COMMONWEALTH of VIRGINIA
Department for the Aging

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August 23, 2011

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Note: The web addresses (links) in this document may change over time. The Department for the Aging does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.

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11-195

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman, Director of Administrative Services

DATE: August 23, 2011

SUBJECT: White House Memo Urges Agencies to Cut Budgets

The following was reported by NASUAD.

On Wednesday, August 17, 2011, Jacob Lew, Director of the Office of Management and Budget released a memorandum for the heads of departments and agencies throughout the Federal government urging them to cut their 2013 budgets by at least five percent and to identify additional reductions that would cut budgets by at least 10 percent. "In light of the tight limits on discretionary spending starting in 2012, your 2013 budget submission to OMB should provide options to support the President's commitment to cut waste and reorder priorities to achieve deficit reduction while investing in those areas critical to job creation and growth," Lew wrote.

While budget submissions are expected to show lower overall spending, OMB also expects agencies to identify programs that provide opportunities to enhance economic growth to "double down" on. Cutting ineffective or low-priority programs to support investment in these growth programs is a priority for the 2013 budget.

The OMB released mechanisms for efficiency increases, which include: priority investments related to economic growth which the department proposes to expand or protect; cost-saving efforts that will improve operational efficiency and improve the rate of return to taxpayers; explanation of how agencies will acquire, analyze, evaluate, and use data to improve policy and operational decisions; and considerations of duplication and overlap.

The letter in full can be found here.

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11-196

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Joseph D. Hoyle
Policy Analyst

DATE: August 23, 2011

SUBJECT: Article on Medicare's 46th Anniversary

In this Dale City Patch article last week, Brenda Kelley Nelum, a member of the Commonwealth Council on Aging, discusses Medicare and its importance for future generations.

http://dalecity.patch.com/articles/standing-up-for-seniors

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11-197

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

AND: Nutrition Directors
Health Promotion and Disease Prevention Coordinators

FROM: Elaine S. Smith, MS, RD
Program Coordinator

DATE: August 23, 2011

SUBJECT: Smoking Cessation Conference

Registration for VDH's Tobacco Use Control & Healthy Communities Projects and the American Cancer Society Conference on November 3 in Richmond, VA is now open.

To go to the conference website, click Conference Website. To view the conference agenda click VDH TUCP Conference Agenda and click REGISTER to register for the conference.

Please distribute this information to others who may be interested.

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11-198

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: August 23, 2011

SUBJECT: Social Security Field Offices Closing a Half Hour Early

Effective August 15, 2011, Social Security field offices nationwide began closing to the public 30 minutes early each day. For example, a field office that is usually open to the public Monday through Friday from 9 a.m. to 4 p.m. now closes daily at 3:30 p.m.

"While agency employees will continue to work their regular hours, this shorter public window will allow us to complete face-to-face service with the visiting public without incurring the cost of overtime for our employees," said Michael J. Astrue, Commissioner of Social Security. "Congress provided our agency with nearly $1 billion less than the President requested for our budget this fiscal year, which makes it impossible for us to provide the amount of overtime needed to handle service to the public as we have in the past."

Most Social Security services do not require a visit to an office. For example, anyone wishing to apply for benefits, sign up for direct deposit, replace a Medicare card, obtain a proof of income letter or inform us of a change of address or telephone number may do so at **www.socialsecurity.gov** or by dialing our toll-free number: **1-800-772-1213** (TTY 1-800-325-0778).

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11-199

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

AND: Nutrition Directors
Health Promotion and Disease Prevention Coordinators

FROM: Elaine S. Smith, MS, RD
Program Coordinator

DATE: August 23, 2011

SUBJECT: Fairfax Fall Prevention Day

Following is a flyer regarding a Fall Prevention event in September planned by the Fairfax Independent Living Program.

Please distribute this information to others who may be interested.

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Fairfax County's

Independent Living Project

Presents:

Fall Prevention Day

September 16, 2011
The Lincolnia Senior Center
4710 North Chambliss St.
Alexandria, Virginia
(703) 914-0223 TTY 711

Experts in fall prevention will share information on what you need to know to prevent a fall.

10:00-Noon	Resource Tables – Chat with an expert
10:00-10:45 a.m.	Strength and Balance Demonstration
10:45-11:00 a.m.	Medication Safety and Fall Prevention
11:00-11:15 am	Stay Safe With Hearing Loss
11:15-11:30 a.m.	Stroke Prevention
11:30-11:45 a.m.	Body Mechanics
11:45-Noon	Wrap Up

Adults over 60 or adults with physical disabilities are welcome.

Pre-registration is required and space is limited. Call Jennifer Edge at **703-324-7210.** TTY 703-449-1186 or email: **jennifer.edge@fairfaxcounty.gov** For information on how to reach this location using public transportation, visit **www.fairfaxconnector.com** or call 703-339-7200; TTY(703)339-1608 or **www.wmata.com** or (202)637-7000; TTY(202)638-3780

www.fairfaxcounty.gov/dfs/OlderAdultServices

This event is of offered in cooperation with The Lincolnia Senior Center

Fairfax County Partners: Department of Family Services, Division of Adult and Aging Services, Fairfax Area Agency on Aging, ElderLink, Fire and Rescue Department, Health Department: Food Safety, Community and Recreation Services, Library Services, Department of Transportation, and Department of Housing and Community Development **Community Partners:** Virginia Department of Health, Virginia Department for the Aging, Northern Virginia Resource Center for Deaf and Hard of Hearing Persons, Inova Health System, CVS/pharmacy,Walgreens Pharmacy RPJ Housing,, and the Alzheimer's Association, National Capital Area Chapter.

To request reasonable accommodations or this information in an alternate format, call 703-324-5374 , TTY 703-449-1186. July 2011. A Fairfax County, Va. publication.

11-200

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Nancy Lo, GrandDriver Coordinator

DATE: August 23, 2011

SUBJECT: Virginia GrandDriver Program

Be Mobile. Drive Safe.
In 2007, fifteen percent of Virginians were age 60 or older. By the year 2030, that number is projected to reach 25 percent. Seniors are the fastest growing population in the United States, according to the U.S. Census.

If you're over the age of 65, you're also more likely to be seriously injured in a car accident, and twice as likely to be killed in a crash as any other age, as reported by the National Highway Traffic Safety Administration. Natural effects of aging like changes in vision, range of motion, size, hearing, and process and reaction time can affect your ability to drive safely. The Virginia GrandDriver program can offer senior drivers, their families, and loved ones opportunities to learn ways to handle these natural changes and keep seniors independent.

Virginia GrandDriver is an initiative of the Virginia Department for the Aging that provides safe driving tips, self-assessment tools, and driver safety events. The program's main goal is to keep you, as a senior citizen, on the road as long as possible, as safely as possible. GrandDriver understands that for many, driving equals independence.

Go to GrandDriver.net to take the *Stay Mobile, Drive Smart Pledge* with your family members, and promise to take a proactive role in committing to drive safely. Find a local CarFit event in your area so you can ensure your vehicle is up to safety standards. In a quick 15 minute check, a trained CarFit professional will personally inspect your vehicle, making sure it meets the 12-point checklist of safety features, including headrest, mirror, and seat positioning. Don't have a car? No problem, you can still go out and about

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using public transportation with the help of Virginia GrandTrans, which finds the most convenient transportation options in your area.

Driving safely is something every driver should strive for, no matter their age. Virginia GrandDriver recognizes that senior drivers have to compensate for age-related changes, but strives to make this transition a smooth one. Virginia GrandDriver is committed to helping you stay on the road as safely as possible, for as long as possible.

For more information about Virginia GrandDriver visit our website at www.granddriver.net or call 1-800-552-3402.

11-201

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors,
Area Agencies on Aging

FROM: Tim Catherman

DATE: August 23, 2011

SUBJECT: VDA Productivity Measure for March thru May 2011

VDA's productivity measure in Virginia Performs is the percentage of frail older Virginians receiving in-home services that remain in the community one year later. It can be viewed at http://vaperforms.virginia.gov. The productivity measure represents the network's ability to keep frail older Virginians in their home over a one year period. This measure is an attempt to show our network's success in helping seniors remain in their homes and communities and avoid or delay institutional care. We encourage you to monitor your AAA's productivity measure. The first attachment is a chart of the statewide average Since July 2009.

The calculation begins by identifying clients in both PeerPlace and AIM that have 2 or more ADLs and received at least one in-home service such as Adult Day Care, Checking, Chore, Home Delivered Meals, Homemaker, or Personal Care during a certain quarter of the previous year divided by the same clients that received an in-home service in the same quarter one year later. The result is expressed as a percentage. Unfortunately, the measure has consistently declined since its high in October – December 2010. This is likely attributable to the increased attention on timely entering closing codes.

The attached sheet shows the productivity measure for all of the AAAs except Appalachian Agency for Senior Citizens, District Three Senior Services, and Crater District AAA which transitioned to PeerPlace within the reporting period without importing AIM data. Additionally there appears to be an anomaly in Southern AAA's data. The most recent quarter's percentage, March thru May 2011, is 64.12%

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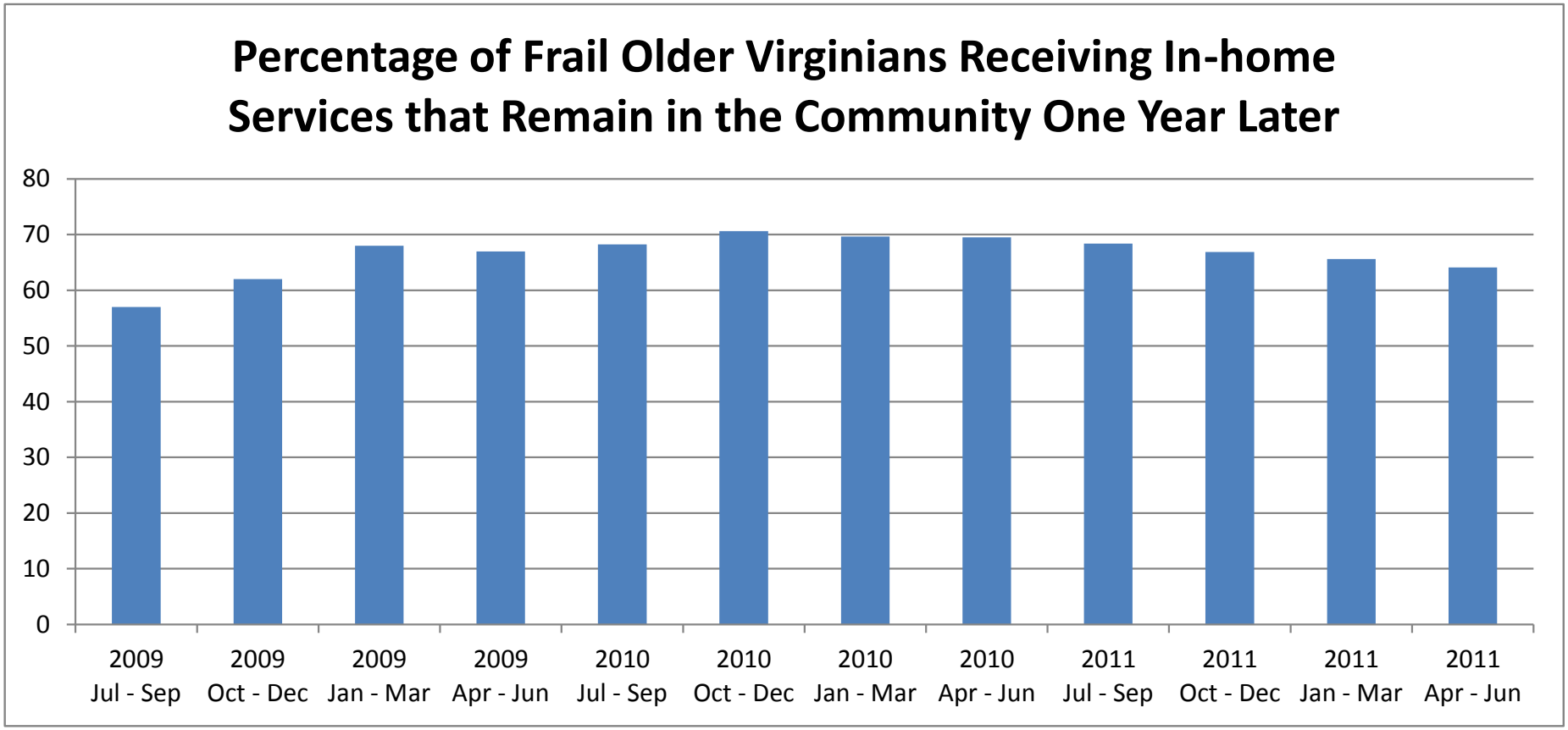
We continue to look forward to improve reporting the impact of the wonderful work you do to help older Virginians remain safe and independent in their homes and communities. If you have any questions about the reporting requirement, please contact Deb Loving by email deb.loving@vda.virginia.gov or phone (804) 662-9323.


Percentage of Frail Older Virginians Receiving In-home Services that Remain in the Community One Year Later
80
70
60
50
40
30
20
10
0
2009 Jul - Sep
2009 Oct - Dec
2009 Jan - Mar
2009 Apr - Jun
2010 Jul - Sep
2010 Oct - Dec
2010 Jan - Mar
2010 Apr - Jun
2011 Jul - Sep
2011 Oct - Dec
2011 Jan - Mar
2011 Apr - Jun

VDA PRODUCTIVITY MEASURE			Unduplicated Totals			ADC			Checking			Chore			HDM			PC			Homemaker			Duplicated Totals		
PSA	PUB	(AIM) AAA Name	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%
8A	107	Alexandria	130	83	63.85%	23	16	69.57%	0	0	0.00%	0	0	0.00%	107	67	62.62%	0	0	0.00%	0	0	0.00%	130	83	63.85%
8B	108	Arlington	196	139	70.92%	0	0	0.00%	0	0	0.00%	0	0	0.00%	164	111	67.68%	36	31	86.11%	0	0	0.00%	200	142	71.00%
8C	109	Fairfax	790	397	50.25%	0	0	0.00%	0	0	0.00%	0	0	0.00%	724	385	53.18%	0	0	0.00%	78	20	25.64%	802	405	50.50%
8D	110	Loudoun	272	137	50.37%	0	0	0.00%	0	0	0.00%	0	0	0.00%	272	137	50.37%	0	0	0.00%	0	0	0.00%	272	137	50.37%
11	114	Central Virginia	426	324	76.06%	0	0	0.00%	0	0	0.00%	0	0	0.00%	380	283	74.47%	0	0	0.00%	70	63	90.00%	450	346	76.89%
12	115	Southern	737	68	9.23%	0	0	0.00%	0	0	0.00%	10	0	0.00%	651	66	10.14%	8	2	25.00%	154	8	5.19%	823	76	9.23%
13	116	Lake Country	434	313	72.12%	5	4	80.00%	384	269	70.05%	0	0	0.00%	320	241	75.31%	9	4	44.44%	53	40	75.47%	771	558	72.37%
14	117	Piedmont	193	165	85.49%	0	0	0.00%	0	0	0.00%	0	0	0.00%	183	159	86.89%	0	0	0.00%	12	7	58.33%	195	166	85.13%
16	119	Rappahannock AAA	228	163	71.49%	0	0	0.00%	12	8	66.67%	0	0	0.00%	137	93	67.88%	0	0	0.00%	92	72	78.26%	241	173	71.78%
22	124	Eastern Shore	154	103	66.88%	0	0	0.00%	0	0	0.00%	0	0	0.00%	142	93	65.49%	11	8	72.73%	8	6	75.00%	161	107	66.46%
		10 AIM agencies reporting	3,560	1,892	53.15%	28	20	71.43%	396	277	69.95%	10	0	0.00%	3,080	1,635	53.08%	64	45	70.31%	467	216	46.25%	4,045	2,193	54.22%
CORRESPONDING DATA FROM VDA VA117:			3,560	1,892	53.15%	28	20	71.43%	396	277	69.95%	10	0	0.00%	3,080	1,635	53.08%	64	45	70.31%	467	216	46.25%			

			Unduplicated Totals			ADC			Checking			Chore			HDM			PC			Homemaker			Duplicated Totals		
PSA	PUB	(PeerPlace) AAA Name	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%	Year Ago	This Qtr	%
1	100	Mountain Empire	418	330	78.95%	67	49	73.13%	74	63	85.14%	0	0	0.00%	212	159	75.00%	76	66	86.84%	126	95	75.40%	555	432	77.84%
4	103	New River	197	133	67.51%	0	0	0.00%	0	0	0.00%	0	0	0.00%	167	108	64.67%	0	0	0.00%	51	41	80.39%	218	149	68.35%
5	104	LOA	562	378	67.26%	2	1	50.00%	0	0	0.00%	0	0	0.00%	544	366	67.28%	10	6	60.00%	18	11	61.11%	574	384	66.90%
6	105	Valley Program	496	284	57.26%	0	0	0.00%	0	0	0.00%	0	0	0.00%	444	263	59.23%	94	42	44.68%	0	0	0.00%	538	305	56.69%
7	106	Shenandoah	120	84	70.00%	0	0	0.00%	0	0	0.00%	0	0	0.00%	74	52	70.27%	39	29	74.36%	24	13	54.17%	137	94	68.61%
8E	111	Prince William	187	88	47.06%	42	25	59.52%	0	0	0.00%	0	0	0.00%	95	42	44.21%	72	31	43.06%	0	0	0.00%	209	98	46.89%
9	112	Rappahannock Rapidan	67	35	52.24%	9	4	44.44%	0	0	0.00%	0	0	0.00%	58	31	53.45%	0	0	0.00%	1	1	100.00%	68	36	52.94%
10	113	JABA	138	87	63.04%	61	32	52.46%	0	0	0.00%	0	0	0.00%	71	48	67.61%	0	0	0.00%	12	8	66.67%	144	88	61.11%
15	118	Senior Connections	293	187	63.82%	8	5	62.50%	8	7	87.50%	0	0	0.00%	270	178	65.93%	13	0	0.00%	1	0	0.00%	300	190	63.33%
17/18	120	BayAging	292	193	66.10%	4	1	25.00%	0	0	0.00%	0	0	0.00%	282	189	67.02%	7	3	42.86%	6	4	66.67%	299	197	65.89%
20	122	Senior Services	268	137	51.12%	0	0	0.00%	0	0	0.00%	0	0	0.00%	227	135	59.47%	47	0	0.00%	9	2	22.22%	283	137	48.41%
21	123	Peninsula	394	251	63.71%	0	0	0.00%	0	0	0.00%	0	0	0.00%	353	236	66.86%	82	34	41.46%	0	0	0.00%	435	270	62.07%
		12 PeerPlace agencies reporting	3,432	2,187	63.72%	193	117	60.62%	82	70	85.37%	0	0	0.00%	2,797	1,807	64.60%	440	211	47.95%	248	175	70.56%	3,760	2,380	63.30%
CORRESPONDING DATA FROM PP STATE RPT			3,428	2,187	63.80%	190	117	61.58%	82	70	85.37%	0	0	0.00%	2,796	1,807	64.63%	440	211	47.95%	248	175	70.56%			

GRAND TOTAL (AIM + PEERPLACE REPORTS):			6,992	4,079	58.34%	221	137	61.99%	478	347	72.59%	10	0	0.00%	5,877	3,442	58.57%	504	256	50.79%	715	391	54.69%	7,805	4,573	58.59%

Revised Date: 07/15/2011

For the Period: 03/01/2011 - 05/31/2011

Produced from AIM Report VA117 and PeerPlace VDA Productivity Measure Staying Home Report

Data is based on clients provided at least one unit of In-Home service during the period (**except deceased**), who also had service during the same quarter last year, had at least 2 ADL's, and have a UAI assessment on file.

Activities of Daily Living (ADL): Bathing, bladder, bowel, dressing, eating, toileting, and transferring.

Appalachian (PSA 2), District 3 (PSA 3) and Crater District (PSA 19) transferred from AIM to PeerPlace with NO Data Migration during the Sep-Nov/2010 reporting period, so they will be omitted from this report until the Sep-Nov/2011 reporting period.

11-202

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: August 23, 2011

SUBJECT: Care Coordination and CCEVP Service Standards

In the Biennium budget passed by the General Assembly for FY 10-11 and FY 11-12, VDA was tasked to collaborate with the AAAs that are authorized to use funding for the Care Coordination for Elderly Virginians Program (CCEVP) to examine and analyze existing state and national care coordination models to determine best practices.
To carry out this directive, VDA convened a work group to examine care coordination models. District Three Senior Services, Prince William AAA, Rappahannock-Rapidan CSB, Central Virginia AAA, Rappahannock AAA and Crater District AAA served on the work group.

As a result of the work group's efforts, four models of support coordination are now approved as options that can be implemented under CCEVP funding. These are Service Coordination Level One, Service Coordination Level Two, S.O.S. and Options Counseling. Attached for your review are the draft service standards for Service Coordination Levels One and Two and S.O.S. The Options Counseling Service Standard has been developed by a separate work group made up of AAA-CIL teams under the AoA Options Counseling Grant.

In addition, VDA has also revised the Care Coordination Title III-B and III-E Service Standard to allow increased eligibility under the OAA definitions of "frail" and "case management."

Please review the draft standards. If you have comments or questions, please send them to Ellen Nau at ellen.nau@vda.virginia.gov no later than **September 15th**.

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Senior Outreach to Services (S.O.S.)

Definition
Senior Outreach to Services (S.O.S.) is a model of service coordination that is designed to provide a mobile, brief intervention that links seniors to supports and services available in their community. Aggressive information and assistance/outreach services are used to reach seniors. A face-to-face interview is conducted with a senior to determine available services that can support him/her living in the community. The seniors are provided aid in accessing and implementing the needed supports and services. Program evaluation is conducted on a regular basis.

Eligible Population
Individuals are eligible for S.O.S. if they are 60 years of age or older and living in the community.

Service Delivery Elements

Program Components:
S.O.S. provider agencies must include the following elements in their programs:

- Resource File:
  S.O.S. service providers must maintain an accurate, up-to-date, and well-organized information system on the opportunities, services and resources available to seniors in the community, including detailed data on service providers.

- Electronic Media:
  The use of electronic media to receive and solicit information via the internet is encouraged in the S.O.S. program.

  Electronic screening tools and web-based systems, such as Virginia Easy Access, Virginia Navigator, BenefitsCheckUp.org and Social Security Administration on-line screening tools can be utilized to benefit the S.O.S. client.

Outreach:
Outreach is the proactive seeking of older persons who may be in need of S.O.S. assistance. Strategies for outreach include, but are not limited to:

- Resource/educational programming provided to congregate housing residents, senior centers, adult day care centers and other locations where seniors gather.

- Service provider information provided to individuals residing in single family homes and congregate housing and to seniors visiting the local Area Agency on Aging seeking services.

DRAFT

Screening/Assessment:
S.O.S. requires a face-to-face interview that informs older persons of available opportunities, services and resources. Screenings/assessments are conducted in the client's home, in community settings, or at the Area Agency on Aging with the older person and, if applicable, with the older person's permission, his or her caregiver.

- The S.O.S. referral form is to be completed in assessments conducted in the client's home and in community settings.

- Home visit and Area Agency on Aging assessments must utilize pages 1 and 4 of the Uniform Assessment Instrument (UAI) (Page 3 optional).

- Community and congregate setting assessments must utilize Page 1 of the UAI or the Quick Form. In the community setting, page 4 of the UAI is to be completed if warranted by the privacy of the setting.

Cost Sharing:
S.O.S. is not a cost sharing program.

Referral/Assistance:
The S.O.S. referral/assistance process includes:

- Advising older persons and their caregivers;

- Providing information to older persons to link them with the opportunities, services, and resources available to meet their needs;

- Assisting the person or caregiver to contact the appropriate community resources; and, if necessary,

- Advocating with agencies on behalf of older persons.

Evaluation:
Program evaluation is an integral part of the S.O.S. model. The process includes, but is not limited to:

- Contacting individuals to determine the outcome of the referral.

- Determining the quality and effectiveness of the referral and the service provided to the person referred.

- Additional assistance to the individual in locating or using needed services may be part of the follow-up.

DRAFT

- Administering, yearly, an anonymous client satisfaction survey to at least 10% of the clients served in the S.O.S. program.

- Aggregating and analyzing information collected through monthly reports and the yearly client satisfaction survey.

Administrative Elements
A qualified service coordinator must administer the S.O.S. program. A qualified service coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills and abilities at entry level. These must be documented on the service coordinator's job application, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct interviews; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; effective oral, written, and interpersonal communication principles and techniques.

- Skills: Service coordinators should have skills in negotiating with consumers and service providers; identifying and documenting a consumer's needs and preferences; identifying services within the established services system to meet the consumer's needs and preferences; and coordinating the provision of services and supports by diverse public and private providers.

- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

Individuals meeting all the above qualifications shall be considered a qualified S.O.S. service coordinator. However, it is preferred that the service coordinator will posses a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition, it is preferable that the service coordinator will have two years of satisfactory experience in the human services field working with older adults or individuals with disabilities.

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It is acceptable for administrative staff to coordinate the Resource/Educational program component of S.O.S.

Units of Service:
Units of service must be reported in Peer Place for each client receiving services. Service units can be reported on a daily basis, but not aggregated (summarized) beyond more than one calendar month. S.O.S. units of service include:

- Persons served (unduplicated);
- The number of referrals made to service providers, including referrals for area agency on aging services;
- Implementations: the number of services implemented and,
- Number of clients (unduplicated) with two or more deficiencies in Activities of Daily Living (ADLs)

Program Monthly Reports

- Aging Monthly Report (AMR) to VDA by the twelfth (12th) of the following month. This report must be updated and submitted even if no expenditures or units of service occurred.
- PeerPlace or AIM client level data transmitted to VDA by the last day of the following month.

Criminal Background Checks:
VDA requires that the agency and their contractors protect clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:
- Staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, techniques for conducting interviews, and procedures for conducting the allowable activities under this service.
- Service coordinators should receive a minimum of 8 hours of in-service training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision/Case Review:
Consultation, supervision and case review shall be available to all staff providing the service.

Client Records:
Service providers must maintain specific program records that include:

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- S.O.S. Referral Form

- UAI – pages 1 and 4 for home visits and area agency on aging assessments; Page 3 is optional. Page 4 of the UAI will be used to determine ADL deficiencies as warranted by the client's condition and status.

- In community and congregate settings, the Quick Form may be used instead of Page 1 of the UAI. Page 4 is to be completed, if warranted by the privacy of the setting. For example, questions related to incontinence may be omitted.

- Consent to Exchange Information Form – consult VDA website for most recent form approved by the Office of the Attorney General of Virginia

- S.O.S. Client/Caregiver Survey Forms

PeerPlace users must make sure that the required data is entered/scanned into that electronic record system.

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Service Coordination Level One
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Service coordination Level One (1) is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.[1] It entails investigating a person's needs, preferences and resources, linking the person to a full range of appropriate services and supports, using all available funding sources, and monitoring to ensure that services specified in the support plan are being provided.

Eligible Population

Service Coordination Level One shall be targeted to those older persons, age 60 years and over, who are deficient in one (1) Activity of Daily Living (ADL). The older individual must be in need of either mobility assistance (either human or mechanical) or suffer from a cognitive impairment, such as Alzheimer's disease or related disorder. Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis.

The Service Coordination Level One Program is part of the state-funded Care Coordination for Elderly Virginians Program and is not an entitlement program. Service Coordination Level One shall be available to the extent that state appropriations allow.

Service Delivery Elements

Service Coordination Level One providers must perform all of the following:

Outreach:

Outreach is the proactive seeking of older persons who may be in need of coordinated services to maintain that older person's living in the community as opposed to an institution.

Intake/Screening

Intake/screening is an initial evaluation of a person's needs for services. The purpose is to obtain enough information to determine the person's likelihood of needing services and whether a full assessment is needed. The information obtained includes the reason for the referral or for the individual seeking help, the informal and formal supports already available, and basic information such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities, in the older person's residence or by telephone.

[1] National Aging Program Information System Reporting Requirements – State Program Report Definitions

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Assessment:

The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning, as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers.

The assessment is conducted prior to provision of any service coordination. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for service coordination and a full Uniform Assessment Instrument is completed. In addition,

- A nutritional screening shall be completed on each client.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Service Planning:

The care plan is the link from the assessment to the delivery of services. Working with the individual and the caregiver(s), the service coordinator develops a plan to: address the problems and strengths identified in the assessment and reflect the person's values and preferences; establish desired person-specific goals; develop a complete list of services and supports to achieve these goals, outline responsibilities of the service coordinator, individual, and informal and formal supports; and identify payment sources for services.

The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of denial into service coordination shall be mailed or conveyed by electronic communication within five (5) working days of completion of the plan of care.

Service Delivery:

Service delivery is the process through which the Service Coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided by outside agencies through collaboration, formal request, or the use of purchase-of-service agreements; coordinating help given by family, friends, and volunteers; and requesting services provided directly by the service coordination agency.

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Monitoring:
Monitoring is the maintenance of regular contact with the individual, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs and preferences change. Contact must be made monthly with the individual for purposes of monitoring the implementation of the care plan.

Reassessment:
Reassessment is the formal review of the individual's status to determine whether their situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs and preferences have changed, the care plan is adjusted. This review is done at least every six months while the individual remains open to care coordination or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s).

If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the individual. The change should be noted on the care plan and in the Service Coordination Level One progress notes. The service coordinator should make two copies of the revised care plan, mailing one to the individual and retaining the other in the individual's support record.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Termination:
Service coordination can be terminated at the discretion of the service provider or the individual. Written notification of termination of service coordination shall be mailed to the individual by the agency 10 business days in advance of the date the action is to become effective.

Administrative Elements

The area agency on aging shall have a written Policies and Procedures Manual for service coordination.

A qualified service coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the service coordinator's job application form or supporting documentation, or observable in the job or promotion interview.

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Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct assessments (including psychosocial, health and functional factors) and use them in care planning; interviewing techniques; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of record documentation; and the service planning process and the major components of a service plan.

- Skills: Service coordinators should have skills in negotiating with consumers and service providers; observing, documenting and reporting behaviors; identifying and documenting a consumer's needs and preferences for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs and preferences; coordinating the provision of services and supports by diverse public and private providers; analyzing and planning for the service needs of older adults and individuals with disabilities, and assessing individuals using the Uniform Assessment Instrument (UAI).

- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

It is required that an individual complete training on the UAI prior to performing Service Coordination Level One.

Individuals meeting all the above qualifications shall be considered a qualified service coordinator; however, it is preferred that the service coordinator will possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition, it is preferable that the Care Coordinator will have two years of satisfactory experience in the human services field working with the older adults or individuals with disabilities.

Job Description: For each paid and volunteer position an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and

- A current description of the minimum entry-level standards of performance for each job.

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Units of Service:

Units of service must be reported in the AIM or PeerPlace database for each client receiving the service. Service Units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours relating to Service Coordination Level One, including travel time for Service Coordination Level One clients. Assessment time is included in hours, if this process leads to Service Coordination Level One. An hour or part of an hour in 15-minute increments is a unit of service.)
- Persons served (unduplicated)

Program Reports:

- Aging Monthly Report (AMR) to VDA by the twelfth (12th) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.
- AIM or PeerPlace client level data transmitted to VDA by the last day of the following month.
- A completed and properly maintained electronic/digital full Uniform Assessment Instrument (UAI) is a mandatory requirement.
- The question "Client in Federal Poverty?" (answer Yes or No) must be asked and recorded.

Organizational Structure:

Service Coordination Level One is a separate and discreet service of an area agency on aging. Service coordinators must be organizationally separate from management of services provided by the agency that the service coordination clients might receive.

Consumer Contributions/Program Income:

The Area Agency on Aging shall formally adopt written policies and procedures, approved by the governing board, regarding the collection, disposition, and accounting for program income.

- Cost Sharing/Fee for Service: Cost sharing/fee for service is permitted for Service Coordination Level One Clients

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation in non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services. [2]

[2] Older Americans Act of 1965 as amended 2006, Section 315(b)

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Quality Assurance:

Criminal Background Checks:

- VDA requires that the agency and its contractors protect clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, arranging services, and monitoring.

- Each staff person must participate in eight (8) hours of in-service training per year. Content should be based on the service coordinator's need for professional growth and upgrading of skills.

Caseload Size:

The ratio of clients to service coordinator must be reviewed annually and is dependent on the following:

- characteristics of the target population served (e.g., very frail, disoriented, without family support);
- complexity of the care plan;
- geographical size of the area covered, taking transportation difficulties into account;
- availability of community-based services; and the extent of responsibility and control over funds that is exercised by the service coordinator.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service. The Case Monitor Section for this service must be utilized in the approved Virginia Department for the Aging electronic data system.

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service and use this analysis to improve the quality of service planning and delivery.

Anonymous client surveys of the service shall be done annually. Surveys should be maintained in an agency file with a summary of the survey results.

Complaint and Appeals:

Service coordination agencies shall have in place a written Complaint Procedures and Appeals Process.

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Client Bill of Rights:
Area Agencies on Aging shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving services and includes basic tenets that should be followed in providing the service. Individuals should receive copies of the bill of rights on commencement of the Service Coordination Level One, and a signed, dated copy must be kept in the individual's support record..

Individual Support Records:
Records must be maintained for all recipients of services. The approved Virginia Department for the Aging electronic record system must contain:

- Consent to Exchange Information Form
- Full Uniform Assessment Instrument (UAI)
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation.
- Care Plan (original and revisions)
- Monthly Progress Notes
- Care Coordination Outcome Report Closing Summary
- The Client Fee recorded in the progress notes
- The Gap Filling Service Form information recorded in the progress notes

The Area Agency on Aging will maintain:

- A copy of the Denial or Termination of Service Coordination Services Letter
- A signed copy of the Client's Bill of Rights/Service Appeals/Termination Policy
- The Client Fee Form
- The Gap Filling Service Form

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Service Coordination Level Two
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Service Coordination Level Two (2) is assistance, either in the form of accessing needed services, benefits, and/or resources or, arranging, in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics, the needed services by providers.[1] It entails investigating a person's needs, preferences, and resources, linking the person to a full range of appropriate services and supports, using all available funding sources, and monitoring to ensure that services specified in the support plan are being provided.

Eligible Population

Service coordination shall be targeted to those older persons, age 60 years and over, who are frail, or have disabilities, or who are at risk of institutional placement. Priority shall be given to older persons who are in the greatest economic or social need and/or residing in rural and geographically isolated areas with particular attention to low-income minority individuals or individuals with limited English proficiency.[2] Such persons shall also be unable to maintain independent living and self-sufficiency in their community due to the inability to define, locate, secure or retain the necessary resources and services of multiple providers on an on-going basis; shall be dependent in two (2) or more activities of daily living; and have significant unmet needs that result in substantive limitations in major life activities.

Service Coordination Level Two is part of the state-funded Care Coordination for Elderly Virginians Program and is not an entitlement program. Service Coordination Level Two shall be available to the extent that state appropriations allow.

Service Delivery Elements

Service Coordination Level Two providers must perform all of the following:

Outreach:

Outreach is the proactive seeking of older persons who may be in need of service coordination. It involves defining and identifying a target population, and devising an outreach mechanism for educating this population about the program. Outreach makes the service known to other providers and helps assure proper referrals and service implementation.

Intake/Screening:

Intake/screening is an initial evaluation of a person's needs for service coordination and/or another service. The purpose is to obtain enough information to determine the person's likelihood of needing service coordination or another service and whether a full assessment

[1] National Aging Program Information System Reporting Requirements – State Program Report Definitions
[2] Older Americans Act of 1965 as amended 2006, Section 306 (a)(4)(A)(i)

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is needed. The information obtained includes the reason for the referral or for the individual seeking help, the informal and formal supports already available, and basic information such as age and income that relates to eligibility for services. Intake/Screening may be provided in the area agency on aging offices, at senior centers and other community facilities, in the older person's residence or by telephone.

Assessment:
The assessment, using the full Uniform Assessment Instrument (UAI), identifies the person's care needs beyond the presenting problem in the areas of physical, cognitive, social and emotional functioning, as well as financial and environmental needs. It also includes a detailed review of the person's current support from family, friends and formal service providers.

The assessment is conducted prior to provision of any further care coordination services. The assessment interview is conducted with the older person and, if applicable and with the person's permission, his or her caregiver(s). It is conducted in the person's residence. If the person is institutionalized or temporarily in another residence, a home visit is conducted after the person's return to the residence. No longer than fifteen (15) working days shall pass between the time a client is referred for care coordination services and a full Uniform Assessment Instrument is completed.

- A nutritional screening shall be completed on each client.
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Service Planning:
The care plan is the link from the assessment to the delivery of services. Working with the individual and the caregiver(s), the service coordinator develops a plan to: address the problems and strengths identified in the assessment and reflect the person's values and preferences; establish desired person-specific goals; develop a complete list of services and supports to achieve these goals, outline responsibilities of the service coordinator, individual, and informal and formal supports; and identify payment sources for services.

The client's agreement with the care plan must be documented. The care plan must be developed within fifteen (15) working days of the completion of the full Uniform Assessment Instrument. Written notification of denial into service coordination shall be mailed or conveyed by electronic communication within five (5) working days of completion of the plan of care.

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Service Delivery:
Service delivery is the process through which the service coordinator arranges and/or authorizes services to implement the care plan. This may involve arranging for services to be provided by outside agencies through collaboration, formal request, or the use of purchase-of-service agreements; coordinating help given by family, friends, and volunteers; and requesting services provided directly by the service coordination agency.

Monitoring:
Monitoring is the maintenance of regular contact with the individual, informal caregivers, and other providers of service. The purpose is to evaluate whether the services are appropriate, of high quality, and are meeting the individual's current needs. Monitoring includes the function of verifying whether a service has been delivered and altering the care plan as the individual's needs and preferences change. Contact must be made monthly with the individual for purposes of monitoring the implementation of the care plan.

Reassessment:
Reassessment is the formal review of the individual's status to determine whether their situation and functioning have changed in relation to the goals established in the initial care plan. Again, service is reviewed for quality and appropriateness. If the person's needs and preferences have changed, the care plan is adjusted. This review is done at least every six months while the individual remains open to care coordination or with any significant change in the person's condition or services. The reassessment interview is conducted with the person in their home and, if applicable and with the person's permission, his or her caregiver(s).

If a change is needed on the care plan prior to the six months reassessment, it can be facilitated with a phone call to the individual. The change should be noted on the care plan and in the Service Coordination Level Two progress notes. The service coordinator should make two copies of the revised care plan, mailing one to the individual and retaining the other in the individual's support record.

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Termination:
Service coordination can be terminated at the discretion of the service provider or the individual. Written notification of termination of service coordination shall be mailed to the individual by the agency 10 business days in advance of the date the action is to become effective.

Administrative Elements
The area agency on aging shall have a written Policies and Procedures Manual for service coordination.

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A qualified service coordinator must possess a combination of relevant work experience in human services or health care and relevant education that indicates the individual possesses the following knowledge, skills, and abilities at entry level. These must be documented on the service coordinator's job application form or supporting documentation, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct assessments (including psychosocial, health and functional factors) and use them in care planning; interviewing techniques; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of record documentation; and the service planning process and the major components of a service plan.

- Skills: Service coordinators should have skills in negotiating with consumers and service providers; observing, documenting and reporting behaviors; identifying and documenting a consumer's needs and preferences for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs and preferences; coordinating the provision of services and supports by diverse public and private providers; analyzing and planning for the service needs of older adults and individuals with disabilities, and assessing individuals using the Uniform Assessment Instrument (UAI).

- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds, and conduct interviews.

It is required that an individual complete training on the UAI prior to performing service coordination.

Individuals meeting all the above qualifications shall be considered a qualified service coordinator; however, it is preferred that the service coordinator will possess a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In addition, it is preferable that the service coordinator will have two years of satisfactory experience in the human services field working with older adults or individuals with disabilities.

Job Description: For each paid and volunteer position an Area Agency on Aging shall maintain:

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- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and

- A current description of the minimum entry-level standards of performance for each job.

Units of Service:
Units of service must be reported in the AIM or PeerPlace database for each client receiving the service. Service Units can be reported on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours relating to service coordination, including travel time for Service Coordination Level Two clients. Assessment time is included in hours, if this process leads to service coordination. An hour or part of an hour in 15-minute increments is a unit of service.)
- Persons served (unduplicated)

Program Reports: Aging Monthly Report (AMR) to VDA by the twelfth (12th) of the following month. If the area agency on aging provides this service, this report must be updated and submitted even if no expenditures or units of service occurred.

- Aim or PeerPlace client level data transmitted to VDA by the last day of the following month.
- A completed and properly maintained electronic/digital full Uniform Assessment Instrument (UAI) is a mandatory requirement.
- The AIM question "Client in Federal Poverty?" (answer Yes or No) must be asked and recorded.

Organizational Structure:
Service Coordination Level Two is a separate and discreet service of an area agency on aging. Service coordinators must be organizationally separate from management of services provided by the agency that the service coordination clients might receive.

Consumer Contributions/Program Income:
The Area Agency on Aging shall formally adopt written policies and procedures, approved by the governing board, regarding the collection, disposition, and accounting for program income.

- Cost Sharing/Fee for Service: Cost sharing/fee for service is permitted for Care Coordination for Elderly Virginians Program Service Level Two Clients.

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation in non-coercive.

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Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services. [3]

Quality Assurance:

Criminal Background Checks:

- VDA requires that the agency and its contractors protect clients by conducting criminal background checks for staff providing any service where they go to or into a client's home.

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, arranging services, and monitoring.

- Each staff person must participate in eight (8) hours of in-service training per year. Content should be based on the service coordinator's need for professional growth and upgrading of skills.

Caseload Size:

The ratio of clients to service coordinator must be reviewed annually and is dependent on the following:

- characteristics of the target population served (e.g., very frail, disoriented, without family support);
- complexity of the care plan;
- geographical size of the area covered, taking transportation difficulties into account;
- availability of community-based services; and the extent of responsibility and control over funds that is exercised by the service coordinator.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service. The Case Monitor Section for this service must be utilized in the approved Virginia Department for the Aging electronic data system.

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service and use this analysis to improve the quality of service planning and delivery.

Anonymous client surveys of the service shall be done annually. Surveys should be maintained in an agency file with a summary of the survey results.

[3] Older Americans Act of 1965 as amended 2006, Section 315(b)

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Complaint and Appeals:
Service coordination agencies shall have in place a written Complaint Procedures and Appeals Process.

Client Bill of Rights:
Service coordination agencies shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving service coordination and includes basic tenets that should be followed in providing the service. Individuals should receive copies of the bill of rights on commencement of Service Coordination Level Two, and a signed, dated copy must be kept in the individual's support record.

Individual Support Records:
Records must be maintained for all recipients of services. The approved Virginia Department for the Aging electronic record system must contain:

- Consent to Exchange Information Form
- Full Uniform Assessment Instrument (UAI)
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation.
- Care Plan (original and revisions)
- Monthly Progress Notes
- Care Coordination Outcome Report Closing Summary
- The Client Fee recorded in the progress notes
- The Gap Filling Service Form information recorded in the progress notes.

The Area Agency on Aging will maintain:

- A copy of the Denial or Termination of Service Coordination Services Letter
- A signed copy of the Client's Bill of Rights/Service Appeals/Termination Policy
- The Client Fee Form
- The Gap Filling Service Form

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