Pennyrile Area Agency on Aging & Independent Living Policy for Assessment & Eligibility

POLICY:

An initial assessment must be completed on every new client entering the aging program, and for any client who has been terminated but is returning to services. Service leveling is also to be completed at the time of initial assessment for Homecare and Title III HM clients.

Reassessments shall be completed every twelve (12) months for Homecare clients and Title III clients to re-evaluate the client's needs and services. Reassessments may also be completed following any significant event, such as the loss of spouse, prolonged hospitalization, moving, etc. Service leveling is also to be completed at the time of reassessment for Homecare and Title III clients.

Eligibility criteria shall follow the latest requirements of the Homecare Regulations and Title III Regulations as set forth by DAIL and any supporting DAIL requirements. Eligibility criteria includes age verification (60 years of age or older, unless exceptions are specified in regulations) by allowable method per DAIL.

PROCEDURES:

See Intake, Referral & Waiting List Policies for how a potential client is scheduled for an assessment.

A qualified Case Manager and/or Assessor conducts the assessment or reassessment in the client's home. The client may have a family member or other individuals present if desired. If the person has Proxy, Power of Attorney, or Guardian, that information must be included in the record in order for that person to legally sign for the client.

After a brief discussion of the programs and possible services, the client or responsible party must sign an application form and date it. If the client cannot sign but make a mark, it should be noted by the case manager in the summary/case note. If at all possible, another party other than the case manager should witness the signature. If someone signs in place of the client, their relationship to the client must also be written next to the signature. Case Managers are never to sign for a client.

Clients who have dementia (Alzheimer's or other types) may or may not have the mental capacity to be able to sign for themselves. In the cases where the client is signing, assessments and case notes should indicate a continuing level of competence for the client to continue signing documents. If there is any doubt, a responsible party should sign or co-sign.

Eligible Homecare clients will receive a Certification of Eligibility (DAS – 888) and a Notification of Eligibility (forms attached) within 30 days of assessment. If a client is deemed ineligible, the same forms are sent with an explanation of why the client was judged to be ineligible and be given the form by which the client may appeal the decision.

Eligible Title III clients will receive a Notification of Eligibility within 30 days of the assessment. If a client is deemed ineligible, the same form is sent with an explanation of why the client was judged to be ineligible and be given the form by which the client may appeal the decision.

All client identification data, requests for services, eligibility for services provided, and maintained follow-up for all Homecare and Title III clients will be maintained with the client file and WellSky (formerly SAMS).

The In Home Services Manager will maintain the client caseload figures for Homecare/Title III Services.

Service leveling is completed for Homecare assessments and reassessments and establishes the minimum contact schedule as follows:
Level 1 – Home Visit every other month
Level 2 – Home Visit every four (4) months
Level 3 – Home Visit every (6) months
Telephone contacts shall be made each month between home visits.

Documentation of service leveling is maintained in all Homecare client files.

Service leveling is also completed for Title III clients (receiving homemaking and/or HDM services) at the time of assessment and reassessment and it establishes the minimum contact schedule as follows:
Level 1 – Home Visit every other month
Level 2 – Home Visit every four (4) months
Level 3 – Home Visit every (6) months
Telephone contacts shall be made each month between home visits.

As a component of the initial assessment (Homecare and Title III) and reassessment (Homecare and Title III), the Case Manager must have the client to complete, date and sign the *Voter Registration Rights & Declination* form. This form provides an explanation of the rights of an individual to register, or decline to vote, or to designate he/she is already registered to vote.

If the client request assistance with registering to vote, the Case Manager shall distribute voter registration forms, assist the client with completion of forms, and ensure the complete voter registration form reaches the appropriate county clerk for processing if submitted to the Case Manager by the client.

Pennyrile Area Agency on Aging & Independent Living Policy
on Fee Determination & Contributions

POLICY:

The Pennyrile Area Development District/Area Agency on Aging & Independent Living will follow the Homecare fee schedule, as amended by DAIL, for clients assessed. Those guidelines will determine if a fee is to be charged to the individual. Persons receiving non-fee services shall be encouraged to contribute a donation.

PROCEDURES:

Once a client has been declared eligible based upon age and level of assistance needed, the Case Manager/Assessor will determine if the client will have to pay a fee for the Homecare Services, that the client is projected to receive. Services like Case Management, Assessment, and Home Delivered Meals do not have a fee attached regardless of income level.

For other services the Case Manager will determine the sources and level of income for the client and all members of the household who contribute funds or are to be counted part of the household for income eligibility purposes. (See regulations for what income of other parties may not be counted.) Verification of income shall be documented in each clients' file. Assets of the individuals are not counted, only income.

If a client's income is not over the maximum for no-fee services, the Fee Determination Worksheet may be stopped without listing any extraordinary expenses. If the client's income is above the maximum, the Case Manager shall first explore the possibility of extraordinary expenses that may be deducted from the income. Reference 910 KAR 1:180 for allowable extraordinary expenses. If the Case Manager has any doubt as to the validity of an expense, he/she should consult the In Home Services Manager who may also request an opinion from DAIL. Eligibility determination is suspended until a decision is made.

Once the annual income level has been established, the amount is plugged into the formula provided by the DAIL (Homecare Fee Schedule) to determine the percentage of cost the client would be expected to pay. That percentage is used on the second page of the Fee Determination Worksheet and multiplied by the Unit Cost and Maximum Unit per Month to determine the maximum monthly fee the client would be charged. If the client is a 100% fee pay or refuses to pay the fee, the Assessment is ended at that point. Clients who need the service, but are unable or unwilling to pay may be referred to the appropriate Title III Case Manager and/or to the likely provider who may have access to other funds. All clients will sign the fee page even if no fee is to be paid.

For all clients determined and agreed to be fee payers at Assessment or Reassessment, their Fee Determination Worksheet will be sent to the In Home Services Manager for review. If it appears the client should pay a fee and has agreed, he/she will forward the copy to the appropriate person in the provider agency who will be responsible for collecting the fee. Fee collection is the responsibility of the provider.

Providers are responsible for soliciting and collecting donations for Homecare and Title III clients. Their solicitations may not include a threat, implied or otherwise, that services will be discontinued if the contribution is not paid. All funds paid voluntarily to the providers must be documented and used to expand services.

Fee determination does not apply to Title III clients.

Pennyrile Area Agency on Aging & Independent Living Policy
For Provision of Case Management Services

POLICY:

The Pennyrile Area Development District/Area Agency on Aging & Independent Living will provide Case Management Services for the Title III and Homecare programs throughout the Pennyrile Area, which includes Caldwell, Christian, Crittenden, Hopkins, Livingston, Lyon, Muhlenberg, Todd and Trigg counties. The Pennyrile Area Development District has adopted the DAIL Case Management Handbook as a guide in the provision of case management services. In doing so, the basic goals have also been adopted.

The goals include:

1. Ensuring access to the continuum of care for functionally impaired elderly.
2. Ensuring the appropriate services (duration, scope, and frequency) are provided.
3. Ensuring that the changing needs of clients and caregivers are addressed.
4. Guaranteeing, through monitoring and evaluation, that high quality services are provided in a timely and cost-effective manner.

PROCEDURE:

Process:

The AAAIL will be open and staffed at least thirty-seven and one-half (37.5) hours per week 8:00AM to 4:30PM, except holidays. After office hours, there will be a voicemail system available to take client calls and/or program referrals. Referrals may also be made 24/7 at the PADD website. Case Managers are expected to be at one of their phones listed during those same times and have voice messaging systems in case they are unavailable. Aging staff shall be informed if a Case Manager is going to be out of touch for any significant length of time (vacations, etc.).

He/She will be responsible for arranging services to be provided, including documentation for providers, the AAAIL central charts and the database system. He/She will work with service providers to assure services are appropriate and in accordance with the client's plan of care. The client and caregivers shall be involved in care planning and will be treated in a respectful and dignified manner. If a client is reassigned to a different Case Manager, the outgoing Case Manager or the In Home Services Manager will notify the client. The new Case Manager will give the client a new copy of the Quality Assurance form with their contact information at the first home visit.

The assigned Case Managers shall be responsible for providing on-going monitoring and revision of services. The care plan, developed in conjunction with the person centered planning team, will identify the scope, duration, and units of services required. Case Managers will track services provided to each client by reviewing monthly unit monitoring reports and documenting whether the client received all services expected or, if not, and why not. Clients who do not receive planned services for more than two weeks shall be reported by the Case Manager to the In Home Services Manager. See Policy and Procedure for Suspensions and Terminations.

Clients who have services suspended/terminated shall be notified of their rights to file a complaint and the resolution process that will be used by PADD.

Monitoring of clients shall be documented in case notes. Any significant contact or activity on behalf of an individual client shall be reason to document a case note. All notes should be entered within 72 hours of the activity in the computer database system. Data entry instructions are to designate the type of contact, service date, and funding source for home visits, telephone calls, assessments, reassessments, and charting notes. Time in and out shall preface every note. Monthly case notes must include a summary of the continued appropriateness of services, the health/safety/welfare of the client, and the consistency of service delivery. Both formal and informal supports are to be considered in the summary.

If a client is receiving a formal support besides the Homecare/Title III provider, that additional provider must be consulted at Assessment/Reassessment time (or when the formal support is added after a client has been on services). These clients are to sign a release that asks the provider to discuss with the Case Manager the client's current services, their prognosis as to the client's continued need for their services, and if additional services or equipment not currently being provided are needed. The person centered planning team shall determine the services needed and then develop the plan of care that shall identify the assessed needs of the client and the services needed to assist with the identified needs. The plan of care shall relate to the assessed problem(s); identify the goal(s) to be achieved; identify the scope, duration, and units of service required including services provided by informal supports; identify the source(s) of service, including natural or informal supports; include a plan for reassessment; be signed by the client or the client's representative and case manager; and be documented on the standardized POC form.

Communication:
The staff of PACS/Senior Centers will provide written communication to the Case Manager/Pennyrile Area Agency on Aging and Independent Living within 2 business days of becoming aware of a client need.

The staff of the PACS/Senior Centers will send an email with the client information/ client need to the Case Manager. PACS Aging Director and the Pennyrile AAAIL In Home Services Manager will also be copied on the email correspondence.

Upon receipt of the email, the Pennyrile AAAIL Case Manager will have 2 business to make contact with the client and begin the process to address the need/and or make referrals to needed resources on behalf of the client.

The Case Manager will also ensure that all correspondence will be documented via case note in the WellSky (formerly SAMS) data system regarding date/time of the referral, client need and action taken on behalf of the CM to assist the client.

Should the situation be an emergency or of urgent need, the PACS/Senior Center staff is to notify the Case Manager/PACS Aging Director/Pennyrile AAAIL In Home Services Manager immediately. Upon receipt of the referral, the Case Manger is to contact the client immediately to provide case management to address the urgency of the client needs.

Qualifications:
All Case Managers shall meet qualifications, certification and training requirements as set forth in the current Homecare Regulations. In addition, these individuals are required to pass a Criminal Records Check and other tests/examinations should a condition be suspected that might endanger the physically vulnerable elderly population (example: TB skin test).

Qualifications for Case Management include: An individual with a bachelor's degree in social in a health or human services profession from an accredited college or university with one (1) year experience in health or human services or the educational OR the experiential equivalent in the field of aging or physical disabilities. A currently licensed RN who has at least two (2) years experience as a professional nurse in the field of aging or physical disabilities. A currently licensed LPN who has at least three (3) years of experience in the field of aging or physical disabilities and a RN to consult and collaborate with regarding changes to the Plan of Care. An individual with a master's degree in health or human services from an accredited college or university which services as a substitute for required experienced.

A copy of a resume, letter of interest, and at least three checked references and transcripts/certifications required for the position shall be on file with the Personnel Office prior to contracting.

Applications for the position of Case Manager for the Pennyrile AAAIL shall be required to authorize the release of police records to the Pennyrile ADD/AAAIL using the state approved format. An applicant with a felony conviction will not be contracted with. In addition, applicants with other convictions may be withdrawn from consideration, if the convictions are deemed to be potentially damaging to the client-case manager relationship should the client

become aware of the convictions. Any convictions that may occur after a contract is signed may be grounds for terminating the contract.

Documentation:
Time in/time out is required on all case management contacts to include assessments, reassessments, home visits, telephone contacts, and monthly monitoring by the case managers. Service providers are also required to document time in/time out for all direct services provided to the client. Each provider is responsible for tracking this on their agency service delivery form.

Proper error correction includes line thru, initials, and date. White out is not allowed and considered an illegal form of error correction. This is expected of case manages and providers on all documentation.

"CM" credentials are to be used with the case manager's signature on all documentation.

Infectious Disease:
Any Case Manger contracting an infectious disease will be required to refrain from any activities that involve direct client contact. The Case Manager shall be allowed to return to face-to-face contact with clients when the Case Manager's attending physician provides a statement that they are no longer contagious. The Aging Staff must be notified as soon as possible of the beginning and ending of this period of no contact as well as the reason why. Annual Infection Control/Universal Precautions training is required as part of the training described below.

Case Manager Training:
Upon contract, all case managers shall receive Case Management Orientation that uses the latest Case Management Handbook from DAIL and shall be completed prior to any activity with clients that would generate billing.

Within the first six (6) months of contracting, the case managers will complete a minimum of sixteen (16) training hours. Case Mangers will attend a Case Manager Training provided by DAIL or their designee, when made available by DAIL. If unavailable, training will be provided by Pennyrile AAAIL. A minimum of sixteen (16) hours of on-going training per year will be provided or approved by the In Home Services Manager. Prior approval must be obtained from the In Home Services Manager for any training the Case Manager may attend on his/her own.

Upon completion of any orientation and/or training sessions, each Case Manager is responsible for completing a training form (see Training Verification Form attached), certificate of attendance, or CEU's and will submit that to the In Home Services Manager who will maintain a training file for each Case Manager and will monitor those files periodically to assure appropriate training hours have been earned. A summary of training will appear at the beginning

of each Case Manager's training file to include title of training, presenter, dates, and number of training hours.

Gratuities & Money Handling:
Per 910 KAR 1:170, Section 3, case managers cannot accept personal gratuities from clients or vendors. Also, case managers cannot be involved in any client financial transaction (including but not limited to paying bills, cashing checks etc.) without prior approval from the In Home Services Manager.

Supervision and Monitoring:
All assessments and terminations are monitored by AAAIL staff and/or the In Home Services Manager. Files are reviewed for accuracy, completeness, and appropriateness of service(s) or termination.

The In Home Services Manager will monitor 10% of each Case Manager's Homecare caseload on a quarterly basis. Case Managers shall receive a corrective action plan with corrections required, if needed. Follow-up will be provided, as needed.

The In Home Services Manager will monitor a random sampling of each Case Manager's Title III caseload on a yearly basis. Case Managers shall receive a corrective action plan with corrections required, if needed. Follow-up will be provided, as needed.

Case Management meetings will be scheduled at least monthly to review procedures, discuss topics as a group, and/or receive training on a relevant issue.

The In Home Services Manager shall be available daily (unless given approved leave) for supervision issues. In Home Services Manager will be available by cell phone on nights and weekends.

Pennyrile Area Agency on Aging & Independent Living Policy
On Reduction, Suspension, and/or Termination of Services

POLICY:

It is the policy of the Pennyrile Area Development District not to reduce, suspend or terminate Homecare or Title III services without client request/consent unless the continuation of services would violate eligibility, assessed needs, supplanting of formal/informal supports, client well-being/safety, or provider safety/ability to perform Homecare and/or Title III services as listed on the Plan of Care.

Case Managers are to inform clients during the initial assessment that services are subject to termination or reduction based on:

(a) Funding reductions;
(b) Change in participant's condition;
(c) Increase in support system;
(d) Eligibility for Medicaid funded services;
(e) Inability to obtain a provider;
(f) Inability or unwillingness to follow the plane of care;
(g) Unwillingness to follow corrective action plan; or
(h) Unresolved safety issues.

If Homecare services are reduced or terminated for reasons other than a reduction in state funding the Case Manager shall:

(a) Inform the participant of the right to file a complaint;
(b) Notify the participant or caregiver of the action taken;
(c) Assist the client and family in making referrals to another agency if applicable;
(d) Provide the client with an updated plan of care created by the Case Manager;
(e) Adjust the services in the WellSky (formerly SAMS).

PROCEDURES:

1. REQUEST: A client may request the reduction or termination of services at any time. The Case Manager/Assessor should discuss the change with the client especially if it is believed to not be in the best interests of the client. If the reason for reduction or termination is based on a complaint about services, the Case Manager shall offer the client an opportunity to file a formal complaint. That offer and client response shall be documented in a case note. A Notification of Eligibility (or) Modification of Services form shall be completed and distributed to client, provider, and central record.

2. VACATION, HOSPITALIZATION, REHABILITATION, NURSING HOME PLACEMENT, ETC: Any situation that occurs where the client is not available for services for

30 days or more is grounds for inactivation or termination of services. If the client has the prognosis that they will return home and still need the services approved after more than 30 days, the Case Manager shall request an extension of the inactivation period for the In Home Services Manager at a maximum of 60 days. When, and, if the In Home Services Manager declares the client must be terminated for inability to receive services, the client shall be notified and given the chance to appeal.

3. CHANGE IN ELIGIBLITY/REDUCTION: Should a Reassessment determine that a client is no longer eligible for services or as much services, termination/modification of services procedures shall be reviewed with the client. The Case Manager will discuss the appeals process should the client wish to appeal the decision. Any changes require a Notification of Eligibility or Modification of Services form to be completed. Any client who does not produce proof of income at the time of the reassessment may have his/her services suspended until that proof is submitted. A 30 day deadline may be set for termination of services if proof of income is not provided.

4. SUPPLANTING OF OR AVAILABILITY OF FORMAL/INFORMAL SERVICES:
Assessments and Reassessments must take into consideration the availability of formal and informal sources to provide the equivalent Homecare/Title III services that are proposed or being provided. When it is determined that the client is eligible for another program providing equivalent services or the client has informal supports to provide for his/her needs, the Case Manager/Assessor shall take the steps to terminate all services or modify just the services for which other sources are available. The actual date of reduction or termination of services should be based on when the alternative supports begin.

If all needs are being adequately met by the informal support system, then the client is deemed ineligible. An applicant who needs respite services shall not be deemed ineligible as a result of this policy/procedure.

5. MEDICAID WAIVER ELIGIBILITY:
All Homecare clients must be screened for Medicaid eligibility at the time of intake through ADRC, assessment, and at the time of reassessment. When it is determined that the client is eligible for Medicaid waiver, the AAAIL staff shall provide contact information and assistance with applying for Medicaid waiver services to meet the client's needs. Any Homecare client that qualifies for services through Medicaid shall obtain services through Medicaid unless the needed services are not available in the region when they reside or there is no service provider able to provide the services. An existing client would be allowed to continue receiving Homecare services until the waiver services are initiated. If the client is eligible, but refuses Medicaid waiver services, then the client would be terminated from Homecare and transferred to Title III services, if funding is available, or placed on the Title III waiting list flagged as "Title III Only".

Services that are needed and unavailable through Medicaid may be provided through the Homecare program as long as the services are not duplicative of what Medicaid provides.

6. DEATH, PERMANENT NURSING HOME PLACEMENT, MOVING OUT OF REGION, ETC: Any situation that occurs that automatically means the client is no longer eligible for/in need of Homecare or Title III services shall result in the immediate termination of services other than Case Management. Whoever is aware of the situation first is to notify the other involved parties.

7. SAFETY OR OBSTACLES TO PROVIDING SERVICES: Case Managers shall be able to temporarily suspend services to a client whenever it is believed that the environment or the client or another person in the home constitute a personal health, safety or welfare risk. Service Providers shall notify the Case Manager and the In Home Services Manager immediately whenever this occurs. If the Case Manager discovers this situation, the Service Provider and the In Home Services Manager shall be notified.

The In Home Services Manager shall initiate an investigation and shall make a decision on the resumption of services, continuation of inactivation, or termination of services. Clients shall be notified in writing by the In Home Services Manager of the conditions that must be changed and a deadline for correction in order for services to be resumed should the investigation determine there is a risk or impediment to services provision. Once the situation is judged to be safe or capable of service delivery, the In Home Services Manager shall notify the Service Provider and Case Manager that services should resume. Case Managers will be expected to monitor the situation more frequently until the In Home Services Manager is assured that the situation has been rectified. Any situation in which abuse or neglect is suspected it shall be reported to Adult Protective Services by the person who observes the reason for suspected abuse/neglect and shall be documented in the client file. If a report is made by any provider, staff, or Case Manager, the In Home Services Manager shall be notified as soon as possible.

NOTE: The Kentucky Home Regulations (910 KAR 1:180) makes it clear that Service Providers may not terminate services to any approved client. Only the client, Case Manager and the district Designee (Pennyrile In Home Services Manager) may make the decision to terminate.

8. NON-FEE PAYING CLIENTS: Clients may be temporarily suspended when it is determined that the required Homecare fees (assigned by the Case Manager based upon Homecare Fee Schedule) are not being paid on a timely basis, per notification from the service provider who is responsible for fee collection. Termination will be considered if a client continues to refuse to pay the required fee for service(s).

9. NEEDS EXCEEDING AVAILABLE SERVICES: Suspension and/or termination will occur when a client's needs exceed available Homecare and/or Title III services and the client's health/safety/welfare is in jeopardy due to lack of sufficient services/supports. The Case Manager will assist the client and family in making referrals to other agencies/services, if applicable.

10. BEHAVIOR ISSUES: Case Managers shall be able to temporarily suspend or terminate services to a client whenever the client's behavior or another person's behavior in the home constitutes a personal health, safety or welfare risk. Behavior includes but is not limited to – inappropriate behavior, intimidating behavior, and threatening behavior. The Rights & Responsibilities form addresses inappropriate behavior(s). Service Providers shall notify the Case Manager and the In Home Services Manager immediately whenever this occurs. A corrective action plan shall be developed and presented to the client, when appropriate.

Pennyrile Area Agency on Aging & Independent Living
Confidentiality Policy

POLICY:
All Contract Case Managers are required to sign a confidentiality agreement. All client information and records shall be kept confidential. Client information will be shared only with the client's permission to persons with a need and a right to know.

PROCEDURE:
Each Case Manager maintains a file for each client he/she serves, and this is maintained in a locked file cabinet in the PADD Office.

If the Case Manager needs to obtain or share verbal or written information with other agencies or health personnel, he/she must obtain the client's written permission. (See Release of Info form) This form includes who can share information, what information is to be shared, and has a date of expiration. As needed this form can be faxed, emailed or copied for another agency's review.

All client information within the Case Manager's possession must be kept secure. When not in the direct possession of the Case Manager, the information must be kept in a locked venue whether car or home. The computers to be used by the Case Managers must require password protected access and any other safety features that may be required by PADD.

Pennyrile Area Agency on Aging & Independent Living
Procedure for Protecting the Storage & Transmittal of Confidential Information

POLICY:

It is the policy of the agency to keep confidential and safe the data electronically stored and transmitted.

PROCEDURE:

1. All staff have password protected access to any software that contains client information.

2. All confidential information on clients is stored on a dedicated server and backed up daily.

3. The Technology Manager is responsible for installing all the feasible protections so that data cannot be accessed by outside sources except in cases where transmitting is permitted.

4. The database system shall be set up to provide the DAIL the following at a minimum, for all assessments:
   a. Demographic information, including family income
   b. Physical health
   c. Activities of daily living and instrumental activities of daily living
   d. Physical environment
   e. Mental and emotional status
   f. Assistive devices, sensory equipment, and communication abilities
   g. Formal and informal resources
   h. Summary & judgment

5. All files are kept in a centralized location under lock and key, located at 300 Hammond Drive, Hopkinsville, KY.

Pennyrile Area Agency on Aging & Independent Living
Policy for Intake, Referral and Waiting Lists

POLICY:

Referrals for services are to be centralized at the Area Agency on Aging & Independent Living at the Pennyrile Area Development District. The ADRC Coordinator or the ADRC back-up staff shall be responsible for entering the referral into the WellSky (formerly SAMS) database system and setting in motion the prioritization, assessment, and provision of services to eligible clients in a manner so that the most deserving clients are served as quickly as possible. Clients in need of services available from other sources shall be referred to those sources. Homecare or Title III services will not supplant existing or potential services from other entities. The ADRC Coordinator or the ADRC back-up staff also verify that individuals are not eligible for the same or similar services through Medicaid as required by 910 KAR 1:180. All referrals must follow the ADRC Process as designated by DAIL.

PROCEDURES:

The ADRC Coordinator enters potential client information into the WellSky (formerly SAMS) database. At that point, the client's status on the waiting list is accessible to Assessors, Case Managers, and potential providers. A copy of the referral form will be sent to the assigned Case Manager. During the *ADRC Level 1 Screening* completion, the potential client will also be provided with community resource information, if there is a waiting list or if it would be more appropriate for their need, and it will be documented on the *ADRC Level 1 Screening* form.

If units of the service requested are available in that county: an Assessment may be scheduled immediately by the In Home Services Manager or a Case Manager.

Potential clients are prioritized based upon the *Priority Rating For Services* form, per DAIL requirements. The form captures components of greatest in need including; low-income minority, living alone, living in rural area, physical or mental limitation which restrict the activities of daily living, and low income. Potential clients also have their Priority Score noted in WellSky (formerly SAMS).

Based upon 910 KAR 1:190 Nutrition Program for Older Persons – "Target Group" is defined as follows: low-income individuals (including low-income minority older individuals), older individuals with limited English proficiency, older individuals residing in rural areas, and older individuals at risk for institutional placement.

Potential clients must not be eligible for the same or similar services through Medicaid unless the individual is: considered inappropriate for person directed services due to an inability to manage

his own services and a lack of availability of a person to act as his representative. Or unable to access the Home and Community Based Waiver through a traditional provider.

Potential clients on the waiting list are contacted on a quarterly basis by the assigned case manager or the In Home Services Manager in order to update and purge the waiting list for all services. Updates on the waiting list are documented on the *Quarterly Waiting List Tracking* spreadsheet that is maintained in Excel through Office 365 – One Drive.

Potential clients on the waiting list are contacted on an annual basis by the ADRC Coordinator in order to update and purge the waiting list for all Homecare and Title III in-home services. Updates on the waiting list are documented on the *Quarterly Waiting List Tracking* spreadsheet that is maintained in Excel through Office 365 – One Drive.

Case Managers will receive a monthly printout of the clients waiting for services in their assigned counties. He/she should check the list for accuracy. Inaccuracies and/or questions should be sent to the In Home Services Manager as soon as possible. Whenever a client's status on the Waiting List changes, the Case Manager or provider (depending on who is aware of the information first) is to notify the other and the In Home Services Manager & ADRC Coordinator by email. It is important that the In Home Services Manager & ADRC Coordinator have all changes to the Waiting List by the first week of every month for the prior month. The ADRC Coordinator is responsible for monthly Homecare and Title III Wait List Report to be sent to DAIL.

Case Mangers may potentially monitor all services provided to a client regardless of funding source. It is expected that the Case Manager is aware of all formal and informal supports and has regular communication with them. Among the agencies and programs, a Case Manager is expected to be aware of: home health agencies, Hospice, Health Departments, Protection & Permanency, Cabinet for Health and Family Services, Community Action Programs, SHIP, Family Caregiver, prescription assistance, USDA Rural Development, and other local, regional, state and federal programs. Most, if not all, of these resources should be available through the Aging Section of the PADD website.

Part of the reason the Case Manger should be aware of other community resources is that clients may need and be eligible for services from other agencies/programs. Case Managers are expected to refer clients to these agencies/programs. In those cases where equivalent services are available from other sources, Case Managers must be sure there is no duplication even if it means terminating a client after it has been determined that he/she is receiving those services.

If the client or caregiver is unable to make contact to another agency/program, the Case Manager may assist them. Referrals will be accomplished by documenting verbal permission (for calls to

agencies) or by completing the Release of Information form (for written documents). Whenever more than one agency may provide a service to a client (ex. – home medical supply), the client must be given all options and asked to make a choice. Case Managers may not advise the client as to one agency over another.

Pennyrile Area Agency on Aging & Independent Living
Contingency Plan

POLICY:

The Pennyrile Area Development District will continue to provide Case Management services regardless of emergencies or other situations that may result in usual care being unavailable.

During inclement weather or a natural disaster, the Case Mangers will make contact with clients in the affected area to offer needed assistance and support.

In the case of a loss of facilities, the Pennyrile Area Agency on Aging & Independent Living would use the National Guard Armory, Hopkinsville as an alternate space for contacting clients and providing case management services. The database has a back-up capacity, which would make most files available in the event of a catastrophe.

The PADD contracts with five professionals who meet the training and qualifications to provide Case Management Services. In the Event of a case manager resigning or being unavailable to provide services at any given time, one of the other trained, qualified AAAIL staff would be assigned to that caseload.

PADD is committed to providing consistent, quality services to all clients. A detailed disaster plan has been developed for both the Area Development District and the Area Agency on Aging & Independent Living.

Pennyrile Area Agency on Aging & Independent Living staff members and contract case managers are also certified with FAST (Functional Service Assessment Team) through FEMA.

Pennyrile Area Agency on Aging & Independent Living
Complaint Policy

POLICY:
Staff and providers will make every effort to work together to ensure clients are satisfied with services and treated in a dignified manner. However, every client shall be given a copy of the PADD Resolution Process which directs the client in making a formal complaint if necessary. Written complaints will be filed in the complaint log.

PROCEDURE:
In the event that a formal complaint is made, the attached complaint form will be completed and filed in both the client's chart and the complaint log. This form will be used to record the initial complaint, as well as actions taken and the resolution.

Complaint log maintained by PADD.

Incidents reported by providers, case managers, and/or staff are also filed in the complaint log. The In Home Services Manager and/or AAAIL Director will provide notification to appropriate staff members and/or providers as needed.

Pennyrile Area Agency on Aging & Independent Living
Policy for Reporting Abuse, Neglect & Exploitation

POLICY:

Any employee who suspects abuse, neglect or exploitation of an adult shall immediately make an oral or written report to the Cabinet, as consistent with KRS 209.030. The report will be logged in the appropriate referral log.

PROCEDURE:

As soon as abuse, neglect, or exploitation is suspected by a case manager or reported to a case manager, he/she will contact the Adult Protective Services. The following information will be given, if known:

Name & Address for the adult, or of any other person responsible for this care.
Age of the adult
Nature and extent of abuse, neglect or exploitation
Any evidence of previous abuse, neglect or exploitation
Identity of the perpetrator, if known
Identify of the complainant, if appropriate
Any other information that might be helpful in the investigation

This report will be recorded, in detail, in the client record along with a Case ID# issued by APS staff.