

Choices for Care

Adult Family Care Services

September 1, 2013

Implementation

Training Materials



Adult Family Care Training Materials

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Choices for Care

Long-term Services and Supports

OVERVIEW

Choices for Care is an 1115 research and demonstration waiver approved by the Centers for Medicare and Medicaid Services (CMS) to use long-term care Medicaid dollars in a way that is different from the traditional Long-term care Medicaid system of nursing home entitlement.

Choices for Care program includes services for:

1. individuals in need of nursing home level of care services (Highest and High Needs Group) AND
2. individuals with lighter needs who can benefit from preventative services (Moderate Needs Group).

GOAL

The primary goal of the Choices for Care waiver is to provide Vermonters with equal access to either nursing facility care or home and community based services, consistent with their choice. (*Choices for Care Regulations*)

GENERAL POLICIES

Long-term care services shall be based on person-centered planning and shall be designed to ensure quality and protect the health and welfare of the individuals receiving services.

Long-term care services shall be provided in a cost effective and efficient manner, preventing duplication, unnecessary costs, and unnecessary administrative tasks. The Department shall manage long-term care services so as to use resources efficiently and to maximize the benefits and services available to the greatest number of eligible individuals. (*Choices for Care Regulations*)

Refer to Choices for Care Regulations Page 1 and 2 for additional General Policies.

Choices for Care Options

(Updated July 2013)

Choices for Care offers long-term care services to Vermonters who need nursing home level of care and who need Medicaid to help pay for the care. If an individual is found clinically and financially eligible, they can choose where they want to receive their services.

For questions about clinical eligibility, contact your local Long-Term Care Clinical Coordinator listed on the back.

For questions about financial eligibility or to receive an application, call 1-800-479-6151 to the ESD Benefits Service Center. Be sure to tell the agent that you have questions about Long-Term Care Medicaid. Or apply online at http://dcf.vermont.gov/esd/health_insurance/ltc_medicaid.

1. Home-Based options

- **Flexible Choices**—A consultant from Transition II helps create an allowance and budget for services that is managed by the individual or an eligible surrogate. The individual or surrogate act as the employer and work within their budget to coordinate services to help stay at home.
- **“Traditional” Home-Based**— A case manager helps coordinate a plan with the individual that may include personal care, adult day services, personal emergency response and some assistive devices/home modification funds. Care may be provided through a local certified home health agency or if eligible, individuals may hire their own caregivers through the consumer or surrogate directed option. The individual chooses either their local Area Agency on Aging or Certified Home Health Agency to provide case management services.
- **Adult Family Care (AFC)** - AFC is a 24-hour, home-based, shared living option for eligible Choices for Care (CFC) participants. Authorized Agencies (AA) are paid a daily tiered rate to contract with private, unlicensed family homes that serve one to two people that are not related to the home provider.

2. Enhanced Residential Care (ERC) option – This option provides 24- hour care and supervision in approved VT licensed Level III Residential Care Homes or Assisted Living Residences. Services include personal care, housekeeping, meals, activities, nursing oversight and medication management. For individuals in the ERC option, the home may also bill Medicaid for Assistive Community Care Services (ACCS) payments as well. The individual pays for room and board. For more information or a list of ERC providers look online at <http://www.dail.state.vt.us/lp/>.

3. Nursing Home option – This option provides 24-hour nursing care, supervision, therapies, personal care, meals, nutrition services, activities and social services provided by a VT licensed Nursing Facility. For more information or a list of nursing homes, look ONLINE at <http://www.dail.state.vt.us/lp/>.

For more information about Choices for Care and the service options, contact your local Department of Disabilities, Aging and Independent Living (DAIL) Long-Term Care Clinical Coordinator, listed on the back. More information about Choices for Care may be found online at: <http://www.ddas.vermont.gov/ddas-policies>.

DAIL District Office	Address	Phone Number	FAX
Barre	Mcfarland State Office Building 5 Perry St., Suite 150 Barre, VT 05641	(802) 476-1646	(802) 476-1654
Bennington	200 Veterans' Memorial Drive, Suite 6 Bennington, VT 05201	(802) 447-2850	(802) 447-6972
Brattleboro	232 Main Street PO Box 70 Brattleboro, VT 05302-0070	(802) 251-2118	(802) 254-6394
Burlington	Mail: 103 So. Main Street Waterbury, VT 05671 Office: Harvest Lane, Williston, VT	(802) 871-3058	(802) 878-1793
Hartford	Gillman Office Building, Complex #1 White River Junction, VT 05001	(802) 296-5592	(802) 295-4148
Middlebury	700 Exchange Street Middlebury, VT 05753	(802) 388-5730	(802) 388-4637
Morrisville	63 Professional Drive, Suite 4 Morrisville, VT 05661	(802) 888-0510	(802) 888-0536
Newport	100 Main St., Suite 240 Newport, VT 05855	(802) 334-3910	(802) 334-3386
Rutland	320 Asa Bloomer Building Rutland, VT 05701	(802) 786-5971	(802) 786-5882
Springfield	100 Mineral Street, Suite 201 Springfield, VT 05156	(802) 885-8875	(802) 885-8879
St. Albans	20 Houghton Street, Suite 313 St. Albans, VT 05478	(802) 524-7913	(802) 527-4078
St. Johnsbury	67 Eastern Ave, Suite 7 St. Johnsbury, VT 05819	(802) 748-8361	(802) 751-3272



Adult Family Care (AFC) Services “At a Glance”



Adult Family Care is a 24-hour Home and Community Based Service option for Vermont's Long-Term Care Medicaid Choices for Care (CFC) Program. This option is available through CFC to participants in the Highest and High needs groups. Adult Family Care provides participants with person-centered supports in a home environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity. Adult Family Care is provided in the residence of the home provider who provides the care and support to no more than two people unrelated to the home provider.

1. Authorized Agencies (AA) -

- a. The AA must be approved by DAIL and maintain an up to date provider agreement.
- b. The AA supports participant goals, strengths and needs by facilitating a home provider match.
- c. The AA ensures the AFC Coordinator works with the participant, AFC home and case manager to develop a person-centered plan and coordinates other services in and out of the AFC home.
- d. The AA contracts with the AFC home providers.
- e. The AA provides a tax free stipend (difficulty of care payment) to AFC home provider.
- f. The AA ensures that each AFC home has a housing inspection once every three years.

2. Adult Family Care (AFC) Home -

- a. The AFC home is owned/rented and lived in by the home provider. It is an unlicensed home that provides 24-hour care and room & board for one or two people (not related to the AFC home provider) in a family setting.
- b. The CFC participant lives with the AFC Home provider who provides care and support according to the person centered plan.
- c. The AFC home enters into a contract with an AA to provide services in exchange for a tax free stipend (difficulty of care payment).
- d. The CFC participant and AFC home provider maintain an up to date room & board agreement.
- e. The participant pays room & board to the AFC home provider according to the DAIL Room & Board standards.
- f. The AFC Home is inspected once every three years.

Over



3. Case Management – The participant chooses either the local Area Agency on Aging or Home Health Agency, who will provide up to 24 hours per calendar year of case management assistance.
 - a. The case manager assists the AA and participant in gaining access to long-term services and supports.
 - b. The case manager is responsible for completing the AFC ILA assessment, AFC Tier, Service Plan and other required CFC documentation.
 - c. The case manager contacts the participant every 60 days and visits quarterly to ensure the participant's needs are being met.
 - d. The case manager provides technical assistance and coordination with the AA and AFC home as needed.

4. Tier Rate - Tiers range from \$75/day to \$152/day, depending on the participant's assessed functional needs.
 - a. Tiers payment covers 24-hour long-term services and supports including (but not limited to) personal care, respite, companion and adult day.
 - b. The Tier payment does not include payment for acute care services (anything covered by insurance) or room & board.
 - c. The Tier is developed by the case manager using the CFC AFC ILA assessment and AFC Tier Worksheet.
 - d. The AA maintains 5% of the tier payment for administrative fees.

5. Room & Board - The person pays for room and board according to the existing DAIL room & board standard. The person must retain at least \$115/month personal needs spending.

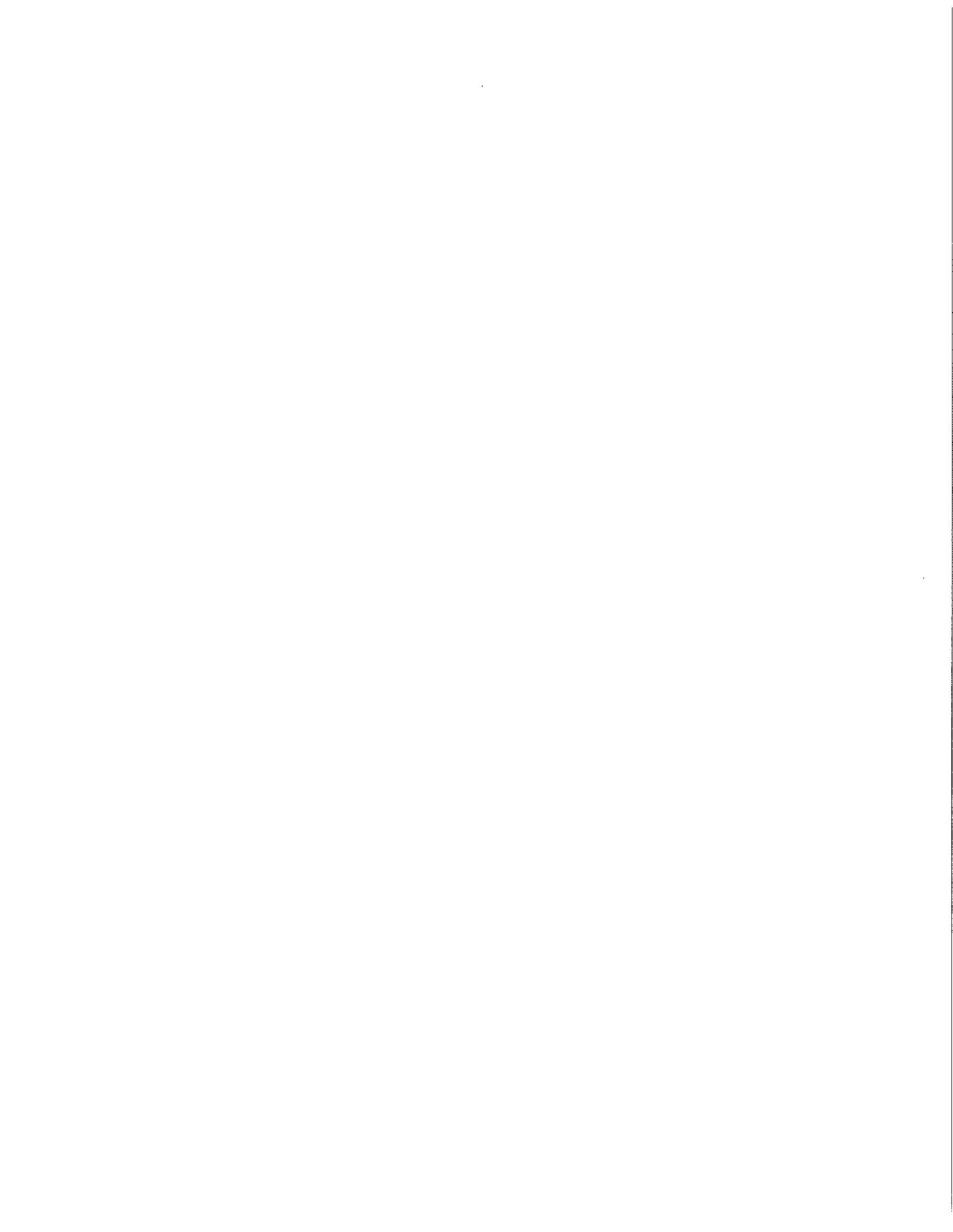


For more details, refer to the CFC High/Highest Needs Manual at



AFC Authorized Agencies (Aug 2013)**CONTACT**

Champlain Community Services Colchester, VT 05446	<i>Elizabeth Sightler</i> 802 655-0511 xt 120
Choice Brain Injury Support Services Montpelier, VT 05601	<i>Nicole Pierce</i> 802 225-6232
Counseling Services of Addison County, Inc. Middlebury, VT 05753	<i>Greg Mairs</i> 802-388-4021
Head Injury Stroke Independence Project Rutland, VT 05701 <i>*AKA Lenny Burke Farm</i>	<i>Marilyn Carter</i> 890-353-8850
Howard Center Burlington, VT 05401	<i>Marie Zura</i> 802 488-6500
NKHS St. Johnsbury, VT 05851	<i>Dixie McFarland</i> 802 748-3181
Northwestern Counseling and Support Services St. Albans, VT 05478	<i>Jean Danis Gilmond</i> 802 524-6555
Rutland Mental Health Services (Community Action Program) Rutland, VT 05702	<i>Michel Kirsten</i> 802 786-7305
United Counseling Service Bennington, VT 05201	<i>Kathy Hamilton</i> 802 442-5491 xt 294



SECTION IV.10. Adult Family Care

A. Definition

A 24 hour care and support option in CFC in which participants live in and receive services in an AFC Home which is contracted by an Authorized Agency.

B. AFC Standards

AFC providers must be authorized by the Department of Disabilities, Aging and Independent Living (DAIL) and comply with the following:

1. All Applicable State and/or Federal Rules and Regulations
2. ASD Housing Safety and Accessibility inspection policy/procedure
3. ASD Disclosure of Information Policy
4. CFC Universal Provider Qualifications and Standards (Section III.)
5. CFC Services (Section IV.)
6. AFC Difficulty of Care payment
7. Critical Incident Policy
8. DAIL Provider Agreement

C. Provider Types

The following provider types are approved to provide and bill for Adult Family Care services when authorized by DAIL and identified on the individuals Service Plan:

- Authorized Agencies (AA) (*Revenue Code 086*)

D. Authorized Agency Responsibilities

Authorized Agency (AA) is an agency authorized by Department of Disabilities, Aging and Independent Living (DAIL) to provide Adult Family Care (AFC). Authorized Agency responsibilities include:

1. 24-hour on-call Backup: Provide twenty-four hour on-call back-up and support to paid caregivers and natural supports.

2. Care Planning: Identify the goals, strengths and needs of the participant through a person centered process. A plan is then developed identifying the services and supports to be delivered in order to meet the individual's needs and goals.
3. Communication: Ensure timely communication and coordination with the Case Manager and the AFC home in the event of any changes in the individual's health, functional needs, preferences or wishes that require changes in the plan of care.
4. Complaints: Inform participants of the AA complaint policy, work to resolve complaints and provide all participants with Ombudsman brochure.
5. Contract: Identify and contract with Adult Family Care (AFC) Home providers.
6. Critical Incidents: Follow established Critical Incident Reporting Procedures.
7. Difficulty of Care Payment: As defined by the Internal Revenue Service (IRS) code Title 26 Section 131, provide a difficulty of care payment (tax free stipend) to contracted AFC home providers as determined by a participant's authorized tier rate. The authorized tier rate is found on the participant's CFC AFC service plan and includes the agency's 5% administration fee.
8. Documentation: Documentation must include the following:
 - 24- hour emergency back- up plan
 - emergency fact sheet
 - comprehensive person centered plan
 - monthly home visits by the AFC coordinator
 - accessibility and home safety inspections
 - a written contract and/or job description for all caregivers describing expectations, responsibilities and compensation
 - back ground checks as specified in the DAIL background check policy
 - training for paid workers including contracted home providers
 - room and board agreement and/or contract for care
 - all required CFC forms
 - quality management activities, including but not limited to critical incident reports and grievances and the resolution
 - Advance Directives, Power of Attorney or Guardianship order
 - applications for other services or public benefits and the
 - ongoing case management activities
 - coordination of documentation and communication with the case management agency
9. Home Inspection: Arrange for home safety and accessibility assessment according to the ASD Housing Safety and Accessibility inspection policy/procedure.
10. Legal Representatives: Maintain a copy of and comply with Advance Directives, Power of Attorney and Guardianship authorities.

11. Live-In Agreement: Oversee the AFC Home “Live-In Agreement”.
12. Matching: Facilitate AFC Home provider matching process, including the inclusion of the participant choice of home providers and selection of caregivers.
13. Monitoring: Ongoing review of the individual’s health and wellbeing, functional needs, service utilization, goals and outcomes.
14. Payment of Services: Submit timely claims to HP and process on-time “Difficulty of Care” payments to the AFC Home provider and other contracted services according to the participant’s person centered plan. Follow the standards established for submitting 94% of the approved tier rate for participants who are in the hospital.
15. Quality Reviews: Participation with DAIL in quality management reviews.
16. Respite: Ensure AFC Home receives adequate respite.
17. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources and providers, including access to community resources and transportation.
18. Staffing: Ensure that staff is trained and background checks (DAIL Background Check Policy) are in place according to the participant’s person centered plan.
19. Training: Ensure that AFC home provider staff receives orientation and training to meet the needs of the participant. Ensure that AFC home provider staff participate in training to obtain (6) hours of continuing education annually.
20. Transitions: Assist participants with moving from the AFC home to a new setting.

E. Adult Family Care Home

A home established and operated for the purpose of providing individualized supports in an environment that is safe, family oriented, and designed to support autonomy and maximize independence and dignity for up to two individuals, unrelated to the operator, enrolled in Choices for Care. The home must be contracted with an Authorized Agency (AA) and the home provider receives a tax free stipend called a “Difficulty of Care” payment. The home must be owned or rented by the home provider and both parties must reside at the same address under the same roof.

The home provider, at all times, shall ensure that the participant’s environment promotes a positive domestic living experience and assist the participant in realizing his/her maximum individual potential for independence.

The home providers' responsibilities include:

1. Providing a residence for the participant that continually meets Safety and Accessibility standards.
2. Maintain a Live-In Agreement with the participant in accordance with the DAIL Room & Board standards.
3. Participating and complying with required home Safety and Accessibility standards.
4. Providing or arranging for care and supervision for the participant 24 hours/day as described in the ILA and person centered plan, including:
 - a. personal care (activities of daily living);
 - b. household tasks (instrumental activities of daily living);
 - c. community access (e.g. shopping and use of community facilities);
 - d. leisure time activities; and
 - e. transportation to a reasonable number of community functions (directed by participant interest).
5. Providing a complete and balanced diet as determined by the participant's needs and desires.
6. Maintaining regular visits or contacts with the participant during hospitalizations, as appropriate to medical and social needs and as determined by the Case Manager or AA Service .
7. Participating in CFC reassessments.
8. Complying with Critical Incident Reporting and mandated reporting of abuse, neglect or exploitation to Adult Protective Services.
9. Maintaining records and recommendations per AFC home provider contract for services.
10. Allowing home visits by DAIL staff, Ombudsman, AA staff and other visitors as determined by the participant or legal representatives.
11. Keeping open communication with the participant, AA Coordinator and Case Manager.
12. Participating in orientation and trainings.
13. Obtaining six (6) continuing education credits annually.

F. Safety and Accessibility Inspection

Each Adult Family Care home will receive a Safety and Assessibility inspection by an agency who has been once every three years. All safety standards outlined in the Safety Checklist must be met.

The State shall incur the expense of the initial inspection and one follow-up inspection.

Refer to the *Adult Family Care Home Safety and Accessibility Inspection Process for Adult Services Division* for more details on the review schedule, Safety Checklist and Accessibility Checklist.

G. Critical Incident Reporting

Critical Incident reports are essential methods of documenting, evaluating and monitoring certain **serious or severe** occurrences, and ensuring that the necessary people receive the information. All AFC participants are subject to Adult Services Division, Critical Incident Reporting process and mandated reporting for Adult Protective Services. *Refer to Section V.14. Critical Incident Reporting for details.*

H. Disclosure of Information for Adult Family Care Home Providers and Respite Workers

Disclosure of Information (DoI) process is intended to assure that Choices for Care Adult Family Care Home Providers (Home Provider) and Adult Family Care respite workers receive relevant information so they can make an informed decision whether to agree to provide care in their own home to Choices for Care Adult Family Care participant. The DoI form shall include relevant information about a person's current status and history of violent behaviors, any potential predictors of violent behavior and any medications they are taking. The information may only be disclosed with the participant or guardian's authorization. *Refer to Section V.15. Adult Family Care Disclosure of Information Procedures for more information.*

I. AFC Limitations

1. AFC payment is limited to the AFC Tier rate as identified on the authorized Service Plan.
2. AFC services are not billable when a participant is in another CFC setting (*nursing facility, ERC*).
3. AFC Services must be billed at 94% of the daily rate (up to 30 days) when the participant is in the hospital.
4. AFC employees with a substantiated record of abuse, neglect, or exploitation of a child or a vulnerable adult shall not be paid to provide CFC services (*DAIL Background Check Policy*).
5. AFC employees who have been excluded from participation in Medicaid or Medicare services, programs, or facilities by the federal Department of Health and Human Services' Office of the Inspector General shall not be paid to provide CFC services (*DAIL Background Check Policy*).
6. AFC employees who have a criminal conviction for an offense involving bodily injury, abuse of a vulnerable person, a felony drug offense, or a property/money crime involving

violation of a position of trust shall not be paid to provide CFC services (*DAIL Background Check Policy*).

7. The participant's legal guardian shall not be paid to provide AFC services to the participant.
8. AFC services shall not be provided to a participant who has left the state of VT for more than 7 consecutive days.
9. CFC shall not pay for home maintenance and repairs.
10. CFC shall not pay for Room and Board.
11. CFC shall not pay for any service already paid to the home provider as described in the Live-In Agreement or in a separate, private arrangement (e.g. "Contract for Care")
12. CFC shall not pay for services covered by other health insurance such as Medicare, Medicaid, VA or private insurance.

SECTION IV. 1. Case Management Services

A. Definition

“Case Management Services” assist individuals in accessing Choices for Care (CFC), VT Long-Term Care Medicaid services as well as other medical, social, and educational services, regardless of the service funding source. Case Management Services provide detailed needs assessment and assist the individual in creating a comprehensive CFC person centered plan. Case Management Services provide ongoing assessment and monitoring. Case Management Services assist the Department of Disabilities, Aging and Independent Living (DAIL) in monitoring the quality, effectiveness and efficiency of CFC services.

B. Case Management Standards

Case Management providers shall be authorized by the DAIL and comply with the following:

1. DAIL Case Management Standards & Certification Procedures
2. DAIL Case Management Agency Certification Procedures (December 2010)
3. CFC Universal Provider Qualifications and Standards (Section III.)
4. CFC Services Principles (Section IV.)

C. Provider Types

The following provider types are approved to provide Case Management Services when authorized by DAIL and identified on the individuals Service Plan:

1. Area Agencies on Aging
2. Home Health Agencies (*as defined by State statute*)

D. Approved Activities

Case Management Services includes tasks associated with the following reimbursable activities:

1. Assessment: A comprehensive review of the individual circumstances, including, but not limited to, social, medical, functional, financial and environmental needs.
2. Care-Planning: A person centered process of identifying the goals, strengths and needs of the individual, including those identified in the assessment process. A plan is then developed to identify the services and supports to be delivered in order to meet the individual’s needs and goals.

3. Service Coordination: The process by which services are obtained for the individual through coordination with multiple resources and providers.
4. Information and Referral: The process by which the individual is fully informed of available options and assisted with referrals.
5. Monitoring: Ongoing review of the individual's health and wellbeing, functional needs, service utilization, goals and outcomes.
6. Participant & Surrogate Employer Certification: The process of assessing and reassessing an employer's certification for the home-based participant or surrogate directed option.
7. Documentation: Documentation includes all required CFC forms, person centered plan, applications for other services or public benefits and the documentation of ongoing case management activities.
8. Travel: Travel time includes getting to and from participant home-visits (or other face-to-face participant visit) and care-planning meetings related to individual service coordination.

E. Limitations

1. Case Management Services are limited to the "approved activities" for individuals authorized by DAIL for Choices for Care in the Home-Based or Enhanced Residential Care (ERC) setting.
2. Case Management Services are limited to a maximum of 48 hours per individual per calendar year.
3. Case Management Services for are limited to a maximum of 24 hours per individual per calendar year for participants in Adult Family Care.
4. Case Management Services may not be delegated to another case manager except under short-term, temporary situations.
5. Case Management Services may be provided and billed for up to 180 days after admission and/or preceding discharge from a nursing facility or hospital, when such services are clearly documented as facilitating the individual's return to the community.

F. Additional Case Management

If a participant needs additional case management services the case manager must submit a completed Services Variance Request Form (CFC 813A) requesting a variance to the service volume limit. The request must describe the case management activities provided to the participant and the unique circumstances that led to the utilization of a high volume of hours. It must be demonstrated that the participant's health or welfare may be at risk without additional case management. Case Management services are limited to approved activities only. Activities such as accounting services (banking & bill paying) and transportation are not approved case management activities. Non-approved activities must be provided by other services and supports. Retroactive requests will not be approved unless the request adequately demonstrates there was an immediate need to provide case management services to the individual in excess of the maximum prior to requesting a variance. Case managers are responsible for managing and tracking the volume of case management services allowed.

Authorized Agency, Adult Family Care Coordinator

“Adult Family Care Coordinators” (AFCC) are employees of the Authorized Agency and are responsible for facilitating the matching process of the individual with an adult family care home when a potential provider has been identified. Once the home provider has been identified the AFCC will do the following:

- Ensure that the identified home provider has passed all back ground checks, has passed the safety and accessibility housing inspection prior to the participant moving in and has a signed contract with the Authorized Agency;
- Assist the individual and home provider in the development of the person centered plan which describes the delivery of services and how they will meet the participants goals and needs as identified in the care plan;
- Facilitate the development of a room and board agreement between the individual and the home provider;
- Provide the case manager with a copy of the person centered plan and room and board agreement;
- Communicate all concerns that may affect the participant to the appropriate people in a timely manner to the Guardian, Authorized Agency, Case Manager or Home Provider;
- Assist the home provider to arrange for respite;
- Contact the case manager in the event of conflict between the participant and the home provider;
- Contact the case manager if there is any significant change in the individual’s health or functional status;
- Critical Incident Reporting.





Choices for Care Application Process “At a Glance”



Step I: Application

1. Choices for Care (CFC) applications are obtained by calling 1-800-479-6151 or online at http://dcf.vermont.gov/esd/health_insurance/ltc_medicaid . Completed applications are sent to DCF/Economic Services Division, Application and Document Processing Center, 103 South Main Street, Waterbury, VT 05671-1500.
2. A DCF case worker contacts the applicant to initiate the financial eligibility process.
3. DCF forwards the application to the local Department of Disabilities Aging and Independent Living (DAIL) Long Term Care Clinical Coordinator (LTCCC) who contacts the applicant to arrange for a face-to-face visit to complete clinical eligibility.

Step II: Clinical Determination:

5. After receipt of the CFC application from DCF, the DAIL LTCCC completes a face-to-face clinical assessment and CFC options education.
6. If clinically eligible, The DAIL LTCCC sends the “Clinical Certification” form CFC 803 to DCF and applicable providers, depending on the long-term care setting the individual has chosen.
7. For Home-Based (HB), Adult Family Care (AFC), Enhanced Residential Care (ERC), and Flexible Choices (FC) the case manager or consultant completes an assessment and Service Plan or Allowance within 14 calendar days, and sends with required documentation to the LTCCC.
8. For Adult Family Care (AFC), Case Manager makes a referral to the chosen Authorized Agency to begin the AFC home matching process.

Step III: Financial Determination:

9. After receipt of Clinical Certification (CFC 803), DCF completes financial eligibility determination and patient share (if applicable).
10. The LTCCC notifies DCF when the CFC setting and service provider is chosen so DCF can finalize the highest paid provider for patient share (if applicable). NOTE: DCF cannot finalize the eligibility until this is done. The CFC application will remain “pending” until then.
11. DCF sends Notice of Decision to applicant, alternate reporter, LTCCC and highest paid provider.

Step IV: Final Authorization:

12. For HB, AFC, ERC, and FC after receipt of the DCF Notice of Decision, if financially eligible, the DAIL LTCCC authorizes the Service Plan or Allowance. A copy of Service Plan or Allowance is sent to the individual and applicable providers.
13. Nursing facilities may start billing after receipt of the DCF Notice of Decision. Other HB, AFC, ERC and FC providers may start billing after receipt of the authorized Service Plan or Allowance.

OTHER:

- When CFC program funds are not available to serve applicants meeting High Needs clinical criteria they will receive a notice that they are being placed on a waiting list.
- Individuals ineligible will receive a denial notice with appeal rights.
- Providers using SAMS may receive DAIL notifications and service authorizations electronically.

Set-up Instructions for SAMS/OMNIA users: (August 2013)

Before using the CFC AFC ILA for the first time, OMNIA users must update OMNIA on their laptop and save the CFC AFC ILA to their Omnia directory. Go to <http://www.ddas.vermont.gov/ddas-forms/sams-omnia-electronic-assessment-forms/omnia-electronic-assessment-forms> and

- a. Update Omnia Catalogue file
- b. Update Omnia Indicator file, and
- c. Save the CFC AFC ILA to the Omnia directory

Once in OMNIA, chose the **VT DAIL CFC AFC ILA 2013** assessment. The ILA form will automatically score the AFC tier based on the person's functional assessment.



CFC AFC ILA

Paper Version September 2013

CFC AFC (Full ILA) 2013

0A. Cover Sheet: INDIVIDUAL IDENTIFICATION

0. ILA is being completed for which (DAIL) program?

- A - Adult day
- B - ASP
- C - HASS
- D - Homemaker
- E - Medicaid Waiver (Choices for Care)
- F - AAA services (NAPIS)
- G - Other
- H - Dementia Respite

1. Date of assessment?

____/____/____

2. Unique ID# for client.

3.a. Client's last name?

3.b. Client's first name?

3.c. Client's middle initial?

4. Client's telephone number.

5. Client's Social Security Number?

6. Client's date of birth?

____/____/____

7. Client's gender?

- M - Male
- F - Female
- T - Transgendered

8.a. Client's mailing street address or Post Office Box

8.b. Client's mailing city or town.

8.c. Client's mailing state.

8.d. Client's mailing ZIP code.

9.a. Residential street address or Post Office box.

9.b. Residential city or town.

9.c. Client's state of residence.

9.d. Client's residential zip code.

0B. Cover Sheet: ASSESSOR INFORMATION

1. Agency the assessor works for?

2. ILA completed by? (name of assessor)

0C. Cover Sheet: EMERGENCY CONTACT INFORMATION

1.a. Primary Emergency contact name?

1.a.1. Primary Emergency contact relationship?

1.b. Primary Emergency contact home phone?

1.b.1. Primary Emergency contact work phone?

1.c. Street address of Primary Emergency Contact?

1.d. City or town of Primary Emergency Contact?

1.e. State of Primary Emergency Contact?

1.f. Zip code for Primary Emergency contact?

2.a. Name of Emergency Contact #2?

2.b. Phone number of the client's Emergency Contact #2?

2.c. Street address or P.O box of the client's emergency contact #2?

2.d. City or town of the client's emergency contact #2?

2.e. State of client's Emergency Contact #2?

2.f. ZIP code of the client's emergency contact #2?

3.a. Client's primary care physician?

3.b. Phone number for the client's primary care physician?

4. Does the client know what to do if there is an emergency?

- A - Yes
- B - No

5. In the case of an emergency, would the client be able to get out of his/her home safely?

- A - Yes
- B - No

6. In the case of an emergency, would the client be able to summon help to his/her home?

- A - Yes
- B - No

7. Does the client require immediate assistance from Emergency Services in a man-made or natural disaster?

- A - Yes
- B - No

8. Who is the client's provider for emergency response services?

9. Comments regarding Emergency Response

0D. Cover Sheet: DIRECTIONS TO CLIENT'S HOME

Directions to client's home

1A. Intake: ASSESSMENT INFORMATION

1. Type of assessment

- A - Initial assessment
- B - Reassessment
- C - Update for Significant change in status assessment

2. Are there communication barriers for which you need assistance?

A - Yes

B - No

3. If yes, type of assistance?

4. Client's primary language.

- E - English
- L - American Sign Language
- F - French
- B - Bosnian
- G - German
- I - Italian
- S - Spanish
- P - Polish
- T - Portuguese
- M - Romanian
- R - Russian
- C - Other Chinese
- V - Vietnamese
- O - Other

4.a. Please specify or describe the client's primary language that is other than in the list.

1B. Intake: LEGAL REPRESENTATIVE

1.a. Does the client have an agent with Power of Attorney?

A - Yes

B - No

1.b. Name of client's agent with Power of Attorney?

1.c. Work phone number of the client's agent with Power of Attorney.

1.d. Home phone number of the client's agent with Power of Attorney.

2.a. Does the client have a Representative Payee?

A - Yes

B - No

2.b. Name of client's Representative Payee?

2.c. Work phone number of the client's Representative Payee.

2.d. Home phone number of the client's Representative Payee.

3.a. Does the client have a Legal Guardian?

A - Yes

B - No

3.b. Name of the client's Legal Guardian?

3.c. Work phone number of the client's Legal Guardian.

3.d. Home phone number of the client's Legal Guardian.

4.a. Does client have Advanced Directives for health care?

A - Yes

B - No

4.b. Name of agent for client's Advanced Directives?

4.c. Work phone number of the client's agent for Advanced Directives?

4.d. Home phone number of the client's agent for Advanced Directives.

4.e. If no Advanced Directives, was information provided about Advanced Directives?

- A - Yes
- B - No

1C. Intake: DEMOGRAPHICS

1. What is the client's marital status?

- A - Single
- B - Married
- C - Civil union
- D - Widowed
- E - Separated
- F - Divorced
- G - Unknown

2a. What is the client's race/ethnicity?

- A - Non-Minority (White, non-Hispanic)
- B - African American
- C - Asian/Pacific Islander (incl. Hawaiian)
- D - American Indian/Native Alaskan
- E - Hispanic Origin
- F - Unknown
- G - Other

2.a Enter the client's self-described ethnic background if OTHER

2b. What is the client's Hispanic or Latino ethnicity? Choose one.

- A - Not Hispanic or Latino
- B - Hispanic or Latino
- C - Unknown

2c. What is the client's race? Choose multiple.

- A - Non-Minority (White, non-Hispanic)
- B - Black/African American
- C - Asian
- D - American Indian/Native Alaskan
- E - White-Hispanic
- F - Unknown
- H - Native Hawaiian/Other Pacific Islander
- G - Other

3. What type of residence do you live in?

- A - House

- B - Mobile home
- C - Private apartment
- D - Private apartment in senior housing
- E - Assisted Living (AL/RC with 24 hour supervision)
- F - Residential care home
- G - Nursing home
- H - Unknown
- I - Other
- J - Adult Family Care Home

4. Client's Living arrangement? Who do you live with?

- A - Lives Alone
- B - Lives with others
- C - Doesn't know

5. Does the client reside in a rural area? Must answer yes for NAPIS

- A - Yes
- B - No

1D. Intake: HEALTH RELATED QUESTIONS: General

1. Were you admitted to a hospital for any reason in the last 30 days?

- A - Yes
- B - No

2. In the past year, how many times have you stayed overnight in a hospital?

- A - Not at all
- B - Once
- C - 2 or 3 times
- D - More than 3 times

3. Have you ever stayed in a nursing home, residential care home, or other institution? (including Brandon Training School and Vermont state Hospital)

- A - Yes
- B - No

4. Have you fallen in the past three months?

- A - Yes
- B - No

5. Do you use a walker or four prong cane (or equivalent), at least some of the time, to get around?

- A - Yes
- B - No

6. Do you use a wheelchair, at least some of the time, to get around?

- A - Yes
- B - No

14. How many prescription medications do you take?

15. About how tall are you in inches without your shoes?

16. About how much do you weigh in pounds without your shoes?

- DD - Housing and Supportive Services (HASS)
- EE - Section 8 voucher, housing
- FF - Subsidized housing
- GG - ANFC
- HH - Essential Persons program
- II - Food Stamps
- JJ - Fuel Assistance
- KK - General Assistance program
- LL - Medicaid
- MM - QMB/SLMB
- NN - Telephone Lifeline
- OO - VHAP
- PP - VPharm (VHAP Pharmacy)
- RR - Emergency Response System
- SS - SSI
- TT - Veterans benefits
- UU - Weatherization
- VV - Assistive Devices

1F. Intake: SERVICE PROGRAM CHECKLIST

1.a. Is the client participating in any of the following services or programs?

- A - Home health aide (LNA)
- B - Homemaker program
- C - Hospice
- D - Nursing (RN)
- E - Social work services
- F1 - Physical therapy
- F2 - Occupational therapy
- F3 - Speech therapy
- G - Adult Day Health Services/Day Health Rehab
- H - Attendant Services Program
- I - Developmental Disability Services
- J - Choices for Care Medicaid Waiver (HB/ERC)
- K - Medicaid High-Tech services
- L - Traumatic Brain Injury waiver
- M - USDA Commodity Supplemental Food Program
- N - Congregate meals (Sr. Center)
- O - Emergency Food Shelf/Pantry
- P - Home Delivered Meals
- Q - Senior Farmer's Market Nutrition Program
- Q1 - Nutritional Counseling
- R - AAA Case Management
- S - Community Action Program (CAP)
- T - Community Mental Health services
- U - Dementia Respite grant/NFCSP Grant
- V - Eldercare Clinician
- W - Job counseling/vocational rehabilitation
- X - Office of Public Guardian
- Y - Senior companion
- Z - VCIL peer counseling
- AA - Association for the Blind and Visually Impaired
- BB - Legal Aid services
- CC - Assistive Community Care Services (ACCS)

7. In the past month how many days a week have you usually gone out of the house/building where you live?

- A - Two or more days a week
- B - One day a week or less

8. Do you need assistance obtaining or repairing any of the following? (Check all that apply)

- A - Eyeglasses
- B - Cane or walker
- C - Wheelchair
- D - Assistive feeding devices
- E - Assistive dressing devices
- F - Hearing aid
- G - Dentures
- H - Ramp
- I - Doorways widened
- J - Kitchen/bathroom modifications
- K - Other
- L - None of the above

1E. Intake: THE NSI DETERMINE Your Nutritional Health Checklist

1. Have you made any changes in lifelong eating habits because of health problems?

- A - Yes (Score = 2)
- B - No

2. Do you eat fewer than 2 meals per day?

- A - Yes (Score = 3)
- B - No

3. Do you eat fewer than five (5) servings (1/2 cup each) of fruits or vegetables every day?

- A - Yes (Score = 1)
- B - No

4. Do you eat fewer than two servings of dairy products (such as milk, yogurt, or cheese) every day?

- A - Yes (Score = 1)
- B - No

5. Do you have trouble eating due to problems with chewing/swallowing?

- A - Yes (Score = 2)
- B - No

6. Do you sometimes not have enough money to buy food?

- A - Yes (Score = 4)
- B - No

7. Do you eat alone most of the time?

- A - Yes (Score = 1)
- B - No

8. Do you take 3 or more different prescribed or over-the-counter drugs per day?

- A - Yes (Score = 1)
- B - No

9. Without wanting to, have you lost or gained 10 pounds or more in the past 6 months?

- A - Yes (Score = 2)
- B - No
- L - Yes, lost 10 pounds or more
- G - Yes, gained 10 pounds or more

10. Are there times when you are not always physically able to shop, cook and/or feed yourself (or to get someone to do it for you)?

- A - Yes (Score = 2)
- B - No

11. Do you have 3 or more drinks of beer, liquor or wine almost every day?

- A - Yes (Score = 2)
- B - No

12. Total score of Nutritional Risk Questions. Add the scores for all Yes answers for questions 1 to 11 in the Nutritional Health Checklist. See below for scoring.

12.a. Is the client at a high nutritional risk level? Must answer for NAPIS.

- Don't know
- No
- Yes

NUTRITIONAL RISK SCORE means:

0-2 **GOOD:** Recheck your score in 6 months
3-5 **MODERATE RISK:** Recheck your score in 3 months
6+ **HIGH RISK:** May need to talk to Doctor or Dietitian Enter any comments.....

13. Is the client interested in talking to a nutritionist about food intake and diet needs?

- A - Yes
- B - No
- C - Don't know

1.b. Does the client want to apply for any of the following services or programs?

- A - Home health aide (LNA)
- B - Homemaker program
- C - Hospice
- D - Nursing (RN)
- E - Social Work Services
- F1 - Physical therapy
- F2 - Occupational therapy
- F3 - Speech therapy
- G - Adult day services/Day Health Rehab
- H - Attendant Services Program
- I - Developmental Disability Services
- J - Choices for Care Medicaid Waiver (HB/ERC)
- K - Medicaid High-Tech Services
- L - Traumatic Brain Injury Waiver
- M - USDA Commodity Supplemental Food Program
- N - Congregate Meals (Sr. Center)
- O - Emergency Food Shelf/Pantry
- P - Home Delivered Meals
- Q - Senior Farmer's Market Nutrition Program
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- R - AAA Case Management
- S - Community Action Program
- T - Community Mental Health Services
- U - Dementia Respite Grant Program/NFCSP Grant
- V - Eldercare Clinician
- W - Job counseling/vocational rehabilitation
- X - Office of Public Guardian
- Y - Senior companion
- Z - VCIL peer counseling
- AA - Association for the Blind and Visually Impaired
- BB - Legal Aid services
- CC - Assistive Community Care Services (ACCS)
- DD - Housing and Supportive Services (HASS)
- EE - Section 8 Voucher (Housing Choice)
- FF - Subsidized Housing
- GG - ANFC
- HH - Essential Persons program
- II - Food stamps
- JJ - Fuel Assistance
- KK - General Assistance Program
- LL - Medicaid
- MM - QMB/SLMB
- NN - Telephone Lifeline
- OO - VHAP
- PP - VPharm (VHAP Pharmacy)
- RR - Emergency Response System
- SS - SSI

- TT - Veterans Benefits
- UU - Weatherization
- VV - Assistive Devices

1G. intake: POVERTY LEVEL ASSESSMENT

1. Are you currently employed?

- A - Yes
- B - No

2. How many people reside in the client's household, including the client?

3. HOUSEHOLD INCOME: Estimate the total client's HOUSEHOLD gross income per month?

\$

4. CLIENT INCOME: Specify the client's monthly income.

\$

5. Is the client's income level below the national poverty level?

- A - Yes
- B - No
- C - Don't know

1H1. Intake: FINANCIAL RESOURCES: Monthly Income

1.a.1. Client's monthly social security income

\$

1.a.2. Monthly social security income of the client's spouse

\$

1.b.1. Client's monthly SSI income

\$

1.b.2. Monthly SSI income of the client's spouse

\$

1.c.1. Client's monthly retirement/pension income

\$

1.c.2. Monthly retirement/pension income of the client's spouse

\$

1.d.1. Client's monthly interest income

\$

1.d.2. Monthly interest income of the client's spouse

\$

1.e.1. Client's monthly VA benefits income.

\$

1.e.2. Monthly VA benefits income of the client's spouse.

\$

1.f.1. Client's monthly wage/salary/earnings income

\$

1.f.2. Monthly wage/salary/earnings income of the client's spouse

\$

1.g.1. Client's other monthly income.

\$

1.g.2. Other monthly income of the client's spouse

\$

1H2. Intake: FINANCIAL RESOURCES: Monthly Expenses

2.a. Client's monthly rent.

\$

2.a.2. Client's monthly mortgage

\$

2.b. Client's monthly property tax.

\$

2.c. Client's monthly heat bill.

\$

2.d. Client's monthly utilities bill.

\$

2.e. Client's monthly house insurance cost.

\$

2.f. Client's monthly telephone bill.

\$

2.g. Monthly amount of medical expense the client incurs.

\$

2.h.1. Describe other expenses

2.h.2. Monthly amount of other expenses?

\$ _____

1H3. Intake: FINANCIAL RESOURCES: Savings/Assets

3.a.1. What is the name of the bank/institution where the client's checking account is located?

3.a.2. What is the client's checking account number?

3.a.3. What is the client's checking account balance?

\$ _____

3.b.1. What is the name of the bank/institution where the client's primary savings account is located?

3.b.2. What is the client's primary savings account number?

3.b.3. What is the client's primary savings account balance?

\$ _____

3.c.1. What is the source of Stocks/Bonds/CDs resources?

3.c.2. What is the amount from Stock/Bonds/CDs?

\$ _____

3.d.1. What is the name of the bank/institution where the client's burial account is located?

3.d.2. What is the client's burial account number?

3.d.3. What is the client's burial account balance?

\$ _____

3.e.1. What is the name of the client's primary life insurance company?

3.e.2. What is the client's primary life insurance policy number?

3.e.3. What is the face value of the client's primary life insurance policy?

\$ _____

3.e.4. What is the cash surrender value of the client's primary life insurance policy?

\$ _____

3.f.1. What is the name of the bank/institution where the client's other account #1 is located?

3.f.2. What is the client's other account number #1?

3.f.3. What is the client's other account #1 balance?

\$

3.g.1. What is the name of the bank/institution where the client's other account #2 is located?

3.g.2. What is the client's other account number #2?

3.g.3. What is the client's other account #2 balance?

\$

1H4. Intake: FINANCIAL RESOURCES: Health Insurance

4.a.1. Does the client have Medicare A health insurance?

A - Yes
 B - No

4.a.2. What is the effective date of the client's Medicare A policy?

___/___/___

4.a.3. What is the client's Medicare A policy number?

4.a.4. What is the client's monthly Medicare A premium? (enter 0 if no premium)

\$

4.b.1. Does the client have Medicare B health insurance?

A - Yes
 B - No

4.b.2. What is the effective date of the client's Medicare B policy?

___/___/___

4.b.3. What is the client's Medicare B policy number?

4.b.4. What is the client's monthly Medicare B premium? (Enter 0 if no premium)

\$

4.c.1. Does the client have Medicare C health insurance?

A - Yes
 B - No

4.c.2. What is the name of the client's Medicare C plan?

4.c.3. What is the effective date of the client's Medicare C policy?

___/___/___

4.c.4. What is the client's Medicare C plan premium? (Enter 0 if no premium)

\$

4.d.1. Does the client have Medicare D health insurance?

A - Yes
 B - No

4.d.2. What is the name of the client's Medicare D plan?

4.d.3. What is the effective date of the client's Medicare D plan?

___/___/___

4.d.4. What is the client's Medicare D plan premium? (Enter 0 if no premium)

\$

4.e.1. Does the client have Medigap health insurance?

A - Yes
 B - No

4.e.2. What is the name of the client's Medigap health insurer?

4.e.3. What is the client's monthly Medigap premium? (Enter 0 if no premium)

\$

4.f.1. Does the client have LTC health insurance?

A - Yes
 B - No

4.f.2. What is the name of the client's LTC health insurer?

4.f.3. What is the client's monthly LTC premium? (Enter 0 if no premium)

\$

4.g.1. Does the client have other health insurance?

A - Yes
 B - No
 C - Don't know

4.g.2. Enter the name of the client's other health insurance carrier, if applicable.

4.g.3. What is the client's other monthly premium? (Enter 0 if no premium)

\$

4.h.1. Does the client have VPharm insurance?

A - Yes
 B - No

4.h.2. What is the effective date of VPharm insurance?

___ / ___ / _____

1H5. Intake: FINANCIAL RESOURCES: Comments

Comment on the client's current financial situation.

1I. Intake: "SELF NEGLECT", ABUSE, NEGLECT, AND EXPLOITATION SCREENING

1. Is the client refusing services and putting him/her self or others at risk of harm?

A - Yes
 B - No
 C - Information unavailable

2. Does the client exhibit dangerous behaviors that could potentially put him/her self or others at risk of harm?

A - Yes
 B - No
 C - Information unavailable

3. Can the Client make clear, informed decisions about his/her care needs (Regardless of the consequence of the decision)?

A - Yes
 B - No
 C - Information unavailable

4. Is there evidence (Observed or reported) of suspected abuse, neglect or exploitation of the client by another person?

A - Yes
 B - No
 C - Information unavailable

5. **ASSESSOR ACTION:** If answer to 1 or 2 is yes refer clients >60 to Area Agency on Aging or if <60 to Adult Protective Services. If 3 is yes, consider a negotiated risk contract. If 4 is yes mandated reporters must file a report of abuse...Enter comments..

2. Supportive Assistance

1. Who is the primary unpaid person who usually helps the client?

- A - Spouse or significant other
- B - Daughter or son
- C - Other family member
- D - Friend, neighbor or community member
- E - None

2. How often does the client receive help from his/her primary unpaid caregiver?

- A - Several times during day and night
- B - Several times during day
- C - Once daily
- D - Three or more times per week
- E - One to two times per week
- F - Less often than weekly
- G - Unknown

3. What type of help does the client's primary unpaid caregiver provide?

- A - ADL assistance
- B - IADL assistance
- C - Environmental support
- D - Psychosocial support
- E - Medical care
- F - Financial help
- G - Health care
- H - Unknown

4. What is the name of the client's primary unpaid caregiver?

5. What is the relationship of the primary unpaid caregiver to the client?

6. What is the phone number of the client's primary unpaid caregiver?

7. What is the address of the client's primary unpaid caregiver?

8. In your role as a caregiver do you need assistance in any of the following areas?

- A - Job
- B - Finances
- C - Family responsibilities
- D - Physical health
- E - Emotional health
- F - Other

9. ASSESSOR ACTION:
If caregiver indicates factors in question #8, discuss options for family support services and make appropriate referrals. Consider completing "Caregiver Self-Assessment Questionnaire"
... Enter any Comments on Client's Support System.

3A. Living Environment: LIVING ENVIRONMENT HAZARDS

1. Do any structural barriers make it difficult for you to get around your home?

- A - Stairs inside home - must be used
- B - Stairs inside home - optionally used
- C - Stairs outside
- D - Narrow or obstructed doorways
- E - Other
- F - None

2. Do any of the following safety issues exist in your home?

- A - Inadequate floor, roof or windows
- B - Inadequate/insufficient lighting
- C - Unsafe gas/electric appliance
- D - Inadequate heating
- E - Inadequate cooling
- F - Lack of fire safety devices
- G - Flooring or carpeting problems
- H - Inadequate stair railings
- I - Improperly stored hazardous materials
- J - Lead-based paint
- K - Other
- L - None of the above

2.a. Other safety hazards found in the client's current place of residence

3. Do any of the following sanitation issues exist in your home?

- A - No running water
- B - Contaminated water
- C - No toileting facilities
- D - Outdoor toileting facilities
- E - Inadequate sewage disposal
- F - Inadequate/improper food storage
- G - No food refrigeration
- H - No cooking facilities
- I - Insects/rodents present
- J - No trash pickup
- K - Cluttered/soiled living area
- L - Other
- M - None

3.a. Other sanitation hazards found in the client's current place of residence

- A - Yes
- B - No
- C - No response

2. Have you felt down, depressed, hopeless or helpless?

- A - Yes
- B - No
- C - No response

3. Are you bothered by little interest or pleasure in doing things?

- A - Yes
- B - No
- C - No response

4. Have you felt satisfied with your life?

- A - Yes
- B - No
- C - No response

5. Have you had a change in sleeping patterns?

- A - Yes
- B - No
- C - No response

6. Have you had a change in appetite?

- A - Yes
- B - No
- C - No response

7. Have you thought about harming yourself?

- A - Yes
- B - No
- C - No response

8. Do you have a plan for harming yourself?

- A - Yes
- B - No

9. Do you have the means for carrying out the plan for harming yourself?

- A - Yes
- B - No

10. Do you intend to carry out the plan to harm yourself?

- A - Yes
- B - No

11. Have you harmed yourself before?

- A - Yes
- B - No

4A. Emotional/Behavior/Cognitive Status: EMOTIONAL WELL BEING

1. Have you been anxious a lot or bothered by nerves?

12. Are you currently being treated for a psychiatric problem?

- A - Yes
- B - No

13. Where are you receiving psychiatric services?

- A - At home
- B - In the community
- C - Both at home and in the community

14. If any question in this section was answered yes, what action did the assessor take?

15. READ. You have just expressed concerns about your emotional health. There are some resources and services that might be helpful; if you are interested I will initiate a referral or help you refer yourself
.....Enter comments if any...

6. Indicate the client's ability to speak and verbally express him or herself.

- A - Speaks normally (No observable impairment)
- B - Minimal or minor difficulty
- C - Moderate difficulty (can only carry simple conversations)
- D - Unable to express basic needs

7. What is the client's ability to make decisions regarding tasks of daily life?

- A - Independent - decisions consistent/reasonable
- B - Modified independence - some difficulty in new situations only
- C - Moderately impaired - decisions poor; cues/supervision
- D - Severely impaired - never/rarely makes decisions

ASSESSOR ACTION:

If **EMOTIONAL HEALTH** issues refer to Area Agency on Aging/Eldercare Clinician or Community mental health
If **COGNITION** issues refer to Doctor or Mental Health professional

4B. Emotional/Behavior/Cognitive Status: COGNITIVE STATUS

1. What was the client's response when asked, 'What year is it?'

- A - Correct answer
- B - Incorrect answer
- C - No response

2. What was the client's response when asked, 'What month is it?'

- A - Correct answer
- B - Incorrect answer
- C - No response

3. What was the client's response when asked, 'What day of the week is it?'

- A - Correct answer
- B - Incorrect answer
- C - No response

4. Select the choice that most accurately describes the client's memory and use of information.

- A - No difficulty remembering
- B - Minimal difficulty remembering (cueing 1-3/day)
- C - Difficulty remembering (cueing 4+/day)
- D - Cannot remember

5. Select the choice that most accurately describes the client's global confusion.

- A - Appropriately responsive to environment
- B - Nocturnal confusion on awakening
- C - Periodic confusion in daytime
- D - Nearly always confused

4C. Emotional/Behavior/Cognitive Status: BEHAVIORAL STATUS

1.a. How often does the client get lost or wander?

- 0 - Never
- 1 - Less than daily
- 2 - Daily

1.b. In the last 7 days was the client's wandering behavior alterable?

- 0 - Behavior not present OR behavior easily altered
- 1 - Behavior was not easily altered

2.a. How often is the client verbally abusive?

- 0 - Never
- 1 - Less than daily
- 2 - Daily

2.b. In the last 7 days was the client's verbally abusive behavior alterable?

- 0 - Behavior not present OR behavior easily altered
- 1 - Behavior was not easily altered

3.a. How often is the client physically abusive to others?

- 0 - Never
- 1 - Less than daily
- 2 - Daily

3.b. In the last 7 days was the client's physically abusive behavior alterable?

- 0 - Behavior not present OR behavior easily altered
- 1 - Behavior was not easily altered

4.a. How often does the client exhibit socially inappropriate/disruptive behavior? (e.g. disruptive sounds, noisiness, screaming, self-abusive acts, etc.)

- 0 - Never
- 1 - Less than daily
- 2 - Daily

4.b. In the last 7 days was the client's socially inappropriate or disruptive behavior symptoms alterable?

- 0 - Behavior not present OR behavior easily altered
- 1 - Behavior was not easily altered

5.a. How often did the client display symptoms of resisting care (resisted taking medications -injections, ADL assistance, or eating) in the last 7 days?

- 0 - Never
- 1 - Less than daily
- 2 - Daily

5.b. In the last 7 days was the client's resistance to care symptoms alterable?

- 0 - Behavior not present OR behavior easily altered
- 1 - Behavior was not easily altered

Comment on behaviors

**5A. Health Assessment (for CFC must be completed by RN/LPN):
DIAGNOSIS/CONDITIONS/TREATMENTS**

1. Describe the client's primary diagnoses.

2. Indicate which of the following conditions/diagnoses the client currently has.

- A - ENDOCRINE-Diabetes
- B - ENDOCRINE-Hyperthyroidism
- C - ENDOCRINE-Hypothyroidism
- D - HEART-Arteriosclerotic heart disease (ASHD)
- E - HEART--Cardiac dysrhythmias
- F - HEART--Congestive heart failure

- G - HEART--Deep vein thrombosis
- H - HEART--Hypertension
- I - HEART--Hypotension
- J - HEART--Peripheral vascular disease
- K - HEART-Other cardiovascular disease
- L - MUSCULOSKELETAL-Arthritis/rheumatic disease/gout
- M - MUSCULOSKELETAL-Hip fracture
- N - MUSCULOSKELETAL-Missing limb (e.g., amputation)
- O - MUSCULOSKELETAL-Osteoporosis
- P - MUSCULOSKELETAL-Pathological bone fracture
- Q - NEUROLOGICAL-Alzheimer's disease
- R - NEUROLOGICAL-Aphasia
- S - NEUROLOGICAL-Cerebral palsy
- T - NEUROLOGICAL-Stroke
- U - NEUROLOGICAL - Non-Alzheimer's dementia
- V - NEUROLOGICAL-Hemiplegia/Hemiparesis
- W - NEUROLOGICAL-Multiple sclerosis
- X - NEUROLOGICAL-Paraplegia
- Y - NEUROLOGICAL-Parkinson's disease
- Z - NEUROLOGICAL-Quadriplegia
- AA - NEUROLOGICAL-Seizure disorder
- BB - NEUROLOGICAL-Transient ischemic attack (TIA)
- CC - NEUROLOGICAL-Traumatic brain injury
- DD - PSYCHIATRIC-Anxiety disorder
- EE - PSYCHIATRIC-Depression
- FF - PSYCHIATRIC- Bipolar disorder (Manic depression)
- GG - PSYCHIATRIC-Schizophrenia
- HH - PULMONARY-Asthma
- II - PULMONARY-Emphysema/COPD/
- JJ - SENSORY-Cataract
- KK - SENSORY-Diabetic retinopathy
- LL - SENSORY-Glaucoma
- MM - SENSORY-Macular degeneration
- MM1 - SENSORY- Hearing impairment
- NN - OTHER-Allergies
- OO - OTHER-Anemia
- PP - OTHER-Cancer
- QQ - OTHER-Renal failure
- RR - None of the Above
- SS - OTHER-Other significant illness

2.a. Enter any comments regarding the client's medical conditions/diagnoses.

3. Select all infections that apply to the client's condition based on the client's clinical record, consult staff, physician and accept client statements that seem to have clinical validity. Do not record infections that have been resolved.

- A - Antibiotic resistant infection (e.g.Methicillin resistant staph)
- B - Clostridium difficile (c.diff.)
- C - Conjunctivitis
- D - HIV infection
- E - Pneumonia
- F - Respiratory infection
- G - Septicemia
- H - Sexually transmitted diseases
- I - Tuberculosis
- J - Urinary tract infection in last 30 days
- K - Viral hepatitis
- L - Wound infection
- M - None
- N - Other

4. Indicate what problem conditions the client has had in the past week.

- A - Dehydrated; output exceeds input
- B - Delusions
- C - Dizziness or lightheadedness
- D - Edema
- E - Fever
- F - Internal bleeding
- G - Recurrent lung aspirations in the last 90 days
- H - Shortness of breath
- I - Syncope (fainting)
- J - Unsteady gait
- K - Vomiting
- L - End Stage Disease (6 or fewer months to live)
- M - None of the above
- N - Other

5. Medical treatments that the client received during the last 14 days.

- A - TREATMENTS - Chemotherapy
- B - TREATMENTS - Dialysis
- C - TREATMENTS - IV medication
- D - TREATMENTS - Intake/output
- E - TREATMENTS - Monitoring acute medical condition
- F - TREATMENTS - Ostomy care
- G - TREATMENTS - Oxygen therapy
- H - TREATMENTS - Radiation
- I - TREATMENTS - Suctioning
- J - TREATMENTS - Tracheostomy care
- K - TREATMENTS - Transfusions
- L - TREATMENTS - Ventilator or respirator

- M - None of the Above
- N - Other

6. Indicate all therapies received by the client in the last seven (7) days.

- A - Speech therapy
- B - Occupational therapy
- C - Physical therapy
- D - Respiratory therapy
- E - None of the above

7. Does the client currently receive at least 45 minutes per day for at least 3 days per week of PT or a combination of PT, ST or OT?

- A - Yes
- B - No
- C - Information unavailable

8. Select all that apply for nutritional approaches.

- A - Parenteral/IV
- B - Feeding tube
- C - Mechanically altered diet
- D - Syringe (oral feeding)
- E - Therapeutic diet
- F - Dietary supplement between meals
- G - Plate guard, stabilized built-up utensil, etc
- H - On a planned weight change program
- I - Oral liquid diet
- J - None of the above

9. Select all that apply with regards to the client oral and dental status.

- A - Broken, loose, or carious teeth
- B - Daily cleaning of teeth/dentures or daily mouth care —by Client or staff
- C - Has dentures or removable bridge
- D - Inflamed gums (gingiva);swollen/bleeding gums;oral abscesses; ulcers or rashes
- E - Some/all natural teeth lost, does not have or use dentures or partial plate
- F - None of the above

10. High risk factors characterizing this client?

- A - Smoking
- B - Obesity
- C - Alcohol dependency
- D - Drug dependency
- E - Unknown
- G - None of the above

**5B. Health Assessment (for CFC must be completed by RN/LPN):
PAIN STATUS**

1. Indicate the client's frequency of pain interfering with his or her activity or movement.

- A - No pain
- B - Less than daily
- C - Daily, but not constant
- D - Constantly

2. If the client experiences pain, does its intensity disrupt their usual activities? (e.g. sleep, eating, energy level)

- A - Yes
- B - No

**5C. Health Assessment (for CFC must be completed by RN/LPN):
SKIN STATUS**

ULCER KEY:

STAGE 1: Persistent area of skin redness (no break in skin) that doesn't disappear when pressure is relieved

STAGE2: Partial skin thickness loss, presents as an abrasion, blister, or shallow crater.

STAGE3: Full skin thickness loss, exposing subcutaneous tissues, presents as a deep crater.

STAGE 4: Full skin thickness loss, exposing subcutaneous tissues, exposing muscle or bone

1.a. Specify the highest ulcer stage (1-4) for any pressure ulcers the client has (specify 0 if the client has no pressure ulcers).

1.b. Specify the highest ulcer stage (1-4) for any stasis ulcers the client has (specify 0 if the client has no pressure ulcers).

2. Indicate which of the following skin problems the client has that requires treatment.

- A - Abrasions or Bruises
- B - Burns (second or third degree)
- C - Open lesions other than ulcers, rashes or cuts
- D - Rashes
- E - Skin desensitized to pain or pressure
- F - Skin tears or cuts
- G - Surgical wound site
- H - None of the above

**5D. Health Assessment (for CFC must be completed by RN/LPN):
ELIMINATION STATUS**

1. Has this client been treated for a urinary tract infection in the past 14 days?

- A - Yes
- B - No

2. What is the current state of the client's bladder continence (in the last 14 days) Client is continent if dribble volume is insufficient to soak through underpants with appliances used (pads or continence program)

- A - Yes Incontinent
- B - No incontinence nor catheter
- C - No incontinence has Urinary catheter

3. What is the frequency of bladder incontinence?

- A - Less than once weekly
- B - One to three times weekly
- C - Four to six times weekly
- D - One to three times daily
- E - Four or more times daily
- F - Not Applicable

4. When does bladder (urinary) incontinence occur?

- A - During the day only
- B - During the night only
- C - During the day and night

5. What is the current state of the client's bowel continence (in the last 14 days, or since the last assessment if less than 14 days)? Client is continent if control of bowel movement with appliance or bowel continence program.

- A - Incontinent
- B - No incontinence nor ostomy
- C - No incontinence has ostomy

6. What is the frequency of bowel incontinence?

- A - Less than once weekly
- B - One to three times weekly
- C - Four to six times weekly
- D - One to three times daily
- E - Four or more times daily
- F - Not applicable

7. When does bowel incontinence occur?

- A - During the day only
- B - During the night only
- C - During the day and night

8. Has the client experienced recurring bouts of diarrhea in the last seven (7) days?

- A - Yes
- B - No

9. Has the client experienced recurring bouts of constipation in the last seven (7) days?

- A - Yes
- B - No

Comments regarding Urinary/Bowel Problems

5E. Health Assessment (for CFC must be completed by RN/LPN): COMMENTS and RN/LPN SIGNATURE

Comments regarding Medical Conditions

Agency of RN/LPN

Name of LPN/RN who completed Health Assessment section SIGN BELOW

LPN/RN Signature

Date LPN/RN completed Health Assessment section

6A. Functional Assessment: ACTIVITIES of DAILY LIVING (ADLs)

KEY TO ADLS:

- 0=INDEPENDENT: No help at all OR help/oversight for 1- 2 times
- 1=SUPERVISION: Oversight/cue 3+ times OR oversight/cue
- 2=LIMITED ASSIST: Non-wt bearing physical help 3+times OR non-wt bearing help + extensive help 1-2 times
- 3=EXTENSIVE ASSIST: Wt-bearing help or full caregiver
- 4=TOTAL DEPENDENCE: Full caregiver assistance every time
- 8= Activity did not occur OR unknown.

1.A. DRESSING: During the past 7 days, how would you rate the client's ability to perform DRESSING? (putting on, fastening, taking off clothing, including prosthesis)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

1.B. Select the item for the most support provided during the last 7 days, for Dressing

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

1.D. Comment on the client's ability in dressing.

2.A. BATHING: During the past 7 days, how would you rate the client's ability to perform BATHING (include shower, full tub or sponge bath, exclude washing back or hair)?

- 0 - INDEPENDENT: No help at all
- 1 - SUPERVISION: Oversight/cueing only
- 2 - LIMITED ASSISTANCE: Physical help limited to transfer
- 3 - EXTENSIVE ASSISTANCE: Physical help in part of bathing activity
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

2.B. Select the item for the most support provided during the last 7 days, for Bathing.

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

2.D. Comments regarding the client's bathing.

3.A. PERSONAL HYGIENE During the past 7 days, how would you rate the client's ability to perform PERSONAL HYGIENE? (combing hair, brushing teeth, shaving, washing/drying face, hands, perineum, EXCLUDE baths and showers)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

3.B. Select the item for the most support provided during the last 7 days, for Personal Hygiene

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

3.D. Comment on the client's ability to perform personal hygiene

4.A. MOBILITY IN BED During the past 7 days, how would you rate the client's ability to perform MOBILITY IN BED? (moving to and from lying position, turning side to side, and positioning while in bed)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

4.B. Select the item for the most support provided during the last 7 days, for Bed Mobility.

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two Plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

4.D. Comments on clients bed mobility.

5.A. TOILET USE During the past 7 days, how would you rate the client's ability to perform TOILET USE? (using toilet, getting on/off toilet, cleansing self, managing incontinence)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

5.B. Select the item for the most support provided during the last 7 days, for Toilet Use

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

5.D. Comment on the client's ability to use the toilet.

6.A. ADAPTIVE DEVICES: During the past 7 days how do rate the client's ability to manage putting on and/or removing braces, splints, and other adaptive devices.

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

6.B. Specify the most support provided for client's ability to care for his/her adaptive equipment.

- 0 - No setup or physical help
- 1 - Setup only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

6.D. Comment on adaptive devices.

7.A. TRANSFER: During the past 7 days, how would you rate the client's ability to perform TRANSFER? (moving to/from bed, chair, wheelchair, standing position, EXCLUDES to/from bath/toilet)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

7.B. Select the item for the most support provided during the last 7 days, for Transfer.

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

7.D. Enter any comments regarding the client's ability to transfer.

8.A. MOBILITY: During the past 7 days, how would you rate the client's ability to perform MOBILITY IN HOME? (moving between locations in home. If in wheelchair, self-sufficiency once in wheelchair)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

8.B. Select the item for the most support provide for mobility in last 7 days

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two + person physical assist
- 8 - Activity did not occur in last 7 days OR unknown

8.D. Comment on the client's ability to get around inside the home.

9.A. EATING: During the past 7 days, how would you rate the client's ability to perform EATING? (ability to eat and drink regardless of skill. Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)

- 0 - INDEPENDENT: No help or oversight OR help provided 1 or 2 times
- 1 - SUPERVISION: Oversight/cueing 3+ times OR Oversight with physical help 1-2 time
- 2 - LIMITED ASSISTANCE: Non-wt bearing physical help 3+ times OR extensive help 1-2
- 3 - EXTENSIVE ASSISTANCE: Weight bearing help OR full caregiver assistance 3+ times
- 4 - TOTAL DEPENDENCE: Full assistance every time
- 8 - Activity did not occur OR unknown

9.B. Select the item for the most support provided during the last 7 days, for Eating

- 0 - No setup or physical help
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two plus persons physical assist
- 8 - Activity did not occur in last 7 days OR unknown

9.D. Comment on the client's ability to eat.

6B. Functional Assessment: INSTRUMENTAL ACTIVITIES of DAILY LIVING (IADLs)

1.A. PHONE: During the last 7 days, Rate the client's ability to use the PHONE. (Answering the phone, dialing numbers, and effectively using the phone to communicate)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

1.B. Indicate the highest level of phone use support provided in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

1.D. Comment on the client's ability to use the telephone.

2.A. MEAL PREPARATION: During the past 7 days, how would you rate the client's ability to perform MEAL PREPARATION? (planning and preparing light meals or reheating delivered meals)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

2.B. Indicate the most support provided for meal prep in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

2.D. Comment on the client's ability to prepare meals.

3.A. MEDICATIONS MANAGEMENT: During the past 7 days, how would you rate the client's ability to perform MEDICATIONS MANAGEMENT? (preparing/taking all prescribed and over the counter medications reliably and safely, including correct dosage at correct times)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

3.B. Indicate the most support provided for medications management in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

3.D. Comment on the client's ability to take his/her medication.

4.A. MONEY MANAGEMENT: During the last 7 days how do you rate the client's ability to manage money. (payment of bills, managing checkbook/accounts, being aware of potential exploitation, budgets, plans for emergencies etc.)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

4.B. Indicate the most support provided for money management in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

4.D. Comment on the client's ability to manage money.

5.A. HOUSEHOLD MAINTENANCE: During the past 7 days rate the client's ability to perform HOUSEHOLD MAINTENANCE. (chores such as washing windows, shoveling snow, taking out garbage and scrubbing floors)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

5.B. Indicate the highest level of household maintenance support provided in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

5.D. Comment on the client's ability to perform household maintenance chores.

6.A. LIGHT HOUSEKEEPING: During the last 7 days how would you rate the client's ability to perform light housekeeping. (dusting, sweeping, vacuuming, dishes, light mop, and picking up)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

6.B. Indicate the most support provided for housekeeping in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

6.D. Comment on the client's ability to do ordinary housekeeping.

7.A. LAUNDRY During the last 7 days how do rate the client's ability to perform laundry. (carrying laundry to and from the washing machine, using washer and dryer, washing small items by hand)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

7.B. Indicate the most support provided for laundry in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

7.D. Comment on the client's ability to do laundry.

8.A. SHOPPING: During the past 7 days, how would you rate the client's ability to perform SHOPPING? (planning, selecting, and purchasing items in a store and carrying them home or arranging delivery if available)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

8.B. Indicate the highest level of shopping support provided in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

8.D. Comment on the client's ability to do shopping.

9.A. TRANSPORTATION: During the past 7 days, how would you rate the client's ability to perform TRANSPORTATION? (safely using car, taxi or public transportation)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

9.B. Indicate the highest level of transportation support provided in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

9.D. Comment on the client's ability to use transportation.

10.A. EQUIPMENT MANAGEMENT: During last 7 days rate client's ability to manage equipment (cleaning, adjusting or general care of adaptive/medical equipment such as wheelchairs, walkers, nebulizer, IV equipment etc.)

- 0 - INDEPENDENT: No help provided (With/without assistive devices)
- 1 - DONE WITH HELP: Cueing, supervision, reminders, and/or physical help provided
- 2 - DONE BY OTHERS: Full caregiver assistance
- 8 - Activity did not occur OR unknown

10.B. Indicate the highest level of care of equipment support provided in the last seven (7) days.

- 0 - No setup or physical help
- 1 - Supervision/cueing
- 2 - Setup help only
- 3 - Physical assistance
- 8 - Activity did not occur or unknown

Assessor's Signature:

Assessor's Title:

Date Completed

CHOICES FOR CARE (CFC) ADULT FAMILY CARE TIER SCORE SHEET

Name of Resident: _____ Case Manager: _____
 AA Provider: _____ Scored by: _____
 Date: _____ AFC Tier: _____

All information is to come from the person's assessed strengths and needs as recorded in the VT Choices For Care Adult Family Care Independent Living Assessment (CFC AFC ILA). All answers that are 0 (independent) or 8 (activity did not occurred) are no (zero) points so are not included below. Check one response that applies for each section, write the points on the line to the right, then total the points from each section at the bottom.

STEP 1: Elimination Status: Section 5D. Health Assessment, Page 17

Section 5D.3. Bladder Incontinence Frequency **D.3 Points** _____
 If B One to three times weekly 5 points
 If C Four to six times weekly 5 points
 If D One to three times daily 10 points
 If E Four or more times daily 20 points

Section 5D.6. Bowel Incontinence Frequency **D.6 Points** _____
 If B One to three times weekly 5 points
 If C Four to six times weekly 5 points
 If D One to three times daily 10 points
 If E Four or more times daily 20 points

STEP 2: Section 6.A. Functional Assessment: Activities of Daily Livings, (ADLs), Pages 18-20

Section 6A., 1.A. Dressing **1.A Points** _____
 If 1 Supervision 2.5 points
 If 2 Limited Assistance 5 points
 If 3 Extensive Assistance 10 points
 If 4 Total Assistance 15 points

Section 6A., 2. Bathing **2.A Points** _____
 If 1 Supervision 5 points
 If 2 Limited Assistance 10 points
 If 3 Extensive Assistance 15 points
 If 4 Total Assistance 23 points

Section 6A., 3.A. Personal Hygiene **3.A Points** _____
 If 1 Supervision 2.5 points
 If 2 Limited Assistance 5 points
 If 3 Extensive Assistance 7.5 points
 If 4 Total Assistance 10 points

Section 6A., 4.A. Mobility in Bed **4.A Points** _____
 If 1 Supervision 2.5 points
 If 2 Limited Assistance 2.5 points
 If 3 Extensive Assistance 5 points
 If 4 Total Assistance 10 points

Section 6A., 5.A. Toilet Use **5.A Points** _____
 If 1 Supervision 2.5 points
 If 2 Limited Assistance 5 points
 If 3 Extensive Assistance 10 points
 If 4 Total Assistance 20 points

Section 6A., 6.A. Adaptive Devices

- If 1 Supervision 2.5 points
- If 2 Limited Assistance 2.5 points
- If 3 Extensive Assistance 5 points
- If 4 Total Assistance 7.5 points

6.A Points _____

Section 6A., 7.A. Transfer

- If 1 Supervision 2.5 points
- If 2 Limited Assistance 5 points
- If 3 Extensive Assistance 7.5 points
- If 4 Total Assistance 12.5 points

7.A Points _____

Section 6A., 8.A. Mobility

- If 1 Supervision 2.5 points
- If 2 Limited Assistance 7.5 points
- If 3 Extensive Assistance 10 points
- If 4 Total Assistance 15 points

8.A Points _____

Section 6A., 9.A. Eating

- If 1 Supervision 2.5 points
- If 2 Limited Assistance 7.5 points
- If 3 Extensive Assistance 15 points
- If 4 Total Assistance 23 points

9.A Points _____

STEP 3: Section 6B Functional Assessment: Instrumental Activities of Daily Living (IADLs) Page 21

Section 6B., 2.A. Meal Preparation

- If 1 Done with Help 23 points
- If 2 Done by Others 30 points

2.A Points _____

Section 6B., 3.A. Medications Management

- If 1 Done with Help 2.5 points
- If 2 Done by Others 7.5 points

3.A Points _____

Add all points from Step1, Step 2 & Step 3.....

Total Score: Add 19 points to total from step 1, 2, &3

STEP 4: AFC Tier Determination: Look up the tier from the score ranges below.

AFC Tier.....

Tier	Score	Daily Rate
1	Less than 52	\$75
2	52 to 66	\$85
3	67 to 75	\$91
4	76 to 86	\$96
5	87 to 96	\$101
6	97 to 106	\$107
7	107 to 119	\$113
8	120 to 135	\$119
9	136 to 168	\$131
10	Greater than 168	\$152

Vermont Department of Disabilities, Aging and Independent Living
Choices for Care
Adult Family Care Home – Service Plan Authorization

Participant Name: _____ Soc. Sec. # _____
 (Please Print)

Address: _____ Initial Assessment Reassessment Change
 Requested Start Date: _____

Phone Number: _____ Date of Birth: _____

Diagnosis: _____ ICD9 Code: _____

Choices for Care Service	Agency Name	Volume	Billed Rate	Planned Costs
<input checked="" type="checkbox"/> Case Management (revenue code 070)		24 hrs/year	\$67.44 /hr	\$134.88 /mo
<input checked="" type="checkbox"/> Adult Family Care (revenue code 086)		*Tier #:	\$ /day	\$ /mo

*Tier table on back

Total Monthly Costs: \$ /mo

Total Annual Costs: \$ /yr

Other Services / Frequency	Payment Source	Other Services / Frequency	Payment Source
<input type="checkbox"/> Skilled Nursing:		<input type="checkbox"/> Other:	
<input type="checkbox"/> H.H. Aide (LNA):		<input type="checkbox"/> Other:	
<input type="checkbox"/> CRT		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

Department of Disabilities, Aging and Independent Living Authorization

Services are authorized effective:

Start Date: _____ through End Date: _____

(A full reassessment must be completed & authorized prior to the service plan expiration in order for Waiver services to continue and to avoid an interruption in Medicaid claims submissions.)

CONSENT TO PLAN OF CARE

I, _____, have been fully informed of the proposed **SERVICE PLAN** and understand the terms as described in this **Service Plan**. I consent to this plan and accept it as an alternative to the other Choices for Care setting options.

▶ _____ Date: _____
Signature of applicant/participant or legal representative

_____ Agency: _____ Phone #: _____
Authorized Agency AFC Coordinator (Print)

▶ _____ Date: _____
Authorized Agency AFC Coordinator Signature

_____ Phone #: _____
Home Provider Contact (Print)

▶ _____ Date: _____
Home Provider Contact Signature

_____ Agency: _____ Phone #: _____
Case Manager (Print)

▶ _____ Date: _____
Case Manager Signature

NOTE: All Plans must be signed by applicant/participant or legal representative (Power of Attorney or legal guardian), Authorized Agency and Choices for Care Case Manager in order for services to be authorized.

Important Information

Changes: The individual or legal representative must report all changes in status to the case manager and Authorized Agency (AA).

Patient Share: The Department for Children and Families (DCF) Notice of Decision includes your patient share amount (if any) that is to be paid to the Authorized Agency (AA) each month.

Provider Billing: Case Management and Authorized Agencies (AA) must retain a copy of the current approved Service Plan as authorization to bill for services. ***The AFC tier rate while admitted in a hospital is 94% of the approved daily tier rate.*** An in-hospital day is determined by where the participant is at midnight on the date of service.

Reassessments: Annual reassessments will start on the date after the previous service plan ends.

Service Plan Changes: Approved service plan changes will start no earlier than the date the service plan and supporting information is received at the DAIL regional office.

AFC Tier Rate Table

Tier	Tier Score	Daily Rate	94% Daily Rate (rate while in hospital)
1	Less than 52	\$75	\$70.50
2	52 to 66	\$85	\$79.90
3	67 to 75	\$91	\$85.54
4	76 to 86	\$96	\$90.24
5	87 to 96	\$101	\$94.94
6	97 to 106	\$107	\$100.58
7	107 to 119	\$113	\$106.22
8	120 to 135	\$119	\$111.86
9	136 to 168	\$131	\$123.14
10	Greater than 168	\$152	\$142.88

ATTACHMENT G



State of Vermont
Division of Disability and Aging Services
Housing Standards and Checklist

Form with fields: Date of Inspection, DESCRIPTION, INDIVIDUAL NAME, Name, Guardian(s), Physical/Mobility Impairments, Date of Occupancy, Services Coordinator, Responsible Agency, Home Provider, 911 Address, City, State, Zip Code, Telephone #.

* The following checklist applies to the main structure of the house, attached structures, or structures within 30 feet of the home.

SMOKE DETECTORS

Is there at least one operable smoke detector located on each level of the home, including the basement, in accordance with the manufacturer's instructions?

Yes No Complete (Initial)

Locations: 1) One photo electric smoke detector installed in a common area.

2) Consumer's bedroom.

3) _____

4) _____

5) _____

Response grid for smoke detectors with Yes, No, Complete columns.

In structures that are spread out horizontally or vertically, additional smoke detectors may be required. This home requires additional smoke detectors in the following areas:

Locations: 1) _____

2) _____

3) _____

4) _____

Response grid for additional smoke detectors.

FIRE EXTINGUISHERS

Is there a fire extinguisher in the kitchen that is:

A minimum gross weight of three pounds?

Charged?

Clearly visible and mounted between the kitchen stove and the exit path?

Response grid for kitchen fire extinguisher.

In a room with a wood burning furnace/stove is there a fire extinguisher that is:

A minimum gross weight of three pounds?

Charged as indicated by a readable gauge?

Clearly visible and mounted between the stove/furnace and the exit path?

Response grid for wood burning furnace fire extinguisher.

ATTACHMENT G

CARBON MONOXIDE DETECTORS

Is there at least one carbon monoxide detector that is installed in a common area such as a hallway or next to the sleeping area?

Yes No Complete
(Initial)

WOOD STOVES

All wood stoves (fireplaces 2nd, 4th, and 5th items) will meet manufacturer's installation requirements, to include:

Is the stove 36 inches from all combustibles (including sheet rock or plaster walls) or are heat shields properly applied to the combustible surface and/or the stove, which reduce the necessary clearance to 18 inches?

Is there a non-combustible hearth of at least 18 inches in front of a loading door?

Is the flue pipe 18 inches from combustibles or are heat shields properly applied to the combustible surface and/or the stove pipe, reducing the necessary clearance to 9 inches?

Has the chimney that serves the wood stove/furnace/fireplace been cleaned within the past 12 months?*

*(All chimneys that serve wood stoves/furnaces/fireplaces must be cleaned annually.)

Do all wood stoves/furnaces/fireplaces have their own designated flue?

Are the vent pipes the correct size and in good condition?

Notes: _____

WATER HEATERS

Does the water heater have a pressure release valve and a 3/4" discharge pipe from the valve to within 6 inches of the floor?

If applicable, is the water heater vented correctly?

HEATING SYSTEM

If an oil/kerosene system:

Is there a clearly marked emergency switch located at or before the entrance to the furnace/boiler room?

Is there a thermal switch located over the burner?

Is there an automatic fuel shut-off switch in close proximity to the burner? (within 10 feet)

If a gas system:

Is there a clearly marked emergency switch located within 5 feet of the burner in the furnace/boiler room?

If there is a boiler style heating system, does it have a pressure release valve?

Is there a 3/4 inch discharge pipe within 6 inches of the floor?

Is the heating system vented according to the appropriate building codes?

If electric heating units are used, is there at least 6 inches of clear space from all combustibles?

Is the system capable of heating all living space to at least 70 degrees Fahrenheit during all weather conditions?

Notes: _____

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ATTACHMENT G

	Yes	No	Complete (Initial)
<u>BEDROOMS/WINDOWS/SECOND EXITS</u>			
Bedroom #1 Location: b/1/2/3 - left/center/right - front/center/rear			
Is the bedroom a minimum of 8 feet in each direction, under a ceiling of at least 6 feet 6 inches?	_____	_____	_____
Does the bedroom have a solid surface door to prevent smoke from entering?	_____	_____	_____
Is there a door directly to outside from the bedroom or one operable window in good repair?	_____	_____	_____
Does the window have a minimum clear opening measuring 20 inches wide x 24 inches tall?	_____	_____	_____
Is the sill of the window <u>not</u> more than 44 inches from the floor?	_____	_____	_____
Bedroom #2 Location: b/1/2/3 - left/center/right - front/center/rear			
Is the bedroom a minimum of 8 feet in each direction under a ceiling of at least 6 feet 6 inches?	_____	_____	_____
Does the bedroom have a solid surface door to prevent smoke from entering?	_____	_____	_____
Is there a door directly to outside from the bedroom or one operable window in good repair?	_____	_____	_____
Does the window have a minimum clear opening measuring 20 inches wide x 24 inches tall?	_____	_____	_____
Is the sill of the window <u>not</u> more than 44 inches from the floor?	_____	_____	_____

NOTE: In new construction, the minimum opening must be 24 inches x 34 inches; **replacement** windows are considered to be new construction.

Notes: _____

GFCI PROTECTION

Does a GFCI outlet/circuit protect the following outlets or fixtures:

Outlets within 6 feet of the kitchen sink?	_____	_____	_____
All bathroom outlets?	_____	_____	_____
All exterior outlets?	_____	_____	_____
Outlets for washing machines, if indicated (or single device outlets)?	_____	_____	_____

GENERAL WIRING

Is the wiring system in good repair and meets the appropriate codes?	_____	_____	_____
Are all wiring connections made in electrical boxes and covered?	_____	_____	_____
Is the use of extension cords minimized?*	_____	_____	_____
*(Extension cords shall not be used to operate "permanent" appliances.)			
Is the home free of Halogen lamps?	_____	_____	_____

Notes: _____

ATTACHMENT G

	Yes	No	Complete (Initial)
<u>HAZARDOUS MATERIALS</u>			
If paints, fuels, or other combustibles are present in the home, are they stored in a separate room or as far away as possible from the furnace or any heat source?	_____	_____	_____
Is the home free of any hazardous/dangerous environmental materials?*	_____	_____	_____
*(If such materials are present, are they or will they be managed in way that is consistent with the Vermont Department of Health guidelines, i.e. asbestos.)	_____	_____	_____
<u>FIREARMS</u>			
Are all firearms securely locked in a gun safe, closet, or with trigger or cable locks, with the key(s) kept in a separate location? (Gun cabinets with glass (incl. Plexi) fronts are allowed if equipped with one of the additional locks described above in place.)	_____	_____	_____
<u>WATER SUPPLY/WASTE DISPOSAL</u>			
Is there a municipal water service, a drilled well, or a shallow well or spring that has been tested at least annually by the Vermont Department of Health or independent lab and verified that the water is potable?	_____	_____	_____
Does the home have municipal sewer service or correctly operating septic system?	_____	_____	_____
<u>DOORS/EXIT PATHS</u>			
Do all stairways have at least one handrail (or two, if indicated)?	_____	_____	_____
Do all decks and porches have railings at the appropriate height? (If less than 30 inches above grade, then 34-36 inches tall; if over 30 inches, then 42 inches tall.)	_____	_____	_____
Are exit doors or paths free from locking mechanisms keyed from the inside?	_____	_____	_____
Notes: _____			
<hr/>			
<u>LEAD (For those dwellings where children 6 and under are present)</u>			
Was the home built before 1978 and if so, are the painted surfaces of the home in good repair and without excessive peeling or cracking?	_____	_____	_____
Are window wells lined as described in the Vermont Department of Health Guidelines?	_____	_____	_____
<u>GARAGES/ADJACENT STRUCTURES (within 30 feet of home)</u>			
Is the wiring system in good repair and meets the appropriate codes?	_____	_____	_____
Are all wiring connections made in electrical boxes and covered?	_____	_____	_____
Is the use of extension cords minimized?*	_____	_____	_____
*(Extension cords shall not be used to operate "permanent" appliances.)			
If paints, fuels, or other combustibles are present in the home, are they stored in a separate room or as far away as possible from the furnace or any heat source?	_____	_____	_____
Are all heating units installed and vented correctly?	_____	_____	_____

ATTACHMENT G

Yes No Complete
(Initial)

ESCAPE PLAN

Does the home have a written workable plan and map that all occupants fully understand regarding what to do if a fire occurs? (This should include how everyone gets out of the residence, where to meet, and who will go to a phone to call the fire department, etc.)*

*Attach a copy of the fire escape plan to the final report submitted to the Division of Disability and Aging Services.

THE FIRE ESCAPE PLAN AS OUTLINED ABOVE SHOULD BE REVIEWED AND PRACTICED AT LEAST EVERY SIX (6) MONTHS.

THE HOME PROVIDER IS RESPONSIBLE FOR INSURING THAT ALL SMOKE AND CARBON MONOXIDE DETECTORS ARE IN WORKING ORDER.

PROCEDURES FOR COMPLIANCE

All items marked "no" will be corrected prior to occupancy, or by 30 days from the date of inspection, whichever is greater. The services coordinator or other agency representative is responsible for ensuring that all items are corrected and submitting a completed report to the Division of Disability and Aging Services no later than thirty (30) days from the date of the inspection. Home providers are required to maintain their home to the standards on this checklist.

Reviewer

Date

Agency Representative

Date

Home Provider/Designee

Date

Agency Use

I certify that all the items on the attached checklist have been completed as of the date listed below:

Date mailed to DDAS: _____

Services Coordinator/
Agency Representative: _____

DDAS Use

Date Received by DDAS: _____

Received by: _____

<p>Mail to: Department of Disabilities, Aging and Independent Living Division of Disability and Aging Services 103 South Main Street - Weeks Building Waterbury, VT 05671-1601</p>

- Original - Division of Disability & Aging Service
- Yellow Copy - Home Provider
- Pink Copy - Services Coordinator
- Gold Copy - Return to DDS upon compliance

ATTACHMENT H

State of Vermont
Department of Disabilities, Aging & Independent Living
Division of Disability & Aging Services
Accessibility Standards and Checklist



DATE OF INSPECTION: / /		Please Print Clearly and Firmly
Consumer Name		
Physical/Mobility Impairments		
Date of Occupancy		
Services Coordinator		
Responsible Agency		
Home Provider		
911 Address		
City, State, Zip Code		
Type of Housing/Comments		

ACCESSIBLE ROUTES – EXTERIOR

**YES NO COMPLETE
(initial)**

- 1. Is there at least 36 inches clear width? _____
- 2. Is it continuous and not interrupted by abrupt level changes or steps? _____
- 3. Is the slope less than 1:20? _____
- 4. Are all cracks or holes less than 1/2 inch? _____
- 5. Are there no protrusions of more than 4 inches between 27 and 80 inches of height (80 inches of headroom)? _____

RAMPS

- 1. Is there a ground level entrance or ramp with a slope no greater than 1:12? _____
- 2. Is there a width of 36 inches between handrails? _____
- 3. Are the landings 60 inches long on top, bottom, and in all changes of direction? _____
- 4. Are all handrails between 34 and 38 inches high on both sides? _____
- 5. Is the diameter of the handrails 1 1/4 to 2 inches, with a minimum clear space from adjacent surface of 1 1/2 inches? _____
- 6. Does the handrail extend 12 inches beyond top and bottom? _____

DOORS

	YES	NO	COMPLETE (initial)
1. Do all doors have a clear width of at least 32 inches?	_____	_____	_____
2. Do all doors have hardware that is easy to operate without twisting or grasping?	_____	_____	_____
3. Is there 60 inches of clearance on the pull side of the door and 48 inches of clearance on the push side?	_____	_____	_____
4. Is the threshold less than 1½ inch high or ramped 1:12 if higher?	_____	_____	_____
5. Is the door pull less than 5 pounds of force?	_____	_____	_____

ACCESSIBLE ROUTES – INTERIOR

1. Are all routes least 36 inches wide?	_____	_____	_____
2. Are level changes are less than ¼ inch unless beveled or ramped?	_____	_____	_____
3. Are there no protrusions of more than 4 inches between 27 and 80 inches of height (80 inches of headroom)?	_____	_____	_____
4. Is there 80 inches of headroom?	_____	_____	_____
5. Is there at least one accessible route to all accessible space?	_____	_____	_____

BATHROOMS

A. Doors and Clearance

1. Is the clear width at least 32 inches?	_____	_____	_____
2. Is the door hardware easy to operate with one hand, without twisting or grasping?	_____	_____	_____
3. Is there sufficient space for a person using a wheelchair to enter, close the door, use the fixtures, reopen the door and exit?	_____	_____	_____

B. Toilets (see figure B4.33.3.2)

1. Is there a clear space in front of the toilet 48 inches deep? (Measured from the front of the toilet)	_____	_____	_____
2. Is the space adjacent to the toilet 48 inches wide?	_____	_____	_____
3. Is the center of the toilet at least 18 inches from the wall?	_____	_____	_____
4. Is the center of the toilet at least 18 inches from any fixture or obstruction?	_____	_____	_____
5. Are grab bars installed on the adjacent wall in back the toilet that are at a height of 33 – 36 inches above the floor?	_____	_____	_____
6. Is the top of the toilet seat at least 15 inches above the floor?	_____	_____	_____
7. Is the toilet paper dispenser installed 19 inches above the floor and within easy reach?	_____	_____	_____

BATHROOMS (continued)

YES NO COMPLETE
(initial)

C. Lavatories

- 1. Is there at least 29 inches clearance from floor to bottom of apron? _____
- 2. Is there a clear floor space of 30 inches by 48 inches at the front? _____
- 3. Do the faucets operate with one hand without twisting or grasping and with no more than 5 lbs. of force? _____
- 4. Are exposed pipes or sharp surfaces insulated and/or covered? _____
- 5. When a medicine cabinet is provided, is one usable shelf no higher than 44 inches above the floor? _____
- 6. Is the mirror mounted with bottom edge 40 inches or less above the floor? _____

D. Bathtubs

- 1. Is there a clear floor area at least 30 inches deep and 60 inches wide?
Example: Figure B 4. 21. 20 (left)
(or) Is there a clear floor area of at least 48 inches deep and 60 inches wide?
Example: Figure B 4. 21. 2a (right) _____
- 2. Is there an in-tub seat or seat at head of tub? _____
- 3. Are grab bars installed horizontally 33 inches to 36 inches above the floor on the long wall and the wall at the foot of the tub?
(or) Is there structural reinforcement that will allow for the installation of grab bars? _____
- 4. Are faucets and controls located as noted in Figures B4. 21. 4? _____
- 5. Is the bathtub rim free from door tracks? _____

E. Shower

- 1. Is the shower at least 36 inches by 36 inches?
(or) Is the shower 30 inches by 60 inches? _____
- 2. Is there a seat provided opposite the controls that is 17 to 19 inches high and extends the depth of the shower? _____
- 3. Are grab bars installed 33 inches to 36 inches above floor?
(or)
Is there structural reinforcement as shown in Figures B4. 22. 4 that will allow for the installation of grab bars? _____
- 4. Are faucet and controls easy to use and are they located as noted in Figures B4. 22. 4? _____
- 5. Is the shower spray hose at least 60 inches long? _____

PROCEDURE FOR COMPLIANCE:

All items marked **no** will be addressed in the accessibility rehabilitation plan to be submitted within 30 days of the accessibility review.

The Rehabilitation plan may be submitted by a Licensed Physical Therapist or Occupational Therapist.

The Service Coordinator is responsible for ensuring that all the items to be addressed will be completed within 90 days of the initial review.

After the modifications are complete a follow up needs to be rescheduled with the reviewer or the Physical or Occupational therapist may complete the certification below.

Reviewer _____ Date _____

Agency Representative _____ Date _____

Home Provider/Designee _____ Date _____

I certify that all the applicable items on the checklist have been completed.

Reviewer _____ Date _____

 Mail to: Department of Disabilities, Aging & Independent Living
Division of Disability & Aging Services
103 South Main Street, Weeks Bldg
Waterbury, VT 05671-1601

- Original: Division of Disability and Aging Services
- Yellow Copy: Agency Director
- Pink Copy: Services Coordinator
- Gold Copy: Return to the Division of Disability & Aging Services upon compliance



AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

DIVISION OF DISABILITIES AND AGING SERVICES

103 SO. MAIN STREET – WEEKS BUILDING

WATERBURY, VT 05671-1601

802.871-3069 FAX 802.871.3052

To: Adult Family Care Authorized Agencies
Choices for Care Case Management Agencies

From: Megan Tierney-Ward, Aging & Disabilities Program Manager

Date: September 1, 2013

Re: Room & Board Memo Revision – Addition of Adult Family Care

Effective September 1, 2013, the Choices for Care program is adding a new service option called Adult Family Care. This memo is to add Adult Family Care to the Room & Board policy.

Providers must ensure that individuals served through a DAIL administered 24-hr home and community-based care option are charged a room & board rate that assures the individual retains a minimum personal spending amount listed below. *Please note that providers may choose to charge a person less for room and board payment so the resident may retain a greater personal needs spending allowance.*

Providers must also give residents proper notice of any change in room & board charges, according to applicable licensing regulations and program standards.

The charts on the next page reflect the room and board payment and personal spending allowance by category of service.

If you have any questions about Adult Family Care, please contact Rio Demers at (802) 871-3364 or rio.demers@state.vt.us.

SSI Increase 2013 – Room & Board

Developmental Services

Description	Total SSI 2013	Room & Board	Minimum Personal Spending
Unlicensed Residential Care Home (also called <i>Board and Care Home</i> or <i>Developmental Home</i> or <i>Shared Living</i>)	808.69	693.69	115.00
Licensed Residential Care Home <i>Level III without ACCS</i>	977.13	862.13	115.00
Licensed Residential Care Home <i>Level IV/TCR</i>	933.94	818.94	115.00
Independent Living	762.04	N/A	N/A

Section 6.2 of the Developmental Services Regulations specifies that the above designation shall be full and complete payment for room and board for people receiving residential services funded through the home and community-based waiver. The same section governs individuals with private means to pay room and board.

TBI Services

Description	Total SSI 2013	Room & Board	Minimum Personal Spending
Unlicensed Residential Care Home (also called <i>Board and Care Home</i> or <i>Developmental Home</i> or <i>Shared Living</i>)	808.69	713.69	95.00
Licensed Residential Care Home <i>Level III without ACCS</i>	977.13	882.13	95.00
Licensed Residential Care Home <i>Level IV/TCR</i>	933.94	838.94	95.00
Independent Living	762.04	N/A	N/A

Choices for Care – Adult Family Care

Description	Total SSI 2013	Room & Board	Minimum Personal Spending
Adult Family Care Home	808.69	693.69	115.00

Assistive Community Care Services (which includes CFC Enhanced Residential Care)

Description	Total SSI 2013	*Room & Board	Minimum Personal Spending
Licensed Level III Residential Care Home and Assisted Living Residences with ACCS <i>*Residents living in a private room with income above SSI may be charged room & board up to 85% of their net income after Medicaid standard deductions and medical deductions.</i>	758.38	*698.38	60.00

Medicaid Protected Income Limit (PIL)

	2012	2013
<i>Outside</i> of Chittenden County	\$958	\$975
<i>Inside</i> of Chittenden County	\$1033	\$1058

Choices for Care - Adult Family Care Live-In Agreement Guidelines (August 2013)

It is the policy of the Department of Disabilities, Aging and Independent Living (DAIL) to support people to reside in the setting of their choice. One housing option is Adult Family Care (AFC). AFC is an arrangement in which a person resides in an unlicensed private home (Owned or rented by the provider) that includes room, board, and care provided to no more than two people unrelated to the AFC Home provider. (*Refer to Choices for Care Manual for details.*)

All AFC home arrangements must have a written Live-in Agreement with the person who is participating in the Vermont Choices for Care (CFC) program. The following outlines the content of the agreement and relevant standards that must be followed as it pertains to this agreement.

I. Agreements must include the following:

1. The name of the AFC Home Provider,
2. The name of the participant,
3. The address of the home,
4. The date that the living arrangement will begin and end,
5. The monthly payment for room & board (see II. below).
6. A description of the household arrangements to include private or shared living spaces,
7. Additional charges not covered under CFC,
8. Termination conditions (see III. below),
9. List of other conditions of the agreement, including house rules and conditions of the living arrangement (such as visitors, pets and use of phone)
10. Adult Family Care Participants' Rights
11. Date and signature of the participant (or legal representative when applicable), and
12. Date and signature of the AFC Home provider.

The Department of Disabilities, Aging and Independent Living (DAIL) has attached a model of this agreement for your convenience. A copy of the completed agreement, including signatures of all required parties, must be kept on file with the Authorized Agency. The agreement must be completed upon move-in, reviewed annually with the participant/legal representative and revised as conditions of the agreement change.

II. Room & Board:

Room & board includes the cost of shelter, food, and basic utilities (electricity, heat, water, sewer, trash/snow removal, and access to basic telephone services). The Department determines the maximum amount of room & board that can be charged to a participant, which is based on the current Supplemental Security Income (SSI) limit minus a required personal spending amount. DAIL notifies applicable providers each year when these amounts change.

As of 2013, the participants must maintain a minimum of \$115 per month in personal spending money and the maximum room & board is 693.69/month. AFC Home providers may choose to charge a person less for room & board payment so that the participant retains a greater personal needs spending allowance. ***Please refer to the most current DAIL Room & Board Standards memo for current Room & Board and minimum personal spending amounts.***

AFC Homes must give participants at least 30-days written notice of any change in room & board charges.

III. Termination of Agreement:

The AFC Home and the participant or legal representative must both agree to a 30-day advance notice of termination of the room & board agreement. The AFC Home may initiate the termination only under the following circumstances:

1. The individual presents a serious threat to self that cannot be resolved through care planning and the individual is incapable of engaging in a negotiated risk agreement;
2. The individual presents a serious threat to other participants of the home or staff that cannot be managed through interventions, care planning or negotiated risk agreements;
3. A court has ordered the move;
4. The individual failed to pay room & board, service or care charges in accordance with the Live-In Agreement;
5. The individual refuses to abide by the terms of the Live-In Agreement; or
6. If the AFC home can no longer meet the participant's needs as identified in the written person centered care plan and according to the contract with the Authorized Agency.

An emergency termination of the room & board agreement may be made with less than 30-day notice under the following circumstances:

1. The participant's attending physician, Authorized Agency and case manager documents in the participant's record that an immediate move is an emergency measure necessary for the health and safety of the individual or other participants; or
2. A natural disaster or emergency necessitates the evacuation of participants from the home; or
3. When ordered or permitted by a court.

Adult Family Care Live-In Agreement *(Optional Template)*

This is an agreement between _____
(AFC Home provider name), and _____ (participant's name),
to enter into a living arrangement where room, board, and long-term services and supports
will be provided at (address of residence) _____
_____.

This living arrangement will begin (or began) on (date) _____ and end on (date)
_____.

Room & Board:

Participant (or legal representative) agrees to pay the AFC Home provider \$ _____ each
month by the _____ of each month, for housing, food, and basic utilities. (Amount shall be
no more than the State allows for room & board.) The participant will maintain
\$ _____ each month for personal spending (must be at least \$115/month).

Household Arrangements: (check all that apply)

Bedroom: () private () shared
Bathroom: () private () shared
Kitchen: () private () shared
Living Room: () private () shared
Other Space: (Describe): _____

Change in Room & Board Amount:

The AFC Home provider shall give the participant at least 30-days advance notice of a
change in the room & board amount. A new Live-In Agreement shall be done to reflect any
changes in the agreement.

Participant Rights and Privileges:

A copy of the Adult Family Care Participants' Rights are attached to this agreement, have
been reviewed with the participant/legal representative and will be reviewed annually with this
Live-In Agreement.

Services:

The AFC Home agrees to maintain a contract with the Authorized Agency and follow all
requirements agreed upon for the provision of services as outlined in the participant's person
centered care plan.

Termination of this Agreement:

The AFC Home and the participant/legal representative both agree to a 30-day advance
notice of termination of the Live-In Agreement, unless mutually agreed upon by both
parties. The AFC home may initiate the termination of the agreement under the
following circumstances:

1. The participant presents a serious threat to self that cannot be resolved through person centered care planning and the participant is incapable of engaging in a negotiated risk agreement;
2. The participant presents a serious threat to other residents of the home or staff that cannot be managed through interventions, person centered care planning or negotiated risk agreements;
3. A court has ordered the move;
4. The participant/legal representative failed to pay room & board in accordance with the room & board agreement;
5. The participant/legal representative refuses to abide by the terms of the admission agreement; or
6. If the AFC Home provider can no longer meet the participant's needs as identified in the person centered care plan and according to the contract with the Authorized Agency.

An emergency termination of the Live-In Agreement may be made with less than 30-day notice under the following circumstances:

1. An emergency move from the AFC Home is necessary for the health and safety of the participant or other residents and the participant's attending physician, Authorized Agency and Case Manager have documented the specific circumstances;
2. A natural disaster or emergency necessitates the evacuation of individuals from the home; or
3. When ordered or permitted by a court.

Other Conditions of this Agreement: *(attach additional pages is necessary)*

Signatures:

We agree to the conditions of this agreement *(Initial all additional pages):*

Participant (or legal representative) signature Date

AFC Home Provider signature Date

Adult Family Care Participants' Rights

1. Every participant shall be treated with consideration, respect and full recognition of the participant's dignity, individuality, and privacy. A home may not ask a participant to waive the participants rights.
2. Each home shall establish and adhere to a written policy, consistent with the Choices for Care (CFC) Adult Family Care (AFC) policy and procedure manual, regarding the rights and responsibilities of participants, which shall be explained to the participant prior to or at the time of moving in with a home provider.
3. Participants may retain personal clothing and possessions as space permits, unless to do so would infringe on the rights of others or would create a fire or safety hazard.
4. A participant shall not be required to perform work for the Home Provider. If a participant chooses to perform specific tasks for the Home Provider the participant shall receive reasonable compensation which shall be specified in a written agreement with the participant.
5. Each participant shall be allowed to associate, communicate and meet privately with persons of the participants own choice. Participants may have visitors during times indicated in the live in agreement. Participants may accept or refuse their visitors.
6. Each participant may send and receive personal mail unopened.
7. Participants have the right to reasonable access to a telephone for private conversations. Participants shall have reasonable access to the home's telephone. Any restrictions of telephone use shall be in writing. Any participant may, at the participant's own expense, maintain a personal telephone in his or her own room. Toll charges will be addressed in the live in agreement.
8. A participant may voice a complaint without interference, coercion or reprisal. Each home shall provide a written complaint procedure to give to the participant for resolving concerns or complaints at the time of moving in with the home provider. The complaint procedure shall follow CFC Manual Section V.13. A participant filing a complaint will be made aware of the Office of the Long Term Care Ombudsman and the designated Vermont Protection and Advocacy Organization as an alternative.
9. Participants may manage their own personal finances. The home provider shall not manage a participant's finances unless requested in writing by the participant, legal representative or guardian and then in accordance with the participant's wishes. The home provider shall keep a record of all transactions and make the record available, upon request, to the participant or legal representative, and shall provide the participant with an accounting of all transactions at least quarterly. Participant funds must be kept separate from other accounts or funds of the home.
10. The participant's right to privacy extends to all records and personal information. Personal information about a participant shall not be discussed with anyone not directly involved in the participant's care. Release of any record, excerpts from or information contained in such records shall be subject to the participant's written approval, except as requested by representatives of the Authorized Agency or DAILE to carry out its responsibilities or as otherwise provided by law.
11. The participant has the right to review the participant's medical or financial records upon request.
12. Participants shall be free from mental, verbal or physical abuse, neglect, and exploitation.

13. Participants subject to voluntary move from the home shall:
 - a. Be allowed to participate in the decision-making process of the home concerning the selection of an alternative placement;
 - b. Provide at least a thirty (30) day notice of a pending move to the home provider
14. Participants subject to involuntary move from the home shall:
 - a. Receive a thirty (30) day notice of a pending move if it is determined that the home provider is no longer able to meet the participants care needs;
 - b. Be allowed to participate in the decision-making process of the Authorized Agency concerning the selection of a new home provider or other placement;
 - c. Receive a pending move notice on or after thirty-one (31) consecutive days of hospitalization; and
15. Participants have the right to refuse care to the extent allowed by law. This includes the right to move from the home. The home must fully inform the participant of the consequences of refusing care, which may include a negotiated risk contract. If the participant makes a fully informed decision to refuse care, the home must respect that decision and is absolved of further responsibility. If the refusal of care will result in a participant's needs increasing beyond what the home is able to provide, or will result in the home being in violation of AFC requirements, the home may issue the participant a thirty (30) day notice of move.
16. Participants have the right to return to the home after a hospital stay, provided the home is able to meet the participants care needs and provided, the participants welfare, or that of other participants will not be adversely affected.
17. Participants have the right to formulate advance directives as provided by state law and to have the home follow the participants' wishes.
18. Participants have the right to choose their own doctor and other health care professionals.
19. Participants have the right to be informed about eligibility for hospice services and the circumstances under which hospice services may be available to the participant.
20. Participants have the right to be away from the home for voluntary leaves, unless a legally appointed guardian directs the home otherwise. Participants have the right to make decisions about such voluntary leaves without influence from the home.
21. These participants' rights shall not limit, modify, abridge or reduce in any way any rights that a participant otherwise enjoys as a human being and citizen.

SECTION V.14. Critical Incident Reporting

Critical Incident (hereafter referred to as incident) reports are essential methods of documenting, evaluating and monitoring certain **serious or severe** occurrences, and ensuring that the necessary people receive the information. These guidelines describe the information that the ASD need to carry out their monitoring and oversight responsibilities. Content reflects standard definitions, applicable populations for required reporting, timelines, and methods for reporting incidents.

A. Definition

Critical Incident is a serious or severe situation in which:

- Any actual or alleged event, incident or course of action involving the perceived or actual threat to a participant's health and welfare; or
- Any actual or alleged event, incident or course of action involving the perceived or actual threat to his/her ability to remain in the community.

B. Choices for Care (CFC) Services Subject to Critical Incident Reporting

As of August 2013, participants utilizing the following CFC services are subject to the Adult Services Division (ASD) Critical Incident process outlined in this section:

- Adult Family Care Home, and
- Money Follows the Person in all CFC settings.

C. Types of incidents that must be reported to Adult Services Division (ASD)

The types of situations that must be reported to ASD include but are not limited to the following incident types.

1. Alleged abuse/neglect & exploitation

All actual or suspected abuse, neglect or exploitation of or by a person enrolled in services as required by 33 V.S.A. Chapter 69. *NOTE: Providers will be reporting to both ASD and APS.*

2. Criminal Act

Any serious illegal act, alleged or suspected, must be reported, including any act that warrants incarceration of a person enrolled in services. Any circumstance indicating a duty to warn must be reported. If it would violate professional ethics or federal law to make such a report, one is not required.

3. Destruction of Property

Including but not limited to fire, flood, breakdown or cessation to the home's physical plant's major services (plumbing, heat, water supply, etc.) or supplied service, which disrupts the normal course of operation.

4. Medication Error

A medical error is a preventable adverse effect of care, whether or not it is evident or harmful to the person. This includes but is not limited to; administration of the wrong drug to the wrong person or in the wrong way or at the wrong time or wrong dose or wrong frequency or a missed dose. A participant's refusal to take a medication is not considered an error and should be documented in the person's record.

5. Medical Emergency

A serious, life threatening, medical event or injury, for a person served, that requires immediate emergency evaluation by medical professionals.

6. Missing Person

A person enrolled in services who is identified as missing by law enforcement, the media, staff, family, caregivers, or other natural supports (unexplained absence). A person served is considered "missing" if the person's housemate or support staff cannot locate him or her and there is reason to think that the person may be lost or in danger. A report is not required for people who live with unpaid caregivers or housemates (such as natural family), unless the caregiver or family requests assistance in locating the person or the person has been identified as missing by law enforcement.

7. Potential Media Involvement

Any incident, marked by seriousness or severity, that is likely to result in attracting negative public attention, or lead to claims or legal action against the State.

8. Seclusion or Restraint

Any seclusion or restraint "**Restraint**" includes:

- **Mechanical restraint:** any items worn by or placed on the person to limit behavior or movement and which cannot be removed by the person. Mechanical restraints include devices such as mittens, straps, arm splints, harnesses, restraint chairs, bed rails and bed netting.
- **Physical restraint:** any method of restricting a person's movements by holding of body parts to keep the person from endangering self or others (including seclusion or physical escort to lead the person to a place he or she does not want to go).**Chemical restraint:** the administration of a prescribed or over-the-counter medicine when all the following conditions exist: the primary purpose of the medication is a response to problematic behavior rather than a physical health condition; and, the prescribed medicine is a drug or dosage which would not otherwise be administered to the person as part of a regular medication regimen; and, the prescribed medicine impairs the individual's ability to do or accomplish his or her activities of daily living (as compared to the individual's usual performance when the medicine is not administered) by causing disorientation, confusion, or an impairment of physical or mental functioning.

Restraints that occur fewer than 8 hours apart may be reported in a single report.

Restraints that occur more than 8 hours apart must be reported in separate reports.

Guardians must be notified verbally immediately of any restraint, unless the restraint is done according to a written support plan that the guardian has approved and the guardian has stated that he/she does not wish to receive immediate notification of restraints.

9. **Suicide attempt (or lethal gesture)** Death would likely result from the suicide attempt or gesture and the person requires medical attention.
10. **Untimely or Suspicious death**

D Agency/Provider Reporting Procedures & Timeframe

The following process is required for all participants enrolled in the CFC Adult Family Care option, and CFC participants enrolled in Money Follows the Person in all settings.

1. Any CFC service provider that becomes aware of a critical incident listed above is required to complete a critical incident report (CFC 850) and submit it to ASD, as soon as possible, and no later than **48 hours of discovery of the incident**.
2. Reports shall be:
 - a. faxed to ASD at (802) 871-3052 or
 - b. scanned and emailed to the ASD Critical Incident email address AHS.DAILASDCIR@state.vt.us, or
 - c. submitted online (to be developed).
3. If the reporter cannot access a fax machine or email within 48 hours, they must call (802)-871-3035 as soon as possible (ASAP) **within 48 hours** of discovery of the incident. ASD staff will document the incident while speaking with the Reporter. If ASD is not available to answer the CIR call, (after regular business hours or on the weekend) the reporter shall leave a voicemail message including at least their name and contact information and the person(s) involved in the incident. The reporter must submit a written report as soon as possible after the phone call.
4. Adult Protective Services: Pursuant to Vermont statute 33 V.S.A. Chapter 69, all Choices for Care service providers are mandated to report suspicion of adult abuse, neglect and exploitation to the Division of Licensing and Protection (DLP), Adult Protective Services (APS) <http://www.dlp.vermont.gov/protection>. Mandated reporters are required to submit a critical incident report to the Adult Services Division AND report **within 48 hours to APS** by calling 1-800-564-1612 or out-of-state call (802) 871-3326 or online at <http://www.dlp.vermont.gov/guidelines/report>.
5. For participants of the Adult Family Care option, the reporter of the incident shall also notify the participant's Authorized Agency **within 24 hours** of discovery of the incident.

6. For Adult Family Care option, the Authorized Agency shall notify the guardian, (private or public), case manager and home provider of any incident **within 24 hours** of discovery of the incident.
7. For non-Adult Family Care MFP participants, the reporter (if not the case manager) must notify the CFC case manager **within 24 hours** of discovery of the incident.
8. For non-Adult Family Care MFP participants, the case manager shall notify the legal guardian (private or public) and other appropriate service providers **within 24 hours** of discovery of the incident.
9. Licensed Providers: CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection <http://www.dlp.vermont.gov/regs>.
10. Internal Incident Reports: If the reporter works for an agency that has its own internal reporting requirement they must complete their internal process in addition to the ASD & APS reports.

E. DAIL/ASD Procedures & Timeframes:

1. When ASD receives an incident report during regular business hours, an ASD quality specialist will review the incident to determine if any action, remediation or improvement plan is needed and record the incident. ASD's follow-up response to each incident is based on multiple factors including but not limited to the individual's needs, the incident, actions taken and resolution to the incident.
2. When ASD quality specialist receives an incident report over the phone they will ask for all the information on Critical Incident Form (CFC 850).

ASD quality specialist will review the incident information to determine:

- If the incident meets the CIR definition
- If the incident has been resolved
- If the incident includes suspected abuse, neglect or exploitation
- If the incident includes suspected Medicaid fraud or abuse
- If appropriate actions were taken
- If additional information is required
- If investigation and remediation is required
- If the report was made in the required timeframe
- If there are any additional concerns triggered by the incident (trends)

3. ASD quality specialist will contact agencies, providers, family or appropriate authorities or emergency services for any incidents in which the CFC participant is still missing or in need of immediate assistance.
4. ASD quality specialist will submit a report to APS for all incidents that include suspected abuse, neglect or exploitation **within 48 hours**.
5. ASD quality specialist will report all incidents that include suspected Medicaid fraud or abuse to Department of Vermont Health Access (DVHA) Program Integrity (PI) Unit (802.879.5900) **within 72 hours** of discovery of the incident report.
6. ASD quality specialist will contact appropriate individuals or agencies for additional information as necessary. ASD quality specialist may request an internal investigation report from the provider. ASD quality specialist may conduct an investigation incorporating the following information:
 - a. circumstances leading up to and culminating in the critical incident;
 - b. any current practice, procedure or factor involved in providing the service that contributed to the occurrence of the critical incident;
 - c. actions considered, developed or required as follow up to the critical incident
7. ASD Quality Specialist will review critical incident data to identify any repeat patterns, trends or concerns within **2 business days** of receipt of a report.
 - a. If there is a concern, the ASD Quality Specialist will follow up with the ASD Quality Improvement (QI) committee within **2 business days**.
 - b. The QI committee will review the information and determine if any actions are necessary within **2 business days** of receipt of the information.
 - c. If deemed necessary by the ASD QI committee a Critical Incident Improvement Plan may be requested from the provider which may include:
 - i. Actions to be taken to prevent reoccurrences or improve response in the event of similar incidents;
 - ii. A date by which the actions will be taken;
 - iii. The AA or provider agency staff responsible for taking the actions.
 - iv. The ASD Quality Specialist will work in collaboration with the involved entities to ensure completion of a Critical Incident Improvement Plan.
8. ASD Quality Improvement Committee will conduct oversight of staff and providers to ensure critical incident reporting policies are being followed. Corrective action will be taken as needed to ensure these entities comply with critical incident reporting requirements.





Adult Services Division Critical Incident Reporting Form

Reporting Criteria

The purpose of Critical Incident reporting is to document, evaluate and monitor certain **serious or severe** occurrences that affect the wellbeing of program participants. Choices for Care Participants utilizing the Adult Family Care Home and Money Follows the Person Program in all settings, are subject to the Adult Services Division Critical Incident process outlined in the Choices for Care Manual in Section V.14

<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-highest-needs-section-v-14-critical-incident-reporting>

Definition

A Critical Incident is a serious or severe situation in which:

- Any actual or alleged event, incident or course of action involving the perceived or actual threat to a participant's health and welfare; or
- Any actual or alleged event, incident or course of action involving the perceived or actual threat to his/her ability to remain in the community.

Instructions:

Reports to ASD should be made within 48 hours of discovery of the incident via:

- a. faxed to ASD at (802) 871-3052 or
- b. scanned and emailed to the ASD Critical Incident email AHS.DAILASDCIR@state.vt.us
- c. Phone (802) 871-3035, when access to email or fax is not possible
- d. Pursuant to Vermont statute 33 V.S.A. Chapter 69, all Choices for Care service providers are mandated to report suspicion of adult abuse, neglect and exploitation to the Division of Licensing and Protection (DLP), Adult Protective Services (APS)
<http://www.dlp.vermont.gov/protection>. Mandated reporters are required to submit a critical incident report to the Adult Services Division AND report within 48 hours to APS by calling 1-800-564-1612 or out-of-state call (802) 871-3326 or online at <http://www.dlp.vermont.gov/guidelines/report>.
- e. CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection <http://www.dlp.vermont.gov/regs>.
- f. For participants of the Adult Family Care option, the reporter of the incident shall also notify the participant's Authorized Agency within 24 hours of discovery of the incident.
- g. For Adult Family Care option, the Authorized Agency shall notify the guardian, (private or public), case manager and home provider of any incident within 24 hours of discovery of the
- h. For non-Adult Family Care MFP participants, the reporter (if not the case manager) must notify the CFC case manager within 24 hours of discovery of the incident.
- i. For non-Adult Family Care MFP participants, the case manager shall notify the legal guardian (private or public) and other appropriate service providers within 24 hours of discovery of the incident.



Adult Services Division Critical Incident Reporting Form

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<http://www.ddas.vermont.gov/ddas-policies/policies-cfc/policies-cfc-highest/policies-cfc-highest-documents/cfc-highest-needs-section-v-14-critical-incident-reporting>

Definition

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- e. CFC providers that are licensed under the Vermont Home Health Agency Designation and Operation Regulations, Residential Care Home Licensing Regulations, Assisted Living Residence Licensing Regulations, and the Nursing Home Licensing and Operating Rule must also follow the applicable incident reporting criteria found in state regulation with the Division of Licensing and Protection <http://www.dlp.vermont.gov/regs>.
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- h. For non-Adult Family Care MFP participants, the reporter (if not the case manager) must notify the CFC case manager within 24 hours of discovery of the incident.
- i. For non-Adult Family Care MFP participants, the case manager shall notify the legal guardian (private or public) and other appropriate service providers within 24 hours of discovery of the incident.



Adult Services Division Critical Incident Reporting Form

Fax Completed Form to 802-871-3052 or Email to AHS.dailasdcir@state.vt.us

Participant's Information

First Name:

Last Name:

Guardian:

Guardian Phone:

Choices for Care Program: Adult Family Care
 (Check all that apply) Money Follows the Person

Reporter Information

Name:

Agency:

Email:

Phone:

Incident Information

Date of Incident:

Time of Incident:

Date Incident Discovered:

Date Incident Reported to ASD:

Law Enforcement Involved: Yes No

Persons Present or Involved:

Incident Location:

Type of Incident (Identify Primary Type of Incident - Check One)

Criminal Act: <input type="checkbox"/>	Potential Media Involvement: <input type="checkbox"/>
Missing Person: <input type="checkbox"/>	Seclusion or Restraint: <input type="checkbox"/>
Medication Error: <input type="checkbox"/>	Destruction of Property: <input type="checkbox"/>
Medical Emergency: <input type="checkbox"/>	Untimely or Suspicious death: <input type="checkbox"/>
Suicide Attempt: <input type="checkbox"/>	Other: <input type="checkbox"/>
*Alleged Abuse Neglect or Exploitation: <input type="checkbox"/>	

****Must Report to APS within 48 Hours****



Adult Services Division
Critical Incident Reporting Form

Fax Completed Form to 802-871-3052 or Email to AHS.dailasdcir@state.vt.us

Describe the Incident

Actions Taken (Check all that apply)

Reassessment:	<input type="checkbox"/>	Emergency Services Utilized:	<input type="checkbox"/>
Care Plan Reviewed:	<input type="checkbox"/>	Medical Treatment Required:	<input type="checkbox"/>
Care Plan Revised:	<input type="checkbox"/>	PT/OT Referral:	<input type="checkbox"/>
Backup Plan Revised:	<input type="checkbox"/>	Increased Case Management:	<input type="checkbox"/>
Increased Visits:	<input type="checkbox"/>	Skilled Nursing Ordered:	<input type="checkbox"/>
Increased CM Hours:	<input type="checkbox"/>	Physician Follow -up:	<input type="checkbox"/>
No Action Taken:	<input type="checkbox"/>	Negotiated Risk Contract:	<input type="checkbox"/>
Hospital Admission:	<input type="checkbox"/>	Nursing Home Admission:	<input type="checkbox"/>
Admit Date:	<input type="checkbox"/>	Admit Date:	<input type="checkbox"/>
Discharge Date:	<input type="checkbox"/>	Discharge Date:	<input type="checkbox"/>
Other:	<input type="text"/>		

Notifications (Enter Date)

Guardian:	<input type="checkbox"/>	Adult Protective Services:	<input type="checkbox"/>
Case Manager:	<input type="checkbox"/>	Authorized Agency:	<input type="checkbox"/>
Other:	<input type="text"/>		

Incident Review

Was the Incident Preventable? Yes No

What actions could you, or others do, to prevent future incidents?



SECTION V.15. Adult Family Care Disclosure of Information (DoI) Policy & Procedure

The Disclosure of Information (DoI) process applies to the Adult Family Care (AFC) option and is intended to assure that AFC Home Providers (Home Provider) and AFC respite workers receive relevant information so they can make an informed decision whether to agree to provide care in their own home to a Choices for Care AFC participant. The DoI form shall include relevant information about a person's current status and history of violent behaviors, any potential predictors of violent behavior and all medications they are taking. The information may only be disclosed with the participant or guardian's authorization.

1. The AA shall explain the purpose of the Disclosure of Information (DoI) notice to the participant and/or legal guardian.
2. In order to provide consent and sign a DoI form, the participant and/or guardian must be informed of all relevant facts and be deemed to possess sufficient mental capacity to understand and appreciate the nature and effect of the disclosure at the time of signing the form. If the participant does not have capacity to consent, participant's legal representative may provide consent on participant's behalf.
3. The AA shall complete the DoI form which must contain relevant information concerning the participant's history of violent behaviors and any potential predictors of violent behaviors.
4. If the participant or guardian declines to consent to the disclosure of any and all information deemed relevant or important, the DoI form shall reflect that the participant/guardian declined to consent to the disclosure.
5. After the participant or guardian consents or decline consent, the AA shall release the DoI information to the potential home provider and respite worker.
6. The Home Provider and respite worker shall include the information on the DoI or refusal to consent in their decision whether or not to agree to the placement or provide respite services.
7. The AA will maintain a copy of the consent in the participant's confidential file.
8. All providers shall maintain confidentiality with respect to any and all participant records, including the DoI Form.

3) Any known warning signs of dangerous behavior towards others (for example, alcohol or drug use, failure to take medications as prescribed, behavioral signs and symptoms

4) Any relevant information needed to protect the consumer from harm (for example, people who have victimized or endangered the individual, behaviors that may indicate possible future self-injurious behavior, level of supervision needed).

Signature of Participant/Guardian Date

Signature of Authorized Agency Staff Date

I do not agree to this placement or to provide respite services. I understand that I must return this document(s) to the Authorized Agency immediately

Signature of Home Provider/Respite Provider Date

I consent to this placement even though the Participant / Guardian has not authorized sharing information that the AA believes is relevant.

Signature of Home Provider / Respite Provider Date

AFC Document Inventory 8/21/13

AFC FORMS		
#	Name	Location
1	AFC Tier Worksheet (CFC 700) - New	Forms: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#highest
2	AFC Service Plan (CFC 705) - New	
3	AFC Agreement for Live-In Care (CFC 704) - Revised	
4	AFC Disclosure of Information Form (CFC 703) - New	
5	AFC Home Safety Checklist (CFC 701) - New	
6	AFC Home Accessibility Checklist (CFC 702) - New	
7	AFC Critical Incident Form (CFC 706) - New	
8	AFC ILA (paper version)	
9	AFC ILA (SAMS/Omnia version)	
CFC MANUAL		
#	Name	Location
1	Update header CFC Highest/High manual intro paragraph to include "Manual updated 08/13 to reflect addition of Adult Family Services." Replace all sections: <ul style="list-style-type: none"> - Cover Page - Preface - Glossary of Terms - Section I: General Policies (8/13) - Section II: Eligibility (8/13) - Section III: Universal Provider Qualifications & Standards (8/13) - Section IV: Services (8/13) - Section IV: Services - 1. Case Management Services (8/13) - Section IV: Services - 2. Adult Day Services (8/13) - Section IV: Services - 3. Personal Care Services (8/13) - Section IV: Services - 4. Respite Care Services (8/13) - Section IV: Services - 5. Companion Services (8/13) - Section IV: Services - 6. Assistive Devices & Home Modifications (8/13) - Section IV: Services - 7. Personal Emergency Response System (8/13) - Section IV: Services - 8. Enhanced Residential Care (8/13) - Section IV: Services - 9. Nursing Facility (8/13) - Section IV: Services - 10. Flexible Choices (8/13) - Section IV: Services - 11. Adult Family Care (8/13) - Section IV: Procedures (8/13) - Section V: Procedures - 1. Application & Eligibility Determination Procedures (8/13) - Section V: Procedures - 2. Waiting List Procedures (8/13) - Section V: Procedures - 3. Initial Assessment & 	Policies and Guidelines - http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#policies

	Reassessment Procedures (8/13) <ul style="list-style-type: none"> - Section V: Procedures - 4. Monitoring Procedures (8/13) - Section V: Procedures - 5. Changes & Start Date Procedures (8/13) - Section V: Procedures - 6. Initiating Services Procedures (8/13) - Section V: Procedures - 7. Denial & Termination Procedures (8/13) - Section V: Procedures - 8. Notices, Variances & Appeals Procedures (8/13) - Section V: Procedures - 9. Utilization Review Procedures (8/13) - Section V: Procedures - 10. Enrollment & Billing Procedures (Updated March 2013) (8/13) - Section V: Procedures - 11. Informed Consent & Negotiated Risk Procedures (8/13) - Section V: Procedures - 12. Medicare Advocacy Project (MAP) Procedures (8/13) - Section V: Procedures - 13. Complaints (8/13) - Section V: Procedures - 14. Critical Incident Reporting Procedures (8/13) - Section V: Procedures - 15. AFC Disclosure of Information Procedures (8/13) - Section VI: Assessment Tools (8/13) - Section VII: Forms (8/13) 	
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PROGRAM MATERIALS

#	Name	Location
1	What's New (DDAS Home Page) <ul style="list-style-type: none"> - AFC Description Paragraph - Link to <i>AFC Service "At-A-Glance"</i> – New - Link to <i>Authorized Agency List</i> - Link to <i>FAQ</i> sheet - Link to <i>Choices for Care Options</i> sheet 	"What's New": DDAS Home Page http://www.ddas.vermont.gov/
2	AFC FAQ Sheet - New	Program Info: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#programs
3	CFC Brochure – Revised (with preamble)	Publications: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#publications
4	CFC Brochure – Revised (without preamble)	
5	<i>Choices for Care Options</i> information sheet (New to web)	CFC Services: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#services
6	Adult Family Care, Authorized Agency Description & Provider List – New <ul style="list-style-type: none"> - AFC Description Paragraph - <i>AFC Authorized Agency List</i> 	Providers of Service: http://www.ddas.vermont.gov/ddas-programs/programs-cfc/programs-cfc-default-page#publications

Choices for Care - Long-Term Care Clinical Coordinators

District Office	Name	Office Phone	Address	Email address	Supervisor
Barre	David O'Vitt, RN	(802) 476-1646 FAX: 476-1654	McFarland State Office Build 5 Perry St., Suite 150 Barre, VT 05641	David.ovitt@state.vt.us	Kathy Rainville
Bennington	Jessica Bird, RN	(802) 447-2850 FAX: 447-2789	150 Veterans' Memorial Dr. Suite 6 Bennington, VT 05201	Jessica.bird@state.vt.us	Kathy Rainville
Brattleboro	George Jurasinski, RN	(802) 251-2118 FAX: 254-6394	232 Main Street, PO Box 70 Brattleboro, VT 05302-0070	George.jurasinski@state.vt.us	Kathy Rainville
Burlington	Paula Brown, RN Jeanne Buley, RN	(802) 871-3058 FAX: 871-1793	Mail: 103 South Main Street, Waterbury, VT 05671 Physical: 94 Harvest Ln, Williston	Paula.brown@state.vt.us Jeanne.Buley@state.vt.us	Sara Lane, RN
Hartford	Sally Garmon, RN	(802) 296-5592 FAX: 295-4148	224 Holiday Drive Suite A White River Junction, Vt 05001	Sally.garmon@state.vt.us	Kathy Rainville
Middlebury	Mary Scarborough, RN	(802) 388-5730 FAX: 388-4637	156 South Village Green, Suite 201 Middlebury, VT 05753	Mary.scarborough@state.vt.us	Sara Lane, RN
Morrisville	Maura Krueger, RN	(802) 888-0510 FAX: 888-0536	63 Professional Dr, Suite 4 Morrisville, VT 05661	Maura.Krueger@state.vt.us	Kathy Rainville
Newport	Paulette Simard, RN	(802) 334-3910 FAX: 334-4818	100 Main St., Suite 240 Newport, VT 05855	Paulette.simard@state.vt.us	Sara Lane, RN
Rutland	Celine Aprilliano, RN	(802) 786-5971 FAX: 786-5882	320 Asa Bloomer Building Rutland, VT 05701	Celine.aprilliano@state.vt.us	Kathy Rainville
Springfield	Joan Sorrentino, RN	(802) 885-8875 FAX: 885-8879	100 Mineral Street, Suite 201 Springfield, VT 05156	Joan.sorrentino@state.vt.us	Kathy Rainville
St. Albans	Brenda Smith, RN	(802) 524-7913 FAX: 527-4078	20 Houghton St, Suite 313 St Albans, VT 05475	Brenda.smith@state.vt.us	Sara Lane, RN
St. Johnsbury	Julie Bigelow, RNC	(802) 748-8361 FAX: 751-2644	67 Eastern Ave, Suite 7 St. Johnsbury, VT 05819	Julie.bigelow@state.vt.us	Sara Lane, RN

Sara Lane, RN
Ph. 871-3045
Cell 498-3538
Fax 871-3052

Kathy Rainville
Ph. 786-5052
Cell 371-8584
Fax 786-5055

**Long Term Care Medicaid Waiver Team Meetings
By Long Term Care Clinical Coordinator (LTCCC)**

Paula Brown Jeanne Buley	3 rd Thursday of the month 3 – 4:30 pm Fanny Allen Basement Board Room Colchester
Mary Scarborough	3 rd Thursday of the month 9:30 – Noon Addison County Home Health Middlebury
Paulette Simard	1 st Wednesday of the month 12:45 – 2:00 pm Newport State Office Bldg DCF- ESD Newport
Julie Bigelow	4 th Wednesday of the month 9 – 11 am Northeastern VT Regional Hospital (NVRH) St. Johnsbury
Brenda Smith	2 nd Tuesday of the month 9 – 10:30 am Franklin County Home Health St. Albans
David O'Vitt	3 rd Thursday of the month 10:00 am McFarland State Office Building Barre
Jessica Bird	4 th Wednesday of the month 1:00 pm Bennington Project Independence Bennington
George Jurasinski	4 th Thursday of the month 1:30pm Rotate Locations Brattleboro
Sally Garmon	1 st Tuesday of the month 9am White River Junction
Celine Aprilliano	3 rd Thursday of the month 8 am Rutland Area VNA Rutland
Joan Sorrentino	3 rd Thursday of the month 10am-12noon Springfield Health &Rehab Springfield
Maura Krueger	1 st Tuesday of the month 12:30 to 2 63 Professional Dr. Suite 4 Morrisville

Area Agencies on Aging:

Champlain Valley

Addison, Chittenden, Franklin, and Grand Isle Counties

(Except for towns of Granville and Hancock)

Champlain Valley Agency on Aging, 76 Pearl Street, Suite 201, Essex Junction, VT. 05452,
Call! toll-free 1-800-642-5119 (V/TTY) or (802)-865-0360. E-mail: info@cvaag.org or visit the
website: www.cvaag.org.

Northeast Vermont

Caledonia, Essex, and Orleans Counties

Area Agency on Aging for Northeastern Vermont, 481 Summer Street, Suite 101 St.
Johnsbury, VT 05819, (802) 748-5182. Call! 1-800-642-5119 (V/TTY) or e-mail:
info@nevaaa.org or on the web at www.nevaaa.org

Southeast Vermont

Windham and Windsor Counties

(Except for towns of Bethel, Rochester, Royalton, Sharon, Stockbridge; includes towns of
Searsburg, Readsboro, Thetford and Winhall)

Senior Solution (Council on Aging for SE VT), 56 Main St., Suite 202, Springfield, VT 05156
(802) 885-2655 or toll free 1-800-642-5119 (V/TTY). Website:
www.SeniorSolutionsVT.org Email: information@seniorsolutionsVT.org
Facebook: www.facebook.com/SeniorSolutionsVT

Southwest Vermont

Bennington and Rutland Counties

(Except for towns of Pittsfield, Winhall, Readsboro, Searsburg)

Website: <http://www.svcoa.org>

Southwestern Vermont Council on Aging

Administrative offices: East Ridge Professional Bldg, 1085 U.S. Route 4 East, Unit 2B,
Rutland, VT 05701, (802) 786-5991 or Call! 1-800-642-5119 (V/TTY,) svcoa@svcoa.org.

Bennington County Offices: 169 North St., Bennington, VT 05201, (802) 442-5436 or Call! 1-
800-642-5119 (V/TTY)

Home Health Agencies (August 2013)

Addison County Home Health and Hospice

PO Box 754

Middlebury, VT 05753

Telephone: 802-388-2957 or 802-388-7259

Fax: 802-388-6126

Bayada Home Health Care (Not currently a provider of CFC Case Management services)

110 Kimball Avenue, Suite 250

South Burlington, VT 05403

Telephone: 802-655-7111

Fax: 802-655-8281

Caledonia Home Health Care, Inc

161 Sherman Drive

St. Johnsbury, VT 05819

Telephone: 802-748-8116

Fax: 802-748-4628

Central Vermont Home Health and Hospice

600 Granger Road

Barre, VT 05641

Telephone: 802-223-1878

Fax: 802-223-6835

Franklin County Home Health and Hospice

3 Home Health Circle, Suite 1

St. Albans, VT 05478

Telephone: 802-527-7531

Fax: 802-527-7533

Lamoille Home Health and Hospice

54 Farr Avenue

PO Box 790

Morrisville, VT 05661

Telephone: 802-888-4651, 802-888-7058, 802-888-4672

Fax: 802-888-7822

Manchester Health Services

PO Box 1224

Manchester Center, VT 05255

Telephone: 802-362-2126

Fax: 802-362-4884

Visiting Nurse Assoc. of Vermont and New Hampshire

1 Hospital Court
Bellows Falls, VT 05101
Telephone: 802-463-4761
Fax: 802-463-4842

Visiting Nurses Assoc. of Chittenden and Grand Isle Counties

1110 Prim Road, Suite 1
Colchester, VT 05446
Telephone: 802-658-1900
Fax: 802-860-6149

Visiting Nurses Assoc. (VNA) and Hospice of Orleans and Essex Counties

46 Lakemont Road
Newport, VT 05855-1550
Telephone: 802-334-5213
Fax: 802-334-8822

Rutland Area Visiting Nurses Assoc.

7 Albert Cree Drive
Rutland, VT 05701
Telephone: 802-775-0568
Fax: 802-775-2304

Visiting Nurses Assoc. and Hospice of Southwestern Vermont

1128 Monument Avenue
Bennington, VT 05201
Telephone: 802-442-5502
Fax: 802-442-4919

**Department of
Disability, Aging &
Independent Living**
Commissioner
Susan Wehry, M.D.

Adult Services Division

**Adult Services
Division**
Division Director
Lora Nielsen
760003

Program Tech II
Colleen Forkas
760147

**Money Follows the
Person Grant**
Project Director
Linda Martinez
760330

**Quality & Program
Management Unit**

Quality & Program
Relations Program
Director
Suzanne Leavitt
760254

Quality & Program
Participant Specialist
Kathy Rainville
760185

Quality Outcomes
Specialist
Tara Powell
760275

Aging & Disabilities
Program Admin
Marie Bean
760005

Program Tech II
Janet Merrill
760100

**Choices for Care
Highest and High
Needs**

Sara Lane
Aging & Disabilities
Program Supervisor
760149

Long Term
Care Clinical
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Julie Bigelow
LTCCC 760279

Paula Brown
LTCCC 760286

Jeanne Buley
LTCCC 760278

Paulette Simard
LTCCC 760285

Brenda Smith
LTCCC 760287

Mary Scarborough
LTCCC 760280

**Choices for Care
Highest and High
Needs**

Under Recruitment
Aging & Disabilities
Program Supervisor
761011

Long Term
Care Clinical
Coordinators (LTCCC)

Celine Aprillano
LTCCC 760284

Jessica Bird
LTCCC 760281

Sally Gannon
LTCCC 760277

George Juraskinski
LTCCC 760325

Maura Krueger
LTCCC 760283

Joan Sorrentino
LTCCC 760294

David O'Vitt
LTCCC 760168

**Long Term
Services & Supports**
Aging & Disabilities Program
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Megan Tierney-Ward
760135

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Housing &
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765004

Denise Beasley
Housing &
Community
Specialist
765004

Jill Allen
Housing &
Community
Specialist
765004

Arlita Weber
Housing &
Community
Specialist
765004

Under Recruitment
Administrative
Assistant B
760326

Leah Ziegler
Quality Program
Specialist
760328

Rio Demers
Quality Program
Specialist
760329

Matt Corjay
Senior Planner
760327

Mary Woods
Transition Coordinator
760323

Herman Fossi
Transition Coordinator
760324

Debra Currier
Transition Coordinator
760325

**Attendant Services &
Consumer Directed Services
Choices for Care
Moderate Needs Services**
Mary Collins
Independent Living Services Consultant
760148

**Nurse Case Manager
Complex Cases
Adult High Tech**
Mary Gerdt
760256

Contacts

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