_____ HCE_____

Health conditions	Quarterly Care Plan Review Dates:	Co-Pay Amount: _____
A)	_____ _____	DOEA-FUNDED Monthly Care Plan Cost: _____
B)		
C)	_____ _____	Annualized DOEA-FUNDED Care Plan Cost: _____

Date *if different from CP date*	Problem/Gap - Service	Frequency/ Duration	Begin MM/DD/YY	End MM/DD/YY	Provider Non-DOEA (ND) DOEA (D)	Unit Cost

I have participated in developing this care plan through discussion regarding my assessed needs, and the services and service providers available to help meet those needs. I understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. I authorize the provider to release information concerning the services I receive under all programs to the Florida Department of Elder Affairs.

Client Signature	Case Manager Signature
Caregiver / Designee Signature:	
Date of Signature:	Date of Signature:

DOEA CARE PLAN

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Care Plan Date_____

Consumer:		SSN:			Case Manager	
Date *if different from CP date*	Problem/Gap - Service	Frequency/ Duration	Begin MM/DD/YY	End MM/DD/YY	Provider Non-DOEA (ND) DOEA (D)	Unit Cost

Comments: