

CHAPTER 2

Intake, Prioritization and Case Management

Table of Contents

TABLE OF CONTENTS

<u>Section:</u>	<u>Topic</u>	<u>Page</u>
I.	Purpose and Goals of Case Management	2-4
II.	Legal Basis and Specific Legal Authority	2-6
III.	Service Requirements	
A.	Section 1: Case Management and the Role of the Case Manager	2-7
1.	Basic Functions and Responsibilities	2-7
2.	Recommended Staffing and Caseload Standards	2-12
3.	Job Description Inclusion Requirements	2-13
4.	In-Service Training Program	2-18
B.	Section 2: Intake and Prioritization	2-19
1.	Intake	2-19
2.	APCL Maintenance & Prioritizing Enrollment of New Consumers	2-21
C.	Section 3: Client Assessment	2-25
1.	Purpose	2-25
2.	Criteria for Administration of the Client Assessment	2-26
3.	Conducting the Interview	2-29
4.	Assessment Scores	2-31
5.	Assessment Instructions—DOEA Form 701D	2-32

Table of Contents

<u>Section:</u>	<u>Topic</u>	<u>Page</u>
D.	Section 4: Care Planning and Service Arrangement	2-33
1.	Definition and Purpose	2-33
2.	Development of the Care Plan	2-34
3.	Review and Evaluation of Services	2-37
4.	Review and Update of the Care Plan	2-38
5.	Case Closure/Service Termination	2-40
E.	Section 5: Case Record	2-42
1.	Purpose	2-42
2.	Content of the Case Record	2-43
3.	Standards for Security and Privacy of Case Records	2-45
4.	Retention of Case Records	2-46
5.	Case Narrative Guidelines	2-47
IV.	Grievance Proceedings	2-50
V.	Attachments:	
	Attachment 1: Authorization for Release of Information	2-51
	Attachment 2: Case Management Program Comparison	2-52
	Attachment 3: Care Plan, Page 1, (DOEA Form 203A)	2-58
	Attachment 4: Care Plan, Additional Pages (DOEA Form 203B)	2-59
	Attachment 5: Care Plan Instructions	2-60

Purpose and Goals of Case Management

PURPOSE AND GOALS OF CASE MANAGEMENT:

PURPOSE OF CASE MANAGEMENT:

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

- A. Gatekeeper:** The case manager is the community care service system "gatekeeper" with the knowledge and responsibility to link clients' needs to the most beneficial and least restrictive array of community services and resources.
- B. Client Centered:** Case management is client centered. Case managers should make every effort to link clients with appropriate formal and informal support, regardless of the agency or organization offering the services and advocate on the client's behalf to help the client to receive the assistance needed.
- C. Limiting Services:** Case managers should not limit services only to those services offered by their agency.
- D. Coordination:** Case managers should ensure full coordination of services provided by various agencies and individuals and pay particular attention to the scheduling of services in the home of the client.
- E. Linking Services:** Case management is the link between social services programs, home and community-based service providers and health care delivery systems, such as physicians, hospitals, health maintenance organizations (HMO's) and nursing homes.
- F. Informal Support Systems:** Case management provides the contact through which the family, caregivers, neighborhood help organizations and voluntary services assist the client. The case manager is a developer of informal support systems, one of the most necessary and productive components of long term care. Case managers should actively pursue informal resource development.
- G. Assistance to Families:** Case managers assist clients' families as well as clients. Allowing for legally competent clients to choose who participates in decisions about their care, case managers will encourage families to be involved and link them with respite care resources as needed.
- H. Family Training:** Case managers should encourage family members to receive training in caregiving methods.

Purpose and Goals of Case Management

GOALS OF CASE MANAGEMENT:

The goals of case management are:

- A. Self-Sufficiency:** To coordinate services that assist clients in becoming more independent, remaining in the least restrictive environment, and attaining or maintaining the highest level of physical, mental and psychosocial well being.
- B. Quality Assurance:** To ensure effective and efficient client care through the following activities:
 1. Initiating or terminating services;
 2. Increasing or decreasing services;
 3. Assessing client needs in a comprehensive manner;
 4. Determining client satisfaction with services.
 5. Planning and arranging for appropriate services (duration, scope, frequency) provided to clients within a reasonable time period and that produce effective results.
 6. Coordinating services through community care service systems and eliminating unnecessary overlap of services, as possible.
 7. Documenting gaps between services that are needed and those presently being received for planning and budgeting purposes.
- C. Continuum of Care:** To provide access to holistic care, ranging from services in the home to institutional care.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Legal Basis and Specific Legal Authority

LEGAL BASIS AND SPECIFIC LEGAL AUTHORITY:

Program: **Specific Legal Authority:**

ADI **Chapter 430.501-504, F.S.**

CCE **Chapter 430.201-207, F.S.**

Abuse Hotline **Section 827.07, F.S.**

HCE **Chapter 430.601-608, F.S.**

LSP **Specific Appropriations**

OOAIIIB **Older Americans Act, Title III, Part B, Section 321 (a)(5)(A)
42 U.S.C. 3030d**

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

SERVICE REQUIREMENTS

SECTION 1: CASE MANAGEMENT AND THE ROLE OF THE CASE MANAGER

BASIC FUNCTIONS AND RESPONSIBILITIES:

Functions and responsibilities of the case manager include the following:

- A. Investigating Community Resources:** The case manager is responsible for knowledge about all formal and informal community resources in order to coordinate client services.
- B. Receiving and Documenting Referrals:** Agencies may use a separate intake worker or a case manager to receive referrals for services.
 - 1. Receiving:** The intake worker/case manager shall determine whether the client appears to meet program eligibility guidelines or must be referred to another agency.
 - 2. Documenting:** All referrals to other agencies shall be documented.
- C. Networking with other Agencies:** The case management agency shall develop a network with other agencies to assist clients in obtaining needed services.
 - 1. Networking:** This network will provide valuable information, save valuable time coordinating client services and prevent service duplication. .
 - 2. Referring:** The case manager is responsible for making referrals when appropriate. This may include such agencies or offices as Department of Children and Families (Food Stamps), Social Security Administration or Veterans Administration.
- D. Completing the Client Assessment:** The case manager shall complete the Assessment Instrument (DOEA 701B). The assessment will determine the client's level of functioning, existing resources, and gaps in service provision (see Assessment Instructions 701D for details).

E. Obtaining an Authorization for Release of Information: The case manager will request the applicant to sign an authorization for release of information form.

1. This authorization will ensure that necessary information is shared with service delivery staff and agencies involved to aid them in providing appropriate services.
2. A sample release form is included as Attachment 1 to this chapter. Agencies may use this form or may develop an agency specific form using the same content. This form shall be completed annually during reassessment.

F. Developing a Care Plan: If the client is determined eligible for services after the assessment instrument is completed, a care plan and confidential file must be developed for each client. The case manager shall use the uniform care plan (DOEA 203A and DOEA 203B) to develop with the client and important others (such as spouse or caregiver) ways to address service needs. :

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

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

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

J. Communicating with Other Agencies:

1. **Agency Involvement:** It is very important for all agencies involved to know when a client's needs change or when an agency, for whatever reason, modifies its services.
2. **Assistance:** Some agencies may be able to provide assistance or know of other resources to help the client.
3. **Staffings:** One way to ensure communication and coordination of services is to meet on a regular basis with other agencies for particular case staffings.

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

1. Initiating and maintaining the case record;
2. Documenting pertinent information in the case record and updating the record when conditions change or following periodic contacts with the client; and
3. Writing in a fashion to enable an independent reviewer to fully understand the client's status and services and obtain a good overview of case management. Legibility of handwriting or use of word processing along with a legend of abbreviations used are vital to a good case record. (See Section 5 of this chapter, Case Record, for required documentation.)

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

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

2. **Care Plan Review:** The review is not a complete reassessment, but a review of service goals and changes in the client's status that may warrant modification to the care plan. The case manager will discuss any changes in the care plan with the client and caregiver for acceptance prior to changes in service provision. The case manager will verify service quality and client satisfaction.
- M. **Client Reassessment:** For case management as well as planning and coordination purposes, the case manager must perform a face-to-face client reassessment at least once every year.
 1. **Reassessment Form:** The case manager shall complete the Assessment Instrument (DOEA 701B) form in accordance with the instructions in Section 3 of this chapter, Client Assessment.
 2. **Reassessment Results:** Reassessment results are to be used to evaluate and modify the care plan, if needed.
- N. **Discontinuing or Modifying Services:** The decision to discontinue or modify services shall include the client, family members or caregiver after a review and update of the client's situation.
 1. **Improvement of Condition:** If the client's health or functional status improves, then the case manager shall modify the care plan accordingly, accommodating assistance from family members or other community supports. If formal services are no longer needed, the case manager shall terminate services.
 2. **Deterioration of Condition:** If the client's health deteriorates to the extent that more extensive care is needed, then the case manager shall assist the person in locating the most appropriate, least restrictive, and most cost-effective alternate living arrangement.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Service Requirements

**Section 1: Case Management and the Role of the Case Manager:
Basic Functions and Responsibilities**

3. **Client Behavior Problems:** The case manager may close the case when the client exhibits either of the following behaviors:
 - a. Refuses to continue services; or
 - b. Is uncontrollable, uncooperative, or combative.
 - c. The case manager will document in the case narrative circumstances of the situation and the progression of the behavior problems.
4. **Documentation:** The case record must reflect adequate documentation for service modification or termination. The client must be notified in writing 10 calendar days in advance of the termination of services, except in the case of death, the client moving out of the service area, the client moving to an assisted living facility or nursing home, or the client requesting the termination.

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

1. **Florida Statutes:** The Florida Abuse Hotline was established by Section 827.07, F.S., to record all such incidences.
2. **Hotline:** On-call coverage for reporting of abuse, neglect, or exploitation of disabled or infirmed, aged adults is provided 24 hours a day, seven days a week by the Florida Abuse Hotline staff at a TOLL-FREE NUMBER:
1-800-96 ABUSE (1-800-962-2873).
3. **Investigation:** Each complaint of alleged abuse, neglect, or exploitation accepted by the hotline is phoned to the designated adult protective services investigator in the respective district for contact and action.

RECOMMENDED STAFFING AND CASELOAD STANDARDS:

Listed below are recommended staffing, caseload and case manager supervision standards:

- A. **Caseload:** A caseload consists of those clients determined eligible and receiving case management services.
 - 1. **Average Caseload:** DOEA suggests maintaining a caseload of 60-70 clients per case manager full time equivalent (FTE).
 - 2. **Over Average Caseloads:** Caseloads exceeding 100 clients per case manager require a waiver from the area agency on aging.
- B. **Case Manager Supervisor:** Case manager supervisors may be established in larger agencies employing five or more case managers.
 - 1. **Supervisor's Caseload:** The case manager supervisor may handle a small number of cases, not to exceed half of the size of a case manager's caseload (30-35 clients).
 - 2. **Alternate Supervision:** In smaller projects, supervision may be provided by the project director or other project staff with direct service experience.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

JOB DESCRIPTION INCLUSION REQUIREMENTS:

A. CASE MANAGER:

- 1. Major Functions:** Major functions of the case manager's job description are:
 - a. Referral and Assessment:** Receives referrals and completes initial and annual client assessments.
 - b. Information:** Provides information as needed in order to involve the client and/or primary caregiver in the care plan.
 - c. Care Plan:**
 - i.** Develops care plans, arranges for and follows-up on services provided; and
 - ii.** Reviews care plans with other professionals involved with service provision.
 - d. Follow-up:** Provides follow-up as needed.
 - e. Home Visits:** Makes home visits.
 - f. Case Records:** Maintains individual case records.
 - g. Informal Support Network:** Develops informal support network (relatives, volunteers, friends, etc.) when there is no caregiver or when additional help is needed.
 - h. Expanded Support Network:** Builds an expanded support network with members of the client's immediate community.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

2. Major Duties: Case managers' major duties are as follows:

- a. **Client Assessment:** After the new client is screened and it is determined that funding is available to provide services, the case manager will schedule a face-to-face visit with the client to complete the Assessment Instrument (701B). The form will generate a priority rank to prioritize the client in comparison with all other clients waiting for services. If the applicant can be served, the Assessment Instrument (DOEA Form 701B) will be completed within fourteen business days after receiving the referral. In all cases, the Assessment Instrument (701B) will be completed face-to-face with the client before services are begun. The assessment helps to identify the client's conditions and resources in relation to:
 - i. Mental Health/Behavior/Cognition;
 - ii. Physical Health;
 - iii. Activities of Daily Living (ADLs);
 - iv. Instrumental Activities of Daily Living (IADLs);
 - v. Nutrition Status;
 - vi. Health Conditions/Special Services/Medications;
 - vii. Caregiver Status;
 - viii. Social Resources; and
 - ix. Environmental Risks.
- b. **Care Plan Development:** Develops care plan in conjunction with the client/client's representative, spouse or family, obtaining the client's concurrence and signature or that of the client's representative if the client is unable to sign the care plan. If the client is legally incompetent, his/her guardian must sign the care plan.
- c. **Care Plan Review:** Reviews care plan with supervisor at initial development. This may be a team activity for subsequent reviews.
- d. **Services:** Arranges for services and coordinates service delivery.

Service Requirements:

**Section 1: Case Management and the Role of the Case Manager:
Job Description Inclusion Requirements**

- e. **Respite Care:** Arranges respite care for caregivers as needed. Refers caregivers to, or arranges for, counseling/support groups in order to relieve the stresses of the caregiver role.
- f. **Training:** Encourages and may arrange for caregivers, family members or friends to attend training where possible.
- g. **Client Reassessment:** Completes written client reassessment at least annually and more frequently if conditions warrant.
- h. **Client Record:** Completes and maintains a client record with progress reports and forms related to service provision and ongoing documentation.
- i. **Supervisory Role:** May supervise other personnel.
- j. **Other Duties:** Performs other duties as necessary.

3. **Minimum Qualifications:** A case manager must meet one of the following qualifications:

- a. A bachelor's degree in social work, sociology, psychology, nursing, gerontology or a related social services field; or
- b. Year for year related job experience or any combination of education and related experience may be substituted for a bachelor's degree upon approval of the AAA.

B. CASE AIDE:

1. Major Functions:

- a. Case aides are para-professionals who complement or supplement the work of case managers.
- b. Case aide activities are billed as case aide services and not case management services.

2. Major Duties:

- a.** Assist with the implementation of care plans;
- b.** Assist with accessing medical and other appointments;
- c.** Perform follow-up contacts. This may include the monthly contact with the HCE caregiver;
- d.** Oversee quality of provider services;
- e.** Deliver supplies and equipment;
- f.** Assist with paying bills;
- g.** Assist the client or caregiver in compiling information and completing applications for other services and public assistance;
- h.** Facilitate linkages of providers with recipients via telephone contacts and visits;
- i.** Determine client satisfaction with services provided;
- j.** Arrange, schedule and maintain scheduled services;
- k.** Document activities in the case record;
- l.** Reconcile and voucher activities;
- m.** Assist with HCE monthly contact to confirm caregiver eligibility; and
- n.** Record telephone and travel time associated with billable case aide activities.

3. Provider Qualifications:

- a.** Minimum qualifications for case aides include a high school diploma or GED.
- b.** Job related experience may be substituted for a high school diploma or GED upon approval of the AAA.

C. CASE MANAGER SUPERVISOR:

1. **Major Duties:** Case manager supervisor's major duties are as follows:
 - a. **Supervision:** Supervises case managers and case aides;
 - b. **Care Plans:** Reviews care plans at initial development, and as necessary, and ensures follow-up on all care plans;
 - c. **Reviews, Reassessments, Case Records:** Ensures completion of semiannual reviews and annual assessments for clients and that appropriate case records are maintained.
 - d. **Service Delivery:** Ensures that providers deliver services as scheduled, within specified time frames and without negative incident.
 - e. **Coordination:** Resolves service delivery problems and ensures coordination among community care providers.
 - f. **Problem Resolution:** Resolves problems between the case manager and client or caregivers.
 - g. **Quality Assurance:** Reviews service provision to ensure effective and efficient client care.
 - h. **Home Visits:** Makes random client home visits for the following objectives:
 - i. To ensure that service plans are followed;
 - ii. To become familiar with the client's environment; and
 - iii. To ensure accuracy of case recordings.
 - i. **Respite Care:** Ensures that respite care is arranged for caregivers as needed.
 - j. **In-Service Training:** Arranges for in-service case manager training.
 - k. **Informal Support Systems:** Ensures that case managers are actively developing informal support systems among clients' neighbors and community volunteers.
 - l. **Caregiver Training:** Ensures that caregivers, family members or friends receive training where possible.

IN-SERVICE TRAINING PROGRAM:

- A. Program Development:** Each provider agency shall develop an in-service training program for case management staff.
- B. Minimum Standards:** Each provider agency shall conduct at a minimum an annual in-service training of six hours and will document the duration and content in case management staff records.
- C. Description and Allocation of Funds:** Each provider agency shall describe and allocate budget funds for training in the provider application.
- D. Minimum Standards:** Training will include, at a minimum, the following topics:
 - 1. Overview:** Overview of community care services;
 - 2. Relationship:** Relationship of case management to the community care services system;
 - 3. Completion of Forms:** Use and completion of assessment instruments and care plans;
 - 4. Interviewing:** Interviewing skills and techniques;
 - 5. Record Keeping:** Record-keeping procedures;
 - 6. CIRTS:** Client Information and Registration Tracking System (CIRTS) procedures;
 - 7. Aging Network Overview:** Overview of the aging network (AAA, DCF, AHCA, DOEA and other agencies) and the agency's relationship to the community care service system;
 - 8. Caregiver Training:** Caregiver training regarding responsibilities and resource development techniques; and
 - 9. Coordination Training:** Interagency coordination and informal network development training.

INTAKE AND PRIORITIZATION:

The following information addresses the provider agency responsibilities as they pertain to the intake and prioritization processes.

INTAKE:

A. Entrance to Community Care Service System:

Individuals seeking services may enter the community care service system by direct contact with an access point.

B. Intake Process:

1. **Process Commencement:** The intake process begins when an individual contacts the Elder Helpline or other access point seeking assistance.
2. **Necessary Information:** Essential information about the nature of the person's physical, mental and functional abilities/concerns/limitations/problems, as well as general background information, is obtained during the intake process to assist in screening for eligibility and appropriate service referrals.

C. The Prioritization Assessment Form (701A):

1. **DOEA Form 701A:** The Prioritization Assessment Instrument is used to collect common information about applicants/clients applying for services funded by the Department of Elder Affairs.
 - a. It is also used to prioritize persons so that those in greatest need and with the least assistance available will receive services first.
 - b. This form is used over the phone or in person.
 - c. Call the client within three business days after receiving a referral to complete a Prioritization Assessment Form (DOEA Form 701A).
 - d. If the applicant can be served, the Assessment Instrument (DOEA Form 701B) will be completed within fourteen business days after receiving the referral.
 - e. If the applicant cannot be served, he/she is placed on the Assessed Priority Consumer List (APCL).

2. **Staff Completing the 701A:** Staff who has received training and certification may complete the 701A.
3. **Procedure for Completion of Form:** The procedure for completing the Prioritization Assessment Form is described in the Assessment Instructions (DOEA Form 701D).

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

APCL MAINTENANCE AND PRIORITIZING ENROLLMENT OF NEW CONSUMERS:

A. Trained and certified staff conducts screening and assessment activities of potential consumers as the first step to enrollment on the APCL. The AAA ensures the APCL is maintained in the Client Information and Registration Tracking (CIRTS) System when enrollment in a program for services funded by the department is not available. Staff must inform potential consumers or referring parties about the assessed priority consumer lists and provide suggestions regarding other agencies or sources of assistance, including Medicaid, Food Stamps, and private pay options. Staff must also provide consumers contact information and encourage them to call for re-screening if their situations change.

Staff enters information for consumers waiting for DOEA-funded services in the CIRTS enrollment screen with the program status of APCL. The priority ranking score is automatically generated in CIRTS for these individuals. Only one APCL is maintained for each DOEA-funded program in each planning and service area (PSA.) The AAA must ensure that persons placed on the APCL are re-screened at regular intervals to determine if their situations have changed.

B. CONSUMER ENROLLMENT ON AN APCL

1. New consumers not enrolled on an APCL and not enrolled in a DOEA-funded program
 - a. Individuals enrolled on an APCL will be screened using Form 701A.
 - b. Individuals may be enrolled on more than one APCL after consideration of consumer need, program eligibility and targeting requirements.
2. Consumers receiving case management and dually enrolled (CIRTS Enrollment Screen program status codes set to "APCL" and "ACTV") in the following programs: ADI, CCE, HCE, LSP, OAA, and ADA/ALE Medicaid Waivers.
 - a. Consumers, regardless of priority ranking score, will be assessed by the case manager annually using Form 701B.
 - b. Case managers have the responsibility to conduct semi-annual care plan reviews and annual reassessments. If case management is provided under LSP, then the requirements are the same as those for other DOEA-funded case managed consumers. If case management is not provided, then OAA requirements apply.

- c. If there is a significant change between annual assessments, an “update” type assessment will reflect a new priority ranking score on the APCL.
- 3. Consumers with a CIRTS Enrollment Screen program status code set to “APCL” and not enrolled or receiving services in any DOEA-funded program.
 - a. Consumers with a priority ranking score of 3, 4, 5, 6 and 7 are re-screened every six months using Form 701A.
 - b. Consumers with a priority ranking score of 1 or 2 are re-screened annually using Form 701A.
- 4. Consumers receiving one or more OAA registered services and having CIRTS Enrollment Screen program status codes set to “ACTV” for OAA and “APCL” for any DOEA-funded program.
 - a. Consumers, regardless of priority ranking score, will be reassessed annually using Form 701B, Assessment Type “O.” As noted, this also applies to LSP if the providers operate under OAA requirements.
 - b. Consumers who are enrolled in OAA or LSP for Congregate Meals or Nutrition Counseling and who are also on the APCL for any DOEA-funded program must be re-screened annually using Form 701A or using Form 701B, Assessment Type “O,” in order to generate a priority ranking score for the APCL.
 - c. If there is a significant change between annual assessments, an “update” type assessment will reflect a new priority ranking score on the APCL.
- 5. Consumers screened using Form 701A and received a priority ranking score of 3, 4 or 5 with a CIRTS Enrollment Screen program status code set to “APCL” and subsequently assessed using Form 701B and receive a new priority ranking score of 1 or 2.
 - a. ADI, CCE and HCE applicants are returned to the APCL to allow for prioritization of other consumers on the APCL with priority ranking scores of 3, 4, or 5.

- b. ADA/ALE potential clients not placed on **APPL** status are returned to the APCL to allow for prioritization of other consumers on the APCL with priority scores of 3, 4 or 5. However, ADA/ALE Medicaid Waiver applicants (program code in CIRTS is set to **APPL**) who receive a lower priority ranking score on a 701B continue through the Medicaid waiver application process. The lower priority ranking score on a 701B does not disqualify **applicants** for the Medicaid waiver programs.
- c. The Notice of Instruction (NOI) #061705-1-I-SBCS dated June 17, 2005 provides detail regarding the use of the CIRTS program status code of APPL.

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

Consumer enrollment in DOEA-funded programs is based on available funding, specific program eligibility, targeting and prioritization criteria as stated in law, rule and DOEA contracts.

C. Consumer Enrollment in DOEA-funded Programs to Receive Services

- 1. OAA: OAA targeting and program eligibility requirements apply for consumers enrolled in OAA Title IIIB (supportive services), Title IIIC (nutrition services), Title IIID (preventive health services), and Title IIIE (caregiver services).
- 2. CCE: Pursuant to Section 430.205(5), Florida Statutes, Adult Protective Services referrals in need of immediate services to prevent further harm will be given primary consideration for receiving services in the CCE program. APS high-risk clients (Priority 7) must receive case management and crisis-resolving services within 72 hours of the APS referral per DOEA policy.
- 3. ADI, CCE, HCE, LSP and ADA/ALE Medicaid Waivers: Approval to begin the eligibility process for ADI, CCE, HCE, LSP and ADA/ALE Medicaid Waivers is determined by the availability of funds and the priority ranking of individuals. The order of priority (except for CCE APS high risk referrals) is as follows:
 - a. Individuals designated as Imminent Risk (Priority 6) of being placed in a nursing home (including individuals designated as Aging Out and non-Aging Out individuals);
 - b. Individuals designated as Aging Out (regardless of priority ranking score); and

- c. Individuals with the highest priority score starting with individuals with a priority ranking score of 5.

THIS REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

PURPOSE:

A. CLIENT ASSESSMENT PURPOSE:

1. **Areas of Need:** A comprehensive assessment of the client's condition and changes in that condition revealed during assessment and/or reassessment shall identify areas of need where services and/or informal networks should be developed;
2. **Planning and Budgeting:** Assessment information evolves into the development of profiles on client impairments and service needs, which are useful in planning and budgeting for those needs.

B. ASSESSMENT FORMS:

1. Assessment forms are used to conduct client assessments for all DOEA programs. The assessment forms are listed below:
 - a. **Prioritization Assessment Form (DOEA Form 701A)**
 - b. **Assessment Instrument (DOEA Form 701B)**
 - c. **Congregate Meals Assessment (DOEA Form 701C)**
2. **Assessment Instructions (DOEA Form 701D):** Specific and detailed instructions for completing the assessment forms are included in the Assessment Instructions (DOEA Form 701D).
3. **Development of Care Plan:** The case manager utilizes the information gathered through the assessment in the development of a client centered care plan. The final page of the Assessment Instrument (DOEA Form 701B) is a summary of all assessment information. The page notes: client problems, barriers to meeting these needs, resources available, and the gaps that exist in meeting the client's needs. These gaps become the needed services on the client's care plan.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CRITERIA FOR ADMINISTRATION OF THE CLIENT ASSESSMENT:

A. Assessment Requirement:

Case managers shall complete initial comprehensive client assessments and annual client reassessments for the following programs:

1. **ADI:** Alzheimer's Disease Initiative.
2. **CCE:** Community Care for the Elderly.
3. **HCE:** Home Care for the Elderly.
4. **LSP:** Local Services Program
5. **OAA:** Older Americans Act registered services. (701B form with "O" items/sections completed)

Reassessments: After the initial assessment, annual assessments are referred to as reassessments.

- B. Client Not Capable of Providing Information:** If a client is unable to provide information for the assessment due to illness or impairment, the case manager must attempt to obtain the information from the spouse, family, caregiver or other source.
- C. Assessment Face-to-Face Requirement:** Initial assessments and reassessments must be administered face- to- face with the client using a **new** Assessment Instrument (701B).
- D. Sharing of Completed Assessments:** All DOEA-funded program agencies shall utilize assessments completed by other agency staff who have been trained and certified to complete the assessment forms.
- E. Updates to Completed Assessments:** The following criteria apply regarding updates:
 1. **Assessment Forms Received from Another Agency:** Assessment forms administered by a trained/certified assessor working for another agency shall be reviewed when received to determine if all sections have been completed. Updates shall be made to specific sections of the assessment form as necessary.

2. **Completing Updates:** The update does not require full completion of a new assessment form; however, the update does require a review of the client's condition/situation to determine changes.

Changes in Client Condition: If the client's condition changes during the year
3. and significantly affects the client's functional status, then the case manager shall review the impact of this change and update the assessment form.

- a. Only sections of the assessment with significant changes need to be updated.
- b. The case manager shall make appropriate notations in the case record and revise the care plan accordingly.

Significant Changes: Examples of significant changes which may affect the
4. client's condition include the following:

- a. Changes in health status such as an accident or illness;
- b. Change in living situation;
- c. Changes in the caregiver relationship;
- d. Loss, damage, or deterioration of the home living environment;
- e. Loss of spouse, family member, or close friend; or
- f. Loss in income.

5. Update Face-to-Face Requirement: The case manager will conduct a face-to-face interview with the client to document necessary revisions to the assessment.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

F. Assessment Training and Certification: The following procedures shall be followed in regards to training and certification:

1. **Training/Certification:** Staff must have received training and certification on completing the assessment forms from a planning and service area assessment training team prior to conducting client assessments.
2. **Interim Arrangement:** An interim arrangement may be made for new employees who have not yet obtained certification, which requires a certified worker to review and approve the assessment as documented by the reviewer's signature.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CONDUCTING THE INTERVIEW:

INTERVIEWING TECHNIQUES:

A. Establishing Rapport:

1. **Interview Relationship:** The case manager must make every effort to establish a good interviewing relationship and environment by providing warmth, genuineness, and empathy.
2. **Respect and Dignity:** The case manager must treat the applicant/client with dignity and respect.
3. **“Hints”:** The case manager should refer to “Developing Rapport” in the Assessment Instructions (DOEA Form 701D).

B. Applicant/Client Involvement:

1. **Privacy:** In most cases the applicant should be interviewed alone.
2. **Involvement of Others:** A family member or caregiver may need to be present to provide the assessment information if the applicant/client is confused, very ill, or otherwise unable to provide the necessary information. However, the case manager must try to involve the client as much as possible in the interview.

C. Statement of Interview Intent:

The case manager will state that the intent of the interview is to obtain specific information in order to:

1. Determine what type of assistance the person may need; and
2. Ensure that all eligibility criteria are met.

D. Confidentiality:

The case manager will inform the client that the data collected will be kept confidential; however, with his/her written consent, there may be situations when information will need to be shared with another agency in order to obtain services that will be of assistance. (Refer to Section 5 of this chapter—Case Record for more information on confidentiality).

E. Case Manager Instructions for Interviewing and Conducting Assessments:

Instructions for interviewing and conducting the assessment are included in DOEA Form 701D. Case managers shall follow these instructions.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

ASSESSMENT SCORES:

Two scores are produced when the completed Assessment Instrument is entered into the Client Information and Registration Tracking System (CIRTS).

A. Risk Score:

This score indicates the likelihood that the individual will go into a nursing home.

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

B. Priority Score:

This score indicates the client's need for services.

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

ASSESSMENT INSTRUCTIONS - DOEA Form 701D (Instructions for Forms 701A, 701B, 701C):

Instructions for completion of the DOEA forms 701A, 701B and 701C assessment instruments are included in DOEA Form 701D. These forms are incorporated by reference in Rule Chapter 58A-1, Administration of Administration on Aging Programs, F.A.C.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

SECTION 4: CARE PLANNING AND SERVICE ARRANGEMENT:

DEFINITION AND PURPOSE OF THE CARE PLAN:

A. CASE MANAGER:

The case manager uses the care plan for the following tasks:

- 1. Information Organization:** To organize service information related to client problems/gaps; and
- 2. Documentation:** To document the plan of action to address client problems and needs through the development of service solutions that meet the client's needs.

B. CARE PLAN INCLUSIONS: The care plan should prescribe the following services:

- 1. DOEA Funded:** Services provided through DOEA funded programs; and
- 2. Non-DOEA Funded:** Services funded outside of DOEA or informal services provided by the caregiver, family or friends.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

DEVELOPMENT OF THE CARE PLAN:

A. General: The care plan development is:

1. **Mutual Endeavor:** A mutual endeavor between the case manager, the client, and the caregiver and other family members; and
2. **Roles:** Specifies the roles and contributions of family members.

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

1. **Written Consent:** The client, or caregiver if the client is unable, must be involved in the care plan development and must provide written consent to the plan.
2. **Expectations:** In order to avoid possible false expectations on the part of the client, caregiver and family members, the case manager shall explain, during the initial interview, that services will be planned, and provided as feasible, in keeping with the care plan goals.

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

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

E. Confidentiality: Every caution shall be taken to protect client confidentiality.

1. **Necessary Information:** Only necessary information (e.g., medical history for health services) must be communicated to agencies involved in the care plan. All HIPAA regulations (the federal Health Insurance Portability and Accountability Act of 1996) will be followed at all times.
2. **Client Consent:** The client must provide individual informed client consent before any case information is shared with agencies.

F. Client-Centered Care Planning: Case managers shall perform the following client-centered tasks regarding care planning:

- 1. Case Manager Task:** Case managers shall concentrate on assisting clients to identify:
 - a. What the client identifies as problems;
 - b. What solutions are available to alleviate the problems; and
 - c. Whether the solutions are possible or feasible.
- 2. Commitment:** The client's commitment to the plan is crucial as well as the commitment of the family, caregiver, or other informal providers.
- 3. Case Manager Role:** The case manager should use communication skills to enable the client to perform the following care planning tasks (or the caregiver in the absence of client capability):
 - a. Understand goals;
 - b. Appraise resources; and
 - c. Decide on a course of action.
- 4. Case Manager Identification of Goals:** In some instances, case managers may identify additional goals that they should discuss with the client and, if agreeable, add to the care plan.

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

- 1. Non-DOEA Services:** Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.
 - a. Service Development:** These services can and should be developed to effectively address client needs as an alternative to purchased services from providers of DOEA funded services.

- b. **Preservation of Funds:** Case managers shall emphasize using informal resources whenever possible to preserve program funds for clients with the most critical needs.
- c. **Other Resources:** The case manager and client shall consider informal resources, such as faith-based organizations and civic groups in the development of the care plan.
- d. **Examples:**
 - i. A concerned friend or family member can sometimes arrange to provide homemaker or personal care assistance.
 - ii. A faith-based organization can sometimes provide meals or transportation services.

2. **DOEA Funded Services:** Other services come from the service providers in the local community care service system, which are funded through the department.
3. **Resource Directory:** The case manager should have access to a local community care service system resource directory to assist in selecting and arranging for services.
4. **Client Refusal:** If a client refuses a service(s) recommended by the case manager, the case manager shall document the refusal in the case narrative notes in the client's case file. The case manager may periodically make the suggestion of adding the needed service.

CARE PLAN FORMAT: Refer to Attachment 5 of this chapter for instructions on development of the care plan.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

REVIEW AND EVALUATION OF SERVICES:

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

- 1. Service Satisfaction:** Is the client satisfied with the services? If not, why?
- 2. Quality of Service:** Is the client satisfied with the quality of the services performed? If not, why?
- 3. Interviewer:** The individual conducting the interview is:
 - a.** Not required to observe the service being performed; but is
 - b.** Encouraged to observe services being performed and conduct discussions with the service worker if there is any indication that this action would be beneficial in determining the quality of services (e.g., the client expresses dissatisfaction with the way the service is performed).

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

- a. Rapport:** Service worker's rapport with the client. Does the service worker communicate effectively with the client (including no language barriers)? Does the service worker communicate effectively with the client (including no language barriers)?
- b. Service Worker Attitude:** Service worker's attitude towards job performance. How does the service worker approach the job? Is he/she positive, negative, enthusiastic? Other observations.
- c. Service Worker Compliance:** Service worker's compliance with assigned duties. Are all services being completed as assigned?
- d. Service Worker Dependability:** Service worker's dependability regarding the work schedule. Does the service worker arrive timely, arrive when expected by the client, stay as long as planned in the care plan?
- e. Client Evaluation:** Client's evaluation and assessment of the service provided. Is the client satisfied with the services received?
- f. QA Interview Format:** Agencies may devise their own formats for the quality assurance interview.

REVIEW AND UPDATE OF CARE PLAN:

A. Care Plan Review:

Case manager responsibilities are as follows:

1. **Semiannual Review:** The case manager shall conduct a care plan review and home visit at least semiannually and more frequently, if necessary, depending upon the changes in the client's condition.
 - a. **Definition of Semiannual:** Semiannual is defined as the end of the month, which falls 180 days after the initial service delivery.
 - b. **Example:** If the initial service date is July 23, 2007, then the case manager must complete the semiannual review by January 31, 2008.
2. **Review Schedule:** The case manager shall establish a care plan review schedule for home visits and face-to-face contact with each client based on this standard.
3. **Continuity of Services/Changes in Client Status:** The case manager will monitor for continuity of services and changes in the client's functional status which warrant the following changes in the recommended care plan:
 - a. Increase in services;
 - b. Decrease in services; and
 - c. Any other changes.
4. **Review Parameters:** The review is not a complete reassessment but a review of problems/gaps and changes in the client's functional status that warrant modification of the care plan.
5. **Review Date:** The review date will be posted on the care plan form along with the case manager's initials.

B. Care Plan Update To Case Narrative: The case manager's responsibilities for case narrative are as follows:

1. **Address Goals:** Address each problem/gap listed on the care plan in the case narrative after the semiannual visit.
2. **Progress/Barriers:** The case narrative shall describe progress or barriers encountered.
3. **Instructions:** Refer to section 5 of this chapter, Case Record, for information on case notes.

C. Review Outline: The care plan review will comply with the following guidelines:

1. **Review Date:** The case manager shall visit the client at least semiannually and review the care plan.
2. **Service Needs:** The case manager and client will discuss the following:
 - a. Continuation of current services in relation to the client's identified needs; and/or
 - b. Need for additional services due to changes in condition; and/or
 - c. Acknowledgement of improvements and the corresponding changes in or termination of specific services.
3. **Plan for Services:** The case manager will perform the following tasks regarding client services:
 - a. Review services provided;
 - b. Discuss any changes that need to be made with the client/client's representative, a spouse or caregiver; and
 - c. Revise the care plan as needed.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CASE CLOSURE/SERVICE TERMINATION:

CASE CLOSURE PROCEDURES:

A. Procedures:

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

B. Case Closure:

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

1. **Change in Condition:** The client's condition has declined to the extent that he/she can no longer be safely maintained in the home.
 - a. **Hospitalization:** In the case of hospitalization, the case manager shall maintain contact with the client and hospital social services worker to assist in planning for the client's discharge.
 - b. **Other Placements:** If the client is discharged to a location other than home (i.e. nursing home, assisted living facility, adult family care home or other placement), the case manager shall maintain contact with the client for a three-month period or until such time it is evident that return to the home is no longer possible. Follow-up with the placement facility staff may be completed by correspondence or telephone.
2. **Move Out of County/Service Area:** The case manager shall arrange to transfer client records upon request and communicate with service providers in the client's new area.
3. **Client Death:** The case manager shall close a case upon the death of a client.
4. **Client Ineligibility:** The case manager shall close cases when clients become technically or financially ineligible for services.
5. **Services No Longer Needed:** The case manager shall close cases when services are no longer needed such as the following:
 - a. **Improved Condition:** The client's functional status has improved so that services are no longer required.

- b. **Other Sources Available:** The client's family or other persons are available to assist the client.
- c. **Transfer to Other Program:** The client is transferred to another program.
- d. **Client Request:** The client requests that services be terminated.

C. Responsibilities In Case Closures:

- 1. **Case Manager:** The case manager shall record a brief explanation of the termination reason and the effective date in the case record.
- 2. **Case Management Agency:** The case management agency shall develop and implement the following:
 - a. **Written Notification:** To provide advance written notification to clients when terminating services; and
 - b. **Grievance Rights:** To provide information to clients regarding their right to appeal the decision with the **exception** of the following situations:
 - i. The client has moved out of the service area;
 - ii. The client requested termination;
 - iii. The client has been placed in an assisted living facility or nursing home; or
 - iv. The client has died.
 - c. **Notification Timeframe:** The timeframe for notification shall be established in conjunction with the case management agency's grievance procedures.

CASE RECORD:

PURPOSE OF CASE RECORD:

A. Case Record Purpose: The purpose of the case record is two fold:

- 1. Single Location:** To keep information about the client in a single location; and
- 2. Client Information Retrieval:** To keep the information filed in an orderly fashion for retrieving all pertinent information on a client.

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

- 1. Continuance/Adjustment:** Continuance or adjustment of the client's care plan; and
- 2. Quality Assurance:** The basis for reviewing the client's situation.

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

- 1. Service Planning/Provision:** Plan for and provide appropriate and timely services;
- 2. Update Client Information:** Update information for current and future delivery of services.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CONTENT OF THE CASE RECORD:

The case record shall contain the following items:

A. Assessment Form: Completed client assessment form(s):

1. **DOEA Forms 701A, 701B and/or 701C**, as appropriate;
2. **Updates**; and
3. **Reassessments**.

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

C. Client Authorization: Signed client authorization for release of information form.

D. Case Narrative:

1. **All Case Narratives:** Each narrative entry shall be signed and dated by the case manager who performed the activity. Case narrative entries made by a case aide shall be signed and dated by the aide.
 - a. Case management or case aide services are documented with the actual units of services provided, as well as the time spent on the activity. For billing of case management or case aide services, the time spent in direct service with or on behalf of a client is accumulated on a daily basis. The cumulative amount of time per service is totaled for the day and minutes are rounded up to the nearest quarter of a unit.
 - b. Service logs documenting the delivery of other services provided may be kept in the client file or may be kept in separate files.
2. The case narratives for **Adult Protective Services High-Risk Referrals** require the following additional documentation:
 - a. The specific services authorized and the specific service dates for services provided during the 72 hours following the referral must be recorded. This includes non-DOEA services.
 - b. If services were delayed or not provided, the reason why must be stated and all actions taken in an attempt to provide service must be recorded.

- E. Release of Information:** List of agencies to whom client information has been released.
- F. Co-pay Assessment Form:** Copy of the co-pay form for CCE and ADI clients.
- G. Home Care for the Elderly (HCE) Financial Worksheet:** Copy of the HCE financial worksheet shall be included for HCE clients.
- H. Physician's Assessment/Order:** Copies of the physician's assessment and order if the following services are provided:
 - 1. Home Health Aide;
 - 2. Skilled Nursing;
 - 3. Occupational Therapy;
 - 4. Physical Therapy; and
 - 5. Speech Therapy

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

STANDARDS FOR SECURITY AND PRIVACY OF CASE RECORDS:

- A. Locked Files:** Client records shall be kept in a locked file within the agency.
- B. Client Informed Consent:** The case manager must inform clients of the following:
 - 1. Purpose:** Purpose for which the information is collected; and
 - 2. Manner of Usage:** Manner in which it will be utilized, maintained and disseminated.
- C. Information Obtained:** The case manager shall inform applicants/clients that information obtained about them is:
 - 1. Required** to provide services.
 - 2. Confidential** and protected from loss, defacement, and unauthorized access.
 - 3. Available for review** by applicants/clients and/or their representative.
- D. Case Record Review:** The client and representative/guardian have the right to review the client's case record.
 - 1. Case Manager Responsibility:** The case manager shall review and update the case record before releasing it for the client's review.
 - 2. Case Manager Availability:** The case manager shall be available to discuss the contents of the case record with the client if requested.
 - 3. Method of Case Record Review:** Active case records shall not be mailed to clients. The client may review the record in the case manager's office or, if homebound, request that an authorized staff person bring it to the client's residence for review.
 - 4. Case Record Copy:** The case manager may provide one copy of the case record to the client.

RETENTION OF CASE RECORDS:

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CASE NARRATIVE GUIDELINES:

General Guidelines:

- A. **Reflection of Activity:** Case narratives are completed to reflect activity that relates either directly or indirectly to the implementation of the care plan.
- B. **Framework:** The reviewer should be able to determine the following as it relates to the care plan:
 1. Is the care plan valid?
 2. Are the services appropriate?
 3. Are the services responsive to the client's needs in both duration and intensity?

Case Narrative Sections:

Case narratives shall consist of the following three (3) sections:

- A. **Section 1—Contact Summary:** The following information shall be included in the contact summary:
 1. **Date of Contact**
 2. **Type of Contact:**

<u>Contact:</u>	<u>Abbreviation:</u>
a. Office Visit	OV
b. Telephone Call	TC
c. Field Visit	FV
d. Home Visit	HV

3. **Staff Name:** Name of staff making the contact and person contacted.
- B. **Section 2—Narrative:** A summary of data shall include the following:
 1. **Client's Progress:** The client's progress towards goals.
 2. **Care Plan:** Pertinent data related to the care plan and/or the client's overall situation.

3. **Follow-Up Activity:** Documentation of contacts and other action performed for the client. This includes contacts with external entities and persons as well as agency staffing or other activities performed within the agency that relate directly to the client. Dates of follow-up activity must be documented.
4. **Service Barriers:** Problems encountered in service delivery.
5. **Special Circumstances:** Unique circumstances affecting the case.
6. **Semiannual Contacts:** Each active problem listed in the care plan addressed for each client semiannual contact.
7. **Initial Entries:** Initial entries should reflect the following elements:
 - a. **Available Resources:** Available resources are explored, including involvement of client's family and friends.
 - b. **Client Goals:** Provider is advised of the client's goals (for arranged or referred service only).
 - c. **Consistency:** Service provision is consistent with the care plan.
 - d. **Variances:** Variances from the care plan are addressed including reasons for the change.
 - e. **Other Data:** Any other appropriate data is included.
8. **Assessment Case Notes:** The following applies to case notes taken during the assessment process:
 - a. **Assessment Notes:** Notes taken on the assessment form at the annual assessment or reassessment shall generally serve as case notes for the assessment visit. Any specific information about the client, his/her needs, surroundings, the assessor's observations of the situation, or other information not captured on the assessment form, should be noted in the narrative for the visit, along with the date and the purpose of the visit.
 - b. **Case Note File Entry:** Notes written about the client's problems and needs on the assessment form do not have to be rewritten in the case narrative.

9. Ongoing Narrative: Ongoing narrative must reflect the following:

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Grievance Proceedings

GRIEVANCE PROCEEDINGS:

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Attachment 1: Authorization for Release of Information

Authorization for Release of Information

I, _____, hereby give my consent to release the following information to the _____ representative (name of agency):

1. Any and all information concerning my physical condition, treatment rendered, medical and hospital records, or any other material or information related to my medical history.
2. Any and all social information related to me.

I further authorize _____ to release information to other agencies or persons as they deem necessary in order to arrange services for me under the _____ program.

I understand that the above information is necessary and will only be used by the _____ or its authorized representatives as it pertains to this program.

I further understand that data gathered as a result of my participation in this program will be used in reporting and research; however, my name will not be used.

I also understand that:

1. My refusal to either sign the release of information form or submit needed information may make it difficult to arrange for services to assist me even though I may be considered for this program.
2. If I have had adverse action (termination, suspension, or reduction in service), I may file a grievance.
3. I have the right to inspect my own records and can contest their validity, add data, or request deletion of parts.

Signature

Witness

Date

Date

ABBREVIATIONS FOR TERMS USED IN THE CASE MANAGEMENT PROGRAM COMPARISON MATRIX**Abbreviation:** **Stands for:**

ADI: **Alzheimer's Disease Initiative**

ADLs: **Activities of Daily Living**

IADLs **Instrumental Activities of Daily Living**

CCE: **Community Care for the Elderly**

HCE: **Home Care for the Elderly**

ICP: **Institutional Care Program**

LSP: **Local Service Program**

NH: **Nursing Home**

OAA: **Older Americans Act**

QMB: **Qualified Medicare Beneficiary**

SLMB: **Special Low-Income Medicare Beneficiary**

SSI: **Supplemental Security Income**

Program Service Requirements:

Attachment 2: Case Management Program Comparison

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Program Service Requirements:

Attachment 2: Case Management Program Comparison

COMPONENT	PROGRAM				
	ADI	CCE	HCE	LSP	OAA
CARE PLAN	<p>Uniform Care Plan:</p> <ol style="list-style-type: none"> 1 Indicate review date and initial. 2 Review semiannually. 3 List problems. 4 List service(s) and provider(s): <ul style="list-style-type: none"> A DOEA funded; and B Non-DOEA funded. 5 State frequency and duration of services. 6 State needed services and actual services available. 7 Indicate service(s): <ul style="list-style-type: none"> A Begin date; B End date; C Revised problem date; and D Resolved problem date. 8 Include client, caregiver, and case manager signatures. 9 Update at next semiannual visit for changes. 10 List frequency and duration of case management as a service. 	<p>Uniform Care Plan:</p> <ol style="list-style-type: none"> 1 Indicate review date and initial. 2 Review semiannually. 3 List problems. 4 List service(s) and provider(s): <ul style="list-style-type: none"> A DOEA funded; and B Non-DOEA funded. 5 State frequency and duration of services. 6 State needed services and actual services available. 7 Indicate service(s): <ul style="list-style-type: none"> A Begin date; B End date; C Revised problem date; and D Resolved problem date. 8 Include client and case manager signatures. 9 Update at next semiannual visit for changes. 10 List frequency and duration of case management as a service. 	<p>Uniform Care Plan:</p> <ol style="list-style-type: none"> 1 Indicate review date and initial. 2 Review semiannually. 3 List problems. 4 List service(s) and provider(s): <ul style="list-style-type: none"> A DOEA funded; and B Non-DOEA funded. 5 State frequency and duration of services. 6 State needed services and actual services available. 7 Indicate service(s): <ul style="list-style-type: none"> A Begin date; B End date; C Revised problem date; and D Resolved problem date. 8 Include client, caregiver, and case manager signatures. 9 Update at next semiannual visit for changes. 10 List frequency and duration of case management as a service. 	Follow the criteria for CCE or OAA, as specified in the contract agreement.	For case managed clients, follow the standards for CCE.

Program Service Requirements:

Attachment 2: Case Management Program Comparison

COMPONENT	PROGRAM				
	ADI	CCE	HCE	LSP	OAA
CASE NARRATIVE	Case narratives should include: <ol style="list-style-type: none"> 1 Telephone contacts. 2 Home visits. 3 Case staffings. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Semi annual reviews. 	Case narratives should include: <ol style="list-style-type: none"> 1 Telephone contacts. 2 Home visits. 3 Case staffings. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Semi annual reviews. 7 Units of service for provision of case management. 	Case narratives should include: <ol style="list-style-type: none"> 1 Telephone contacts. 2 Home visits. 3 Case staffings. 4 Client progress on identified problems. 5 Services are consistent with the care plan. 6 Semi annual reviews. 7 Units of service for provision of case management. 	Follow the criteria for CCE or OAA, as specified in the contract agreement.	For case managed clients, follow the standards for CCE.
FORMS	Forms utilized: <ol style="list-style-type: none"> 1 Intake and Assessment 2 Care Plan 3 Co-Pay Assessment Form 4 Release of Information 	Forms utilized: <ol style="list-style-type: none"> 1 Intake and Assessment 2 Care Plan 3 Co-Pay Assessment Form 4 Release of Information 	Forms utilized: <ol style="list-style-type: none"> 1 Intake and Assessment 2 Care Plan 3 HCE Financial Worksheet 4 Release of Information 	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Forms Utilized: <ol style="list-style-type: none"> 1 Intake and Assessment 2 Release of Information
GRIEVANCE	Grievance Procedures: <ol style="list-style-type: none"> 1 Apply to Provider Agency 2 Final Determination with AAA if needed 	Grievance Procedures: <ol style="list-style-type: none"> 1 Apply to Provider Agency 2 Final Determination with AAA if needed 	Grievance Procedures: <ol style="list-style-type: none"> 1 Apply to Provider Agency 2 Final Determination with AAA if needed 	Follow the criteria for CCE or OAA, as specified in the contract agreement.	Grievance Procedures: <ol style="list-style-type: none"> 1 Apply to Provider Agency 2 Final Determination with AAA if needed
HANDBOOK	of Elder Affairs Programs and Services Handbook	Department of Elder Affairs Programs and Services Handbook	Department of Elder Affairs Programs and Services Handbook	Department of Elder Affairs Programs and Services Handbook	Department of Elder Affairs Programs and Services Handbook

Program Service Requirements:

Attachment 2: Case Management Program Comparison

COMPONENT	PROGRAM				OAA (IIIB, IIIC, IIID, IIIE, IIIES, IIIEG, VII)
	ADI	CCE	HCE	LSP	
S E R V I C E S	1 Caregiver Training/Support 2 Case Aide 3 Case Management 4 Counseling (Gerontological) 5 Counseling (Mental Health/ Screening) 6 Education/Training 7 Intake 8 Model Day Care 9 Respite: In-home/ Facility based 10 Specialized Medical Equipment, Services and Supplies	1 Adult Day Care 2 Adult Day Health Care 3 Caregiver Training/Support 4 Case Aide 5 Case Management 6 Chore and Enhanced Chore 7 Companionship 8 Counseling (Gerontological) 9 Counseling (Mental Health/ Screening) 10 Emergency Alert Response System 11 Escort 12 Financial Risk Reduction (Assessment & Maintenance) 13 Health Support 14 Home Delivered Meals 15 Home Health Aide 16 Homemaker 17 Housing Improvement 18 Intake 19 Legal Assistance 20 Material Aid 21 Medication Management 22 Nutrition Counseling 23 Occupational Therapy 24 Other Services 25 Personal Care	1 Adult Day Care 2 Adult Day Health Care 3 Basic Subsidy 4 Caregiver Training/Support 5 Case Aide 6 Case Management 7 Chore and Enhanced Chore 8 Counseling (Gerontological) 9 Counseling (Mental Health/ Screening) 10 Home Delivered Meals 11 Home Health Aide 12 Homemaker 13 Housing Improvement 14 Intake 15 Material Aid 16 Occupational Therapy 17 Other Services 18 Outreach 19 Personal Care 20 Physical Therapy 21 Respite (In-Home & Facility Based) 22 Skilled Nursing Services 23 Specialized Medical Equipment, Services & Supplies 24 Speech Therapy 25 Transportation	Follow the service provisions as specified in the contract agreement.	1 Adult Day Care (IIIB, IIIE) 2 Adult Day Health Care (IIIB, IIIE) 3 Caregiver Training/Support (IIIB, IIIE, IIIEG, VII) 4 Case Aide (IIIB) 5 Case Management (IIIB) 6 Child Day Care (IIIEG) 7 Chore and Enhanced Chore (IIIB, IIIES) 8 Companionship (IIIB) 9 Congregate Meals (IIIC1) 10 Congregate Meals Screening (IIIC1) 11 Counseling (Gerontological)-(IIIB, IIID, IIIE) 12 Counseling (Mental Health/Screening)-(IIIB, IIID, IIIE) 13 Disease Information (IIID) 14 Education/Training (IIIB, IIIE, IIIEG, VII) 15 Emergency Alert Response System (IIIB) 16 Escort (IIIB) 17 Financial Risk Reduction (Assessment & Maintenance)-(IIIE) 18 Health Promotion (IIID) 19 Health Risk Assessment (IIID) 20 Health Risk Screening (IIID) 21 Health Support (IIIB) 22 Home Delivered Meals (IIIC1) 23 Home Health Aide (IIIB) 24 Home Injury Control (IIID) 25 Homemaker (IIIB) 26 Housing Improvement (IIIB, IIIES, IIIEG) 27 Information (IIIB, IIIE) 28 Intake (IIIB, IIIC2, IIIE) 29 Interpreter/Translating (IIIB) 30 Legal Assistance (IIIB, IIIES, IIIEG) 31 Material Aid (IIIB, IIIES) 32 Medication Management (IIID) 33 Nutritional Counseling (IIIC1, IIIC2, IIID) 34 Nutrition Education (IIIC1, IIIC2) 35 Occupational Therapy (IIIB) 36 Outreach (IIIB, IIIC1, IIIC2, IIIE, IIIEG) 37 Personal Care (IIIB) 38 Physical Fitness (IIID) 39 Physical Therapy (IIIB) 40 Recreation (IIIB) 41 Referral/Assistance (IIIB, IIIE, IIIEG) 42 Respite (In-Home & Facility Based)-(IIIB, IIIE) 43 Screening/Assessment (IIIB, IIIC2, IIIE, IIIEG)

Program Service Requirements:

Attachment 2: Case Management Program Comparison

COMPONENT	PROGRAM				
	ADI	CCE	HCE	LSP	OAA
S E R V I C E S C 		<p>26 Pest Control (Initiation, Enhanced Initiation, Maintenance)</p> <p>27 Pest Control (Rodent)</p> <p>28 Physical Therapy</p> <p>29 Respite (In-Home & Facility Based)</p> <p>30 Shopping Assistance</p> <p>31 Skilled Nursing Services</p> <p>32 Specialized Medical Equipment Services, Supplies</p> <p>33 Speech Therapy</p> <p>34 Transportation</p>		Follow the service provisions as specified in the contract agreement.	<p>44 Shopping Assistance (IIIB)</p> <p>45 Sitter (IIIEG)</p> <p>46 Skilled Nursing Services (IIIB)</p> <p>47 Specialized Medical Equipment, Services and Supplies (IIIB, IIIES)</p> <p>48 Speech Therapy (IIIB)</p> <p>49 Telephone Reassurance (IIIB)</p> <p>50 Transportation (IIIB, IIIEG)</p>

CARE PLAN

PAGE ____ OF ____ CONSUMER: _____ SOCIAL SECURITY NUMBER: _____ CASE MANAGER: _____ PROVIDER: _____ WORKER ID: _____		CARE PLAN DATE: _____ _____ _____	DESIRED OUTCOMES: _____ Prevent acute episode or nursing home placement. Short Term(ST), Long Term (LT)	DOEA-FUNDED MONTHLY CARE PLAN COST: ANNUALIZED DOEA-FUNDED CARE PLAN COST: NON-ANNUALIZED DOEA-FUNDED CARE PLAN COST: CO-PAY MONTHLY AMOUNT (circle CCE or ADI): ANNUALIZED CO-PAY AMOUNT: ANNUALIZED NON-DOEA RESOURCE: NON-ANNUALIZED NON-DOEA RESOURCE: Care Plan Total:					
HEALTH CONDITIONS AND SERVICE IMPACT: (a) (b) (c) (d)		CARE PLAN REVIEW: _____ _____ _____ _____	DOEA Funded Source: (1) OAA, (2) MW, (3) ALW, (4) CCE, (5) HCE, (6) ADI, (7) SHINE, (8) Other (Specify) ANTICIPATED SERVICE IMPACT ON HEALTH CONDITIONS: (1) improve (2) maintain (3) decline (4) unknown						
#	Date	Problems/Gaps	Service/Activity	Frequency & Duration Needed: Began (B) Ended (E)	Non-DOEA (ND) / DOEA (D) Planned	Provider: Non-DOEA (ND) DOEA (D)	Date Service: Began (B) Ended (E) Problem: Resolved (RS) Revised (RV)	Unit Cost/ Individual Purchase	Monthly Cost/ Value
<p>I have participated in developing this care plan through discussions regarding my assessed needs, and the services and service providers available to help meet those needs. I understand that the amount of assistance I receive is dependent upon my ability and preference. I understand I am entitled to a grievance review if my services are reduced, changed, or terminated. For Medicaid Waiver services, I accept the services from my choice of enrolled providers, instead of nursing home placement. I understand under Medicaid Waiver, in addition to a grievance review, I am further entitled to a fair hearing. I authorize the provider to release information concerning the services I receive under all programs to the Florida Department of Elder Affairs.</p>									
CONSUMER/RESPONSIBLE PARTY:				CAREGIVER:		DATE:	CASE MANAGER:		DATE:

CARE PLAN

Page _____ of _____			Consumer:			Care Plan Date:			
#	Date	Problems/Gaps	Service/Activity	Frequency & Duration Needed Began (B) Ended (E)	Funded: Non-DOEA (ND) DOEA Funded (D) Planned	Provider: Non-DOEA (ND) DOEA (D)	<u>Date</u> Service: Began (B) Ended (E) Problem: Resolved (RS) Revised (RV)	<u>Unit Cost/</u> <u>Individual</u> <u>Purchase</u>	<u>Monthly</u> <u>Cost/Value</u>

DOEA Form 203B, July 2009

CARE PLAN INSTRUCTIONS

TABLE OF CONTENTS

<u>Section:</u> <u>Topic</u>	<u>Page</u>
I. Overview	2-61
II. Care Planning Concepts	2-62
A. General Concepts	2-62
B. The Four Steps in Developing a Care Plan	2-63
C. Use the Assessment Information	2-64
D. Actively Involve the Client/Client's Representative, Caregiver and Existing Support Systems	2-65
E. Apply Professional Knowledge & Judgment in Using Community Resources	2-66
F. Apply Client Choices & Reflect the Client's Preferences	2-68
III. Completing the Care Plan Form	2-71
IV. Organizing the Care Plan	2-83
V. Care Plan Updates	2-86
VI. Case Narrative	2-87
VII. Case Record	2-88
VIII. Summary	2-90

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

**Attachment 5: Care Plan Instructions
Overview**

OVERVIEW:

Introduction:

This Attachment describes how to develop a care plan. The care plan form, DOEA Form 203A (and DOEA Form 203B for additional pages), is designed to assist the case manager in developing and documenting client care needs, community resources available to meet needs and costs associated with care.

Guiding Principles:

Several principles guide the care plan development:

- A.** Every client should have a current care plan addressing problems identified by the assessment.
- B.** The care plan is based on an assessment as well as observations made between reassessments. It is a holistic evaluation of the client's situation, regarding transportation, finances, medication, mental health, substance abuse, etc.
- C.** The care plan provides a clear picture of the client's needs and identifies services that will be provided to meet the identified needs. It specifies service interventions, frequency and intensity offered, and the expected outcome.
- D.** The care plan will include DOEA-funded services, services provided by insurance companies, family caregivers, local United Way entities, health care taxing districts, and non-DOEA funded services and activities provided by community resources, volunteers, friends and family.
- E.** The client's coping skills and adaptability are assets and should be considered in developing the care plan.
- F.** Client choice and autonomy are important and should be considered in the care planning process.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CARE PLANNING CONCEPTS:

General Concepts:

- A.** Effective care planning is:
 - 1. Client-focused.
 - 2. Derived by the assessment.
 - 3. A team effort with the client/client representative, caregiver, and case manager.
 - 4. Conscious of the cost of care and the safety of the client.

- B.** The resulting care plan will:
 - 1. Respond to the appropriate amount of care required by the client and caregiver, allowing for choices.
 - 2. Be proactive when possible and preventive in nature.
 - 3. Commit a variety of providers to provide services.
 - 4. Include DOEA and non-DOEA funded services and activities.
 - 5. Be for a specific time period, addressing short-term as well as long-term problems.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Attachment 5: Care Plan Instructions
Care Planning Concepts: The Four Steps in Developing a Care Plan

The Four Steps in Developing a Care Plan:

- A.** Use the assessment information.
- B.** Actively involve the client/client representative, caregiver, and existing support systems.
- C.** Apply professional knowledge and judgment in using all community and family resources.
- D.** Apply client choices and reflect the client's preferences.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Attachment 5: Care Plan Instructions
Care Planning Concepts: Use the Assessment Information

CARE PLANNING CONCEPTS: USE THE ASSESSMENT INFORMATION:

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

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Attachment 5: Care Plan Instructions
Care Planning Concepts: Actively Involve the Client/Client Representative, Caregiver
and Existing Support Systems

**CARE PLANNING CONCEPTS: ACTIVELY INVOLVE THE CLIENT/CLIENT'S
REPRESENTATIVE, CAREGIVER AND EXISTING SUPPORT SYSTEMS.**

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

Attachment 5: Care Plan Instructions
Care Planning Concepts: Apply Professional Knowledge and Judgment in
Using Community Resources

**CARE PLANNING CONCEPTS: APPLY PROFESSIONAL KNOWLEDGE AND JUDGMENT
IN USING COMMUNITY RESOURCES:**

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

- A.** Learn as much as possible about the client's situation, including caregivers, employee assistance programs, insurance, etc. With input from the client and caregiver, the case manager can determine if the client can participate in his or her own care, including whether or not the client can pay for some of the services.
- B.** Find out what coping skills the client has and the client's adaptability. Then, decide how much care the client needs, the services the client will receive, and the client's choice in service providers.
- C.** The client should be empowered to choose the services that best meet his/her needs, from service providers of his/her choice. Services should be scheduled in a delivery method that complements the client's lifestyle.
 - 1.** However, when clients need more assistance with managing their care and handling their activities of daily living, it is important to identify help to be provided by family, volunteers, and others.
 - 2.** Consider which DOEA and non-DOEA funded services and activities are available to best meet the client's needs.
 - 3.** Consider all options, including insurance, employee assistance, and faith-based programs.
- D.** Become familiar with the services and community resources available. Following are suggested ways to learn what is available:
 - 1.** Talk with veteran case managers.
 - 2.** Use the resource directories produced by organizations and associations in the area, and the phone book.
 - 3.** Check with local employers and review insurance coverage.

Attachment 5: Care Plan Instructions
Care Planning Concepts: Apply Professional Knowledge and Judgment
in Using Community Resources

- 4.** Contact health care taxing districts, (local government entities which collect funds for a specific cause, such as health care).
- 5.** Contact participants in the local service network, following agency protocols:
 - a.** Senior Centers.
 - b.** Area Agencies on Aging.
 - c.** Community Care for the Elderly provider agencies.
 - d.** Elder Helplines.
 - e.** Department of Children and Families.
- 6.** Consider all sources of help:
 - a.** Families, friends and volunteers.
 - b.** Churches, temples, synagogues or other religious groups.
 - c.** Local service clubs and civic organizations.
 - d.** Local taxing districts.
- E.** Develop a comprehensive list of possible resources. Learn the specifics of services offered by each provider and be aware of eligibility requirements for each.
- F.** Identify a key person and a backup contact with each provider. Write down phone numbers and when key persons are available.
 - 1.** Use available services, including services covered by insurance companies and employee assistance programs.
 - 2.** Consider how to enhance the client's quality of life within the context of his or her life situation.

Attachment 5: Care Plan Instructions
Care Planning Concepts: Apply Client Choices and Reflect the Client's Preferences

CARE PLANNING CONCEPTS: APPLY CLIENT CHOICES AND REFLECT THE CLIENT'S PREFERENCES.

CLIENT AND CAREGIVER DIRECTED OPTIONS:

- A.** Involving the client and caregiver allows for autonomy and choice. Autonomy is self-determination and freedom from unnecessary dependency and having choices in available services and providers. The following guidelines will help:
 1. Find out from the client and caregiver what amount of help is acceptable.
 2. Case management is a required service. Do not mandate other services as a condition for opening the case, if a client does not want a particular service.
 3. Provide enough information about available services and provider options so that the client/client representative and caregiver can make an informed decision.
 4. Do not arrange for others to perform activities that the client or caregiver is able to do.
 5. Exhibit cultural and linguistic sensitivity when working with clients, caregivers, and family members.
 6. Remember clients and caregivers have the right to accept or decline particular services, providers, or other care arrangements.
- B.** Discuss the following topics with the client/client representative and caregiver:
 - 1. Assessment results:**
 - a. Explain the assessment results.
 - b. The assessment results allow the case manager to assist the client to identify service needs and resources that help the client remain living safely in the least restrictive setting, appropriate to the individual's needs.
 - 2. Client goals:**

Document the client's preference in services, providers, and scheduling.

Attachment 5: Care Plan Instructions
Care Planning Concepts: Apply Client Choices and Reflect the Client's Preferences

- a. Discuss the client's coping skills and adaptability to determine how to fill in gaps.
- b. Discuss the client's preference of care to determine desired results.
- c. Understand what the client would like to achieve. What problems does the client currently communicate the need to overcome?

3. Expectations about services:

Inform the client and the caregiver of both DOEA and non-DOEA services and resources available.

- a. Inform the client and caregiver that programs have lists of service providers from which clients may choose.
- b. Discuss the frequency and duration of services to be arranged and the alternatives.
- c. Encourage clients and caregivers to participate in decisions and arrange services according to those which are acceptable and appropriate.
- d. Ask the client and caregiver to identify resources they would like to use.
- e. Emphasize that priority is given to the most frail and that resources are limited.

4. Cost of care:

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

5. Quality assurance:

Inform the client and caregiver that within two weeks following the start of services, a telephone call or visit will be made to determine if services are being provided as planned and if the client is satisfied with services, or if the client wishes to change providers.

- a. Additional contacts may be made as needed, based upon the client's needs.

Attachment 5: Care Plan Instructions
Care Planning Concepts: Apply Client Choices and Reflect the Client's Preferences

- b.** Explain to the client and caregiver that there may be changes, reductions, or terminations in services at the time of the review, based upon the client's needs and achievement of specific goals.
- c.** Talk with the client and caregiver to determine the effects of service delivery in meeting established needs.
- d.** Document all telephone contacts and visits in the case narrative.

6. Client rights:

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

C. A well-developed care plan shall:

- 1.** Address all aspects of the client's care. It represents the client/client representative's, caregiver's, and professional worker's understanding of the situation, based upon the client's needs.
- 2.** Represent the case manager's best professional, objective, and independent judgment, based upon the client's needs.
- 3.** Reflect the client's health conditions, problems, challenges and barriers to problem resolution, outcomes to be attained, and DOEA and non-DOEA funded services and activities provided.
- 4.** Reflect the client's preferences and choice of providers in a document unique to the client.
- 5.** Serve as the information base to measure progress and revise services.
- 6.** Exhibit the caregiver's contributions, maximize other non-DOEA funded services and be used to estimate the cost of needed services and activities.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

COMPLETING THE CARE PLAN FORM:

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

A. General Information:

1. Client Name

2. Social Security Number (SSN)

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

3. Case Manager Name

4. Provider

The provider code is unique for each individual provider within a Planning and Service Area (PSA). The first digit of the provider code usually corresponds to the PSA code.

5. Worker ID:

The worker identification code links the user's ORACLE ID with a provider name and validates the user's access to different screens in CIRTS. A Worker ID must be entered for each person who needs access to CIRTS.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

6. Care Plan Date:

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

7. Care Plan Review Dates:

- a.** Review the care plan every six months or more frequently, if the case manager and supervisor deem it necessary to meet the needs of the client.
- b.** Enter the date and reviewer's initials for each review.

B. Health Conditions and Service Impact:

1. Identify the health conditions documented in the assessment and list them in this section. If more than three conditions exist, list the three, which are most problematic to the client.
2. Conditions which affect the individual's ability to perform activities of daily living determine the degree of frailty and should be included in the care plan.
3. Identify the most appropriate service impact for each health condition and write the corresponding number(s) next to each health condition. Four service impact possibilities are listed on the form.

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

1. Review information provided on the assessment summary to identify problems.
2. List all problems, including medication management and nutritional considerations on the care plan and address them in the case narrative.
3. Challenges and barriers listed in the assessment help to explain why the problem exists.
4. Activities of daily living (ADL) and instrumental activities of daily living (IADL) the client cannot perform independently may cause problems, unless the individual has developed methods of coping and adapting.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

5. Adaptability and coping skills are ways to compensate for deficits and are considered to be resources and assets.
 - a. Resources and assets documented on the assessment summary describe how the client overcomes deficits.
 - b. The use of assistive devices is one means of adapting and employing coping skills.
 - c. Doing activities of daily living in an unconventional or creative way, or allowing others to do certain chores or parts of chores are methods of coping.
 - d. When the individual can use adaptability and coping skills to overcome challenges and barriers, problems may be alleviated or minimized.
6. Gaps exist when problems have been identified, and challenges and barriers cannot be overcome through adaptability or coping skills. Gaps determine service needs.

D. Service/Activity:

1. Identify the specific service or activity to address the gap related to each problem documented on the assessment summary.
2. List both DOEA funded and non-DOEA funded services and activities on the care plan.
3. Services arranged by the case manager or case aide and provided by non-DOEA funded sources must be listed in the care plan.
4. In addition, services which exist at the time of the assessment, not arranged by a member of the case management staff, and provided by non-DOEA funded sources, must be listed in the care plan.
5. Document on the care plan and in the case narrative when a change in the client's service needs or a change in providers occurs.
6. Indicate the date of the change and any unit rate changes on the care plan. Also, notify service providers in writing when changes in service are needed.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

7. Updates are based on changes in the client's health conditions and other circumstances.

E. Frequency and Duration:

1. Record the frequency and duration for services.
 - a. Frequency is how often a service is planned. It is the number of hours, meals, or other units per week, monthly, and annually.
 - b. Duration is how long a service will be provided.
 - i. Services are planned for however long they are needed.
 - ii. Case management can be planned for a year.
 - iii. Other ongoing services can be planned for six months up to a year, since care plans are reviewed semiannually and annually.
 - iv. Services required temporarily or short-term should be planned for shorter periods, such as six weeks to three months.
2. Because of budget restraints and other barriers, services documented on the care plan as needed may not be the same as the services that are planned.
 - a. Needed services represent the frequency and duration of recommended services necessary to address the client's needs to obtain the desired outcomes stated in the care plan.
 - b. Planned services represent the frequency and duration of services, which are actually planned to be provided.
 - c. In order for the care plan to be an accurate reflection of the client's situation, it must be acknowledged that sometimes problems cannot be fully addressed.
 - i. Thus, recognize unmet needs on the care plan and document them in the case narrative.
 - ii. Document all efforts to secure non-DOEA funded services in the case narrative.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

- iii. Enter the begin date and end date for needed and planned services.
- iv. The begin date for needed services must be equal to or prior to the begin date of planned services.

3. When necessary, write “PRN” or “as needed” next to the amount of service noted on the care plan to indicate temporary changes may occur.

- a. Note temporary changes in the case narrative and indicate when these temporary services are terminated.
- b. Specify a duration of three months or less, if it appears the client’s situation may be temporary.
- c. Record permanent changes to the care plan on the form and enter them in CIRTS.

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

F. Desired Outcomes:

1. Enter ST (short-term) or LT (long-term) in the “Desired Outcome” box of the care plan.
 - a. The desired outcome is established for the client based upon the individual’s overall status, not select problems.
 - b. In most situations, the desired outcome is either short-term or long-term.
 - c. In some instances, it is appropriate to enter both ST and LT in the Desired Outcome box because the individual’s overall situation requires varying degrees of assistance.
2. **Short-term outcomes** address immediate concerns.
 - a. The short-term outcome is that the individual’s situation is stabilized and acute episodes or nursing home placement can be delayed or prevented.

Attachment 5: Care Plan Instructions

Completing the Care Plan Form

G. Non-DOEA Funded/ DOEA Funded and Provider:

Document the planned number of hours or other service units in the appropriate column.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

1. Write “ND” for Non-DOEA funded and “D” for DOEA funded. Include the corresponding number for the source.
 - a. Non-DOEA funded sources include family and friends, volunteers, support groups, Medicare, Medicaid, health maintenance organizations (HMO), social health maintenance organization (SHMO), corporation/ employee assistance programs, private insurance, association, religious/ other, and local government.
 - b. DOEA-funded sources include Older Americans Act (OAA), Medicaid Waiver (MW), Assisted Living Waiver (ALW), Community Care for the Elderly (CCE), Home Care for the Elderly (HCE), Alzheimer’s Disease Initiative (ADI), and Serving Health Insurance Needs of Elders (SHINE). “Other” in this section of the form refers to: Local Services Programs (LSP), Respite for Elders Living in Everyday Families (RELIEF) and Long-Term Care Ombudsman Council (LTCOC). The provider refers to the source and the funding method.
2. The following are some examples:
 - a. **Non-DOEA Funded: Example:**

Family and friend	Granddaughter, niece, son, neighbor
Local government and taxing entities	Board of County Commissioners, County Human Resources, City Government, County Taxing District (Health Care Taxing District in Palm Beach), Medicare, Medicaid
Associations/ Religious/ Other	American Diabetes Association, Lutheran Social Services, United Health Maintenance Organization, Volunteer, IBM Corporation, Employee Assistance Program, Private Insurance
Other Non-Profit/ Other	United Way, Habitat for Humanity, Food Bank
Long-term Insurance	Benefits covered under long term care

b. <u>DOEA Funded Provider:</u>	Funding Source:
Older Americans Act (OAA)	Federal
Medicaid Aged and Disabled Adult (A/DA) Waiver	Federal
Assisted Living for the Elderly (ALE) Waiver	Federal
Community Care for the Elderly (CCE)	State
Alzheimer's Disease Initiative (ADI)	State
Home Care for the Elderly (HCE)	State
Local Services Program (LSP)	State
Respite for Elders Living in Everyday Families (RELIEF)	State
Serving Health Insurance Needs of Elders (SHINE)	Federal

c. Assistance may be needed immediately, but not for an extended period of time.

H. Date Services Began (B) and Ended (E):

1. Indicate the date each service began or ended in this column.
2. If a service or activity exists prior to DOEA involvement and is planned to continue, but the date the service began is not known, use the same entry as the problem date for the services begin date.

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

1. Enter the date and "RS" when the problem is resolved and services are no longer needed.
 - a. For example, if the client's problem was an inability to hear because of a lost hearing aid, then replacing the hearing aid resolves the problem and no further service is required.
 - b. Once a resolved or revised date is posted, the problem need not be tracked in the case narrative unless the problem recurs.
2. Enter the date and "RV" when a problem, frequency or duration, service, or desired outcome is revised.
 - a. If the client began receiving two hours a week of personal care services on 8/14/07 and this service was revised to three hours a week on 12/22/07, the care plan would be updated to show the date of the revision.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

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

J. Unit Cost/Individual Purchase:

1. Enter the approved unit rate for the corresponding DOEA-funded service in the unit cost column.
 - a.** The approved rates are based upon those included and approved in the area plan.
 - b.** For an example of a non-DOEA service: If the daughter provides personal care, use the approved DOEA-funded rate for personal care as the non-DOEA funded resource value.
2. If the service is not a service provided by DOEA and the unit rate is not known, a fair market value will need to be computed. There are four suggested ways to figure the needed value:
 - a.** Call at least three sources of the service or activity in the area and average their cost. For example, if three sources of a service charged \$5.00, \$6.00, and \$7.00 per unit, then the fair market value for the service would be \$6.00, (5+6+7=18, divided by 3).
 - b.** Use Web-DB average actual rates from comparable Planning and Service Areas.
 - c.** Use rates from the Mercer study or a similar pricing rate study, or
 - d.** Use market rate surveys as a basis for the determination that suggested rates are reasonable.
3. Enter the individual purchase cost of the item, service or activity, if unit cost does not apply.

K. Monthly Cost/Value:

1. Enter the amount derived from the unit rate multiplied by the planned frequency for costs of DOEA-funded services and activities and for values of non-DOEA funded services and activities.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

2. Record the letter, "c" (cost) or "v" (value) beside the amount entered.
3. Update this information as services begin, end, or their frequencies or unit costs change.
4. Necessary changes should be made in CIRTS at least annually.

L. DOEA-Funded Monthly Care Plan Cost:

Enter the total amount for all DOEA-funded care plan services documented in the Monthly Cost/Value column.

M. Annualized DOEA-Funded Care Plan Cost:

Multiply the number of units planned per week by 52 weeks per year, by the unit cost. Add the total cost of individual periodic purchasing to the annualized care plan cost.

N. Non-Annualized DOEA-Funded Care Plan Cost:

1. Enter the cost of individual purchasing episodes documented in the "Unit Cost/Individual Purchase" column, then show on the plan as the non-annualized DOEA-funded care plan cost.
2. An example of an individual purchasing episode is the repair of a roof or the purchase of a washing machine.
3. Include HCE special subsidy purchases not made monthly.

O. Co-Pay Monthly Amount:

Multiply the monthly co-pay amount by twelve, i.e., \$27.00 X 12 = \$324.00.

P. Annualized Non-DOEA Funded Resource:

1. Enter the total amount for all non-DOEA funded care plan services documented in the Monthly Cost/Value column.
2. The costs of non-DOEA funded sources are not incurred by the state or federal government elderly programs. Thus, non-DOEA funded costs are shown separately.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

3. Non-DOEA funded costs provide crucial information, indicating the value of the agency's use of other resources.

Q. Non-Annualized Non-DOEA Funded Resource:

Enter the value of contributed individual periodic purchasing documented in the Unit Cost/Individual Purchase column, then add the value to the annualized non-DOEA funded resource.

R. Care Plan Total:

Enter the total amount of the care plan, including costs, value of resources, and the co-pay amount.

S. Signature:

1. Sign on the case manager line as the individual developing the care plan.
 - a. The client is to sign the care plan when it is first done, and then once yearly, when reassessed.
 - i. Clients do not have to sign the plan each time there is a revision.
 - ii. Clients must be made aware of and have an opportunity to discuss all revisions.
 - iii. There must be documentation that the client agrees with the revisions.
 - b. If the client is unable to sign the care plan, note that on the signature line.
2. The client's caregiver should sign the form when it is first completed and once yearly, when the client is reassessed.
 - a. Note "HCE" next to the caregiver's signature if the individual is an HCE caregiver.
 - b. The caregiver does not need to sign the care plan each time there is a revision; however, the caregiver must be informed of revisions.

Attachment 5: Care Plan Instructions
Completing the Care Plan Form

3. By signing the care plan, the client acknowledges that he or she has participated in discussions about assessed needs, has helped to develop the care plan, has been given choices to address service needs, and agrees with the care plan provisions.
 - a. Additionally, the client acknowledges that a grievance review can be requested if there is unacceptable change, reduction or termination of services.
 - b. Information must be provided to the client in a language the client can understand and articulate.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

ORGANIZING THE CARE PLAN:

Method One:

A. Long-Term Problems:

Use one page for each long-term problem, (a page per problem).

1. These problems will likely not improve and may require services over a long period of time, i.e., more than 6 months, and may have to be changed or updated throughout the year.
2. Each change or update is shown on a new line of the care plan form.

B. Short-Term Problems:

Use another page to list short-term problems, i.e., 3 to 6 months.

1. These problems will usually improve or be resolved over a short period of time and will not require as many changes or updates during the year.
2. Thus, the “Date Service Began/Ended” column is used most.

C. Example: Long-Term Problem

Health Condition:

The client has emphysema and difficulty breathing when performing activities.

Service Impact on health condition:

Number “2” was selected as the condition may be maintained with intervention.

Problem:

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

Service:

Homemaker services are needed.

Method Two:

- A.** List each problem (short or long-term) on one page in chronological order, including information from the assessment summary related to its challenges and barriers, and the client's coping skills and adaptability.
- B.** Any revisions will also be included chronologically.
- C.** When making revisions to a care plan using this method:
 1. Identify every new entry with the problem number of the original problem statement.
 2. Record a date for each revision followed by "RV" in the "Date Problem Resolved or Revised" column.
 3. If the problem is resolved, record the date of resolution and "RS."

D. Examples:

Short-Term Problem:

Health Condition:

The client has severe arthritis and is limited in her ability to perform physical activity.

Service Impact on health condition:

Number "3" was selected as the condition may decline with intervention.

Problem:

Challenges and barriers to problem resolution are the client's inability to safely get in and out of the bathtub and the caregiver's frailty.

Service:

Home repair service is needed to make the bathtub accessible by installing grab bars.

Long-Term Problem:

Health Condition:

The client has renal cancer, kidney and bladder failure, incontinence problems and is very weak from dialysis. In addition, the client has uncontrolled diabetes.

Service Impact on health condition:

Number "3" was selected as the condition may decline with intervention.

Problem:

Challenges and barriers to problem resolution are the client's inability to drive to the doctor or get around without assistance. The client is also unable to properly manage her health care needs.

Service:

Transportation and home health care are needed services.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CARE PLAN UPDATES:

- A.** Review and update the care plan semiannually.
 - 1. The care plan may be updated more frequently depending upon the client's need for more frequent reviews, such as following a hospitalization, loss of a spouse, or a physical move.
 - 2. During the care plan review, discuss with the client the services provided and determine whether these services meet the client's needs or if changes are required.
 - 3. Review the options and provide choices for the client.
 - a. Are there new problems that need to be addressed?
 - b. Additional problems identified should be added to the care plan.
- B.** Enter "same" or "no change" if some of the columns on the care plan are still accurate and do not need revising or updating, whichever method used. Only the initials of the case manager and review date are required.
- C.** The care plan for each active client will be updated in CIRTS at least annually.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CASE NARRATIVE:

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

1. If no changes are identified, enter a statement covering multiple problems such as, "The client's needs remain the same and all services are continued."
2. Make sure the problem number on the most recent care plan corresponds with the problem number entry which updates the case narrative. There is no need to rewrite the problem statement in the narrative. See the example below:

Problem statement entry from Care Plan:

1. Client is unable to get in and out of the bathtub safely.

Case Narrative Entry Indicating Status of the Problem:

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

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

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

CASE RECORD:

A. Case Record Information:

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

1. **Prioritization Assessment (DOEA Form 701A):** A completed prioritization form if the client was screened prior to the completion of a comprehensive assessment, such as an individual who has been on an assessed priority client list prior to receiving services.
2. **Assessment Instrument (DOEA Form 701B):** A completed and updated assessment form, as well as at least one prior year assessment.
3. **Care Plan Form:** Current and accurate care plan form(s), covering at least the past two years. The form(s) should be signed and dated annually and should reflect the initials and dates of semiannual or more frequent care plan reviews.
4. **Release of Information Form:** A signed authorization for release information form. Written consent is required before any case information may be shared with provider agencies.
5. **Grievance Procedures:** A current notice of grievance procedures, signed and dated by the client, applicable to terminations, suspensions, or reductions in service.
6. **Case Narrative:** A current and accurate case narrative. A current detailed case narrative showing all contacts with the client and the caregiver, and notes regarding the client's progress toward achieving care plan outcomes.
7. **HCE Financial Worksheet:** A financial worksheet for HCE clients. A current and correct form should be included.
8. **Co-pay Assessment Form:** A co-pay assessment form for CCE and ADI clients. A current and correct form should be included.
9. **Specific Forms:** Program specific forms for CCE, ADI, HCE, or OAA. Forms for individual programs should be included.

**Attachment 5: Care Plan Instructions
Case Record**

10. **Other Information:** Any other pertinent information regarding other service providers. Information relative to the client's care, not otherwise captured on a form should be included.
11. **Choice & Options:** Documentation of the choices and options given to the client.

B. Standards for Case Records Maintenance:

1. Client records must be stored in a locked file at the agency.
2. The client must be informed that information collected about the client is required for service provision; the information will be treated in a confidential manner; and will be protected from loss, defacement, or unauthorized access.
3. The client and the caregiver should be told that case record information is available for their review and for the review of individuals they authorize.
4. After case closure, client records shall be retained for a period of six years or longer if required by federal regulations.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK

SUMMARY:

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

THE REMAINDER OF THIS PAGE IS INTENTIONALLY LEFT BLANK