Department for the Aging

Caregiver Services

Standards of Operation and Scope of Services

Based on standards set by the New York City Aging (NYC Aging) and the New York State Office for the Aging.

Updated October 2025

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Introduction

The Title III-E National Family Caregiver Support Program (NFCSP) is part of the Older Americans Act (OAA). NYC Aging-funded caregiver programs assist family and other informal caregivers to care for loved ones at home. The caregiver and the care receiver together form the service "dyad." The caregiver is always the primary client. Long-distance caregivers are served when the care receiver lives in the program's catchment area. The core service components are: **Caregiver Information (Public); Assistance: Case Management (Caregiver); Assistance: Information & Assistance; Caregiver Counseling; Caregiver Support Groups; Caregiver Training; Respite Care; Supplemental Services.** (See Attachment A for definitions of these services).

These standards are applicable to all NYC Aging-funded Caregiver Programs. Caregiver Programs are also required to comply with NYC Aging's General Standards of Operation found at:
https://www.nyc.gov/assets/dfta/downloads/pdf/community/General-Program-Standards-v02-01-2023.pdf

All Caregiver programs must use NYC Aging's client tracking system to register participants and to document service provision.

Section 1. Target Population and Eligibility

Standard 1: Eligibility

The Caregiver program serves eligible individuals in its service area who need caregiver services.

Compliance 1.1. The program serves any caregiver who meets the following eligibility criteria:

- Caregiver is an adult family member or other informal caregiver aged 18 and older, providing care to individual(s) aged 60 and older;
- Caregiver is an adult family member or other informal caregiver aged 18 and older, providing care to individual(s) of any age with Alzheimer's disease and related disorders (e.g., dementia, traumatic brain injury, mild cognitive impairment, and chronic traumatic encephalopathy);
- Caregiver is an older adult relative (not the care receiver's parents) aged 55 and older, living with, and providing care to children under the age of 18; and
- Caregiver is an older adult relative (including the care receiver's parents), aged 55 and older, living with, and providing care to adult(s) aged 18 to 59 with disabilities.

Standard 2: Target Population

The program serves its priority and target population.

Compliance 2.1. The program targets caregivers who demonstrate the greatest economic and social needs:

- Persons of Black, Hispanic, Asian, Native American (American Indian), Alaska Native, Native Hawaiian or Other Pacific Islander origins, and Persons whose origins are of 2 or More Races.
- Persons with incomes at or below 150% of the poverty level.
- Persons with one or more functional deficits in the following areas:
    - Physical functions
    - Mental functions
    - Activities of daily living (eating, bed/chair transfer, dressing, bathing, toiletry and continence); and/or

    - Instrumental activities of daily living (meal preparation, housekeeping, shopping, medications, telephone, travel, and money management).
- Persons with a deficit of social resources, those who are isolated socially, linguistically, or geographically, and/or those affected by other environmental conditions including the following:
    - Language barriers- Limited English Proficiency (LEP);
    - Persons with disabilities;
    - Institutionalized or at risk of institutionalization;
    - Lesbian, gay, bisexual, transgender (LGBT) older adults;
    - Low literacy;
    - Homebound; and,
    - Alzheimer's or other Dementia.

Section 2. Informed Consent and Confidentiality

Standard 3: Informed Consent and Confidentiality

The program obtains informed consent from clients. (See also General Program Standards, Section 2)

Compliance 3.1. Consent to Collect Personal Information. The program obtains signed consent to collect and record data forms from individuals (both caregivers and care receivers) before any personal identifying information is entered into the NYC Aging client tracking system.

- Signed consent is required for all services that will require an intake or assessment.
- When the initial contact is via telephone, verbal consent is accepted and documented in order to proceed with an intake. Signed consent must subsequently be obtained during the initial in-person visit or through other means if necessary, such as via mail, email, or fax.
- If the client withdraws from the service before an in-person visit can be made or signed consent is obtained, the program enters a note in the client's record in NYC Aging's client tracking system and immediately closes the case.
- Verbal consent is acceptable for clients who receive information only. Receipt of verbal consent must be documented and entered into NYC Aging's client tracking system.

Compliance 3.2. Consent to Refer and Share Personal Information. The program obtains signed consent to refer and share personal information before any information is shared for referral or other purposes.

- The program obtains a signed consent to refer and share information within ten (10) business days of an initial assessment. If not obtained within the required timeframe, program must document the reason for the delay.
- If a respite and/or supplemental care client refuses to sign the consent to share/refer, the client is considered to have refused services. This is explained to the client, and if no other assistance is needed, the case is closed/inactivated in NYC Aging's client tracking system.

Compliance 3.3. Revocation of Consent. Client consent is in effect until consent is revoked. If a client revokes consent, that client is considered to have refused service. Any client data shared while consent was in effect cannot be rescinded retroactively, and no client data files may be deleted from NYC Aging's client tracking system.

Compliance 3.4. Mental capacity. Until a person is legally declared mentally incapacitated, the program assumes that they have the capacity to provide informed consent. The caregiver may provide consent on behalf of the care receiver.

Compliance 3.5. Minors/Children. The program may obtain consent from the legal parent or guardian to collect data for children being served by the caregiver program. The program must document the relationship between the caregiver and child being served. If the child is under the care of a kinship caregiver and legally resides with the caregiver who is making other decisions on behalf of the child, then consent may be provided by the caregiver.

Compliance 3.6. Documentation of Consent. The program utilizes the NYC Aging approved consent forms. The program uploads all signed consent forms in the client's record in NYC Aging's client tracking system. Electronic signatures are acceptable.

Compliance 3.7. Consent for non-English Speakers. Consent documents are provided to clients in the language understandable to them.

- If necessary, the program uses a qualified interpreter to aid in the consent process. (See General Program Standards, Standard 9.1)

Compliance 3.8. Client Privacy. The program only shares caregiver and care receiver information with consent, and only: (1) when pertinent to service provision, (2) when requested by authorized agency personnel and/or government representatives in connection with program monitoring, or (3) when legally required to be disclosed by virtue of subpoena, court order, or otherwise. If the program is legally required to disclose any information or records, the program shall provide notice to NYC Aging of such required disclosure.

Section 3. Scope

Standard 4: Public Information

The program provides information to the public about caregiver services and to the target population. (*See Service Definition*)

Compliance 4.1. The program provides public information in accordance with the following requirements:

- Public Information is a planned effort to provide the public with information about services, resources, and entitlements. Such efforts ensure the representation of caregivers' needs and concerns, and highlight the economic, social and cultural diversity among clients.
- Public Information activities include the distribution of newsletters, flyers, pamphlets, and brochures, the use of digital, print, and social media for news, features, public activities, and public presentations by a caregiver program.
- Public Information activities are initiated by the program for the purpose of identifying potential caregivers and encouraging their use of services and benefits. Tabling at a health event or a virtual resource fair/expo may be counted as Public Information.

Compliance 4.2. Public Information Units are captured as Aggregate Events in the NYC Aging client tracking system, and the estimated audience size is captured for each public information activity.

Standard 5: Assistance: Information and Assistance

The program provides information and assistance to caregivers.

Compliance 5.1. Information and Assistance refers to providing information, one-to-one, about available services and opportunities in the community. The information provides family caregivers with instructions on locating and

obtaining resources on their own. The service includes assisting the family caregiver in defining problems/needs and capacities, and facilitating linkage to services to address the problems/identified needs. When appropriate, assistance may also involve worker intervention, negotiation, and advocacy with providers on the family caregiver's behalf to ensure the delivery of needed services and benefits. Follow-up is included. (*See Service Definition*)

Compliance 5.2. Information and Assistance Only Contacts. The program enters Information and Assistance Only Contacts in NYC Aging's client tracking system. Information and Assistance Only Contacts are family caregivers that make one touch contact with the caregiver program. If a family caregiver reaches out more than once for Information & assistance, the caregiver program should consider completing an intake to register the family caregiver as a registered client that regularly receives information and assistance services.

- If caregiver discloses their name and contact information the unit of Information & Assistance can be captured via Client Profile units. If the contact is anonymous then the unit can be captured via Event Profile -Information & Assistance Bulk unit entry.

Compliance 5.3. Promoting Role Identification. The program enhances role awareness of family caregivers who do not identify as family caregivers.

Compliance 5.4. The program provides assistance to family caregivers to obtain access to available services and resources in their community, including assistance with completing forms for benefits.

Standard 6: Assistance: Case Management

Compliance 6.1. Program staff with case management experience conduct a comprehensive assessment of the family caregiver using the required assessment tool. Results of the assessment are documented and used to prepare an appropriate caregiver support plan and to coordinate services that will meet the existing needs.

Standard 7: Intake

The Caregiver program screens each inquiry for eligibility and conducts an intake if the caregiver is accepted for service.

Compliance 7.1. Persons conducting screening/intake are skilled interviewers who provide a consumer-friendly introduction to the program (e.g., reassuring tone, informative, and timely response).

Compliance 7.2. Persons making initial inquiries are interviewed in sufficient depth to determine eligibility (see Standard 1). Note: The program may accept supporting documentation that the caregiver meets eligibility requirements from the referring social service provider (e.g., case management agency or health care provider).

Compliance 7.3. The program determines whether:

- To open a case or provide information and/or a referral for independent follow-up.
- The family caregiver lives in the service area or should be referred to another caregiver program. *Note: If the family caregiver does not live in the program's service area but the care receiver does, the program may provide services to the caregiver in order to assist the care receiver.*

Compliance 7.4. The intake lays the groundwork for developing a trusting relationship with the family caregiver and is used to:

- Conduct a preliminary evaluation of the family caregiver's needs, strengths and preferences;
- Identify and document the immediate need(s) of the family caregiver; and

- Provide preliminary information about available services to help the family caregiver make informed choices.

Compliance 7.5. The program ensures ease of access through telephone, direct contact (walk-in), website, and email, with 7 days/24 hours message capability.

Compliance 7.6. When an intake interview is conducted and consent obtained, the family caregiver is registered into NYC Aging's client tracking system and becomes a client. An intake is opened to enter the information collected and is an initial agreement for ongoing services. If the client is to receive respite or supplemental services, the care receiver's information must also be captured in NYC Aging's client tracking system and appropriate consents obtained for the care receiver.

Standard 8: Assessments and Reassessments

The Caregiver program conducts an initial assessment, performs brief check-ins and completes reassessments as required.

Compliance 8.1. Case Assignment. Each family caregiver is assigned a worker by the program supervisor, who serves as their primary contact.

Compliance 8.2. Initial Assessment. The program completes an assessment within ten (10) business days of the intake interview, using the required assessment tools. If the program is unable to assess a client within the required ten (10) business days, the program must document the reason for delay in the assessment tool in the client's electronic file.

- Caregiver assessments are conducted by an individual who is trained in case management, as required by NYSOFA.
- The purpose of the assessment is to document the needs of the caregiver in a holistic manner that results in a support plan appropriate for the caregiver.
- Initial assessment is used to gain a complete picture of the caregiver/care receiver dyad, including supports, resources, concerns, skills and abilities, limitations, and coping strategies. With the family caregiver's permission, the program may involve formal or informal contacts in the assessment process to gather information. The relationship of the family caregiver to these contacts is documented in the family caregiver's electronic record. A complete caregiver assessment must be offered for all caregivers receiving services.
- If the family caregiver refuses to be assessed, the following services may still be offered: Information and Assistance, Caregiver Counseling, Caregiver Support Groups, and Caregiver Training. However, the minimum required data for Caregiver Counseling, Caregiver Training, must still be collected (age, gender, race, ethnicity, zip code, poverty status, and caregiver/care receiver relationship). A complete caregiver assessment, initial in-home visit and support plan must be provided for clients receiving Respite and/or Supplemental services. The care receiver may be required to complete other assessments and/or paperwork depending upon the respite care services received.

Compliance 8.3. Assessment for Respite and Supplemental Services. The initial assessment for any family caregiver for respite and supplemental services must include an in-home visit and support plan. If the caregiver and care receiver do not reside together, the in-home visit is conducted at the home of the care receiver. If for any reason the caregiver declines an in-home visit, the program must reach out to their NYC Aging program officer for guidance, and document both in the client's electronic file their contact with NYC Aging program officer and the client.

Compliance 8.4. Financial Assessment. The program reviews financial information for the care receiver and/or family caregiver to determine financial eligibility for benefits or entitlements, and to assist with long term care planning and other services. If the family caregiver or care receiver refuses to provide financial information, refusal is noted in the

caregiver's record and program documents the discussion on the long-term service options with the caregiver. Caregiver services may still be provided. The program is to discuss and document benefits and entitlement information is still provided to the caregiver.

Compliance 8.5. Monitoring Calls. Periodic check-ins are conducted every three (3) months and nine (9) months to discuss status of support plan and any new needs for the caregiver and care receiver. On-going three months (3) check-ins are conducted until the case is closed. Case notes are completed by staff after conducting each check-in within five (5) business days.

Compliance 8.6. Reassessments. At least every six (6) months, the program conducts a reassessment using the required assessment tools, until the case is closed. The purpose of the reassessment process is to establish a rapport with the family caregiver and to measure outcomes to ensure that the needs are being met. The reassessment should reflect any changes in the needs of the family caregiver and care receiver since the initial assessment or since the last check-in contact. Adjustments to the caregiver support plan are made, as needed, based on changes to the family caregiver's most recent status and situation.

Compliance 8.7. Reassessment may be conducted via telephone or web-based platforms, unless multiple concerns have been identified. The reassessment is conducted in-home, if appropriate.

Compliance 8.8. Event-Based Reassessment . The program conducts an event-based contact upon notification by the family caregiver, or when changes in a family caregiver's or care receiver's condition or situation require a new caregiver support plan. Examples of situations requiring an event-based reassessment include a major change in health, functional capacity, financial situation, social or physical environment, or formal/informal support system. The program conducts the event-based reassessment particularly for those caregiving dyads receiving respite and/or supplemental services. The event-based reassessment may be conducted virtually.

Compliance 8.9. Client Rights. The worker reviews a statement of Client Rights with the caregiver each time an assessment is conducted, and the caregiver is given a copy. The program must obtain written approval from NYC Aging to make any changes to the Client Rights statement.

Standard 9: Support Planning

The Caregiver program develops service details in the Caregiver Support Plan, based on the assessment of family caregiver needs.

Compliance 9.1. The worker who performs the assessment completes the caregiver Support Plan. When appropriate, other support staff may assist with data entry if needed.

Compliance 9.2. Assigned workers provide information and counseling about available services to help family caregivers make informed decisions/choices.

Compliance 9.3. Service details address the full spectrum of the family caregiver's needs and specified preference through direct services and referrals to programs. The service details specify:

- Services the program will provide, and when applicable, the number of sessions, duration of each session (i.e., type(s) of training/education) and frequency, where relevant to counseling and/or support groups;
- Linkages to other NYC Aging-funded services (e.g., case management, elder abuse services, friendly visiting, and geriatric mental health); and
- Linkages to non-NYC Aging-funded medical, non-medical and other community services.

Compliance 9.4. The Support Plan reflects knowledge of family caregiver needs at different stages in the caregiving process or following a change in care receiver's status (e.g., when a critical event creates a new need for or adjustment to family caregiver services and the family caregiver must learn new skills/coping strategies).

Compliance 9.5. The Support Plan supports family caregiver's strengths, health, mental health, and meaningful engagement in activities unrelated to their caregiving responsibilities.

Compliance 9.6. The Support Plan incorporates long-term planning for the family caregiver and care receiver, as appropriate. It includes one or more required goals, (a) desired outcome(s) and a plan to achieve the goal(s) and outcome(s).

Compliance 9.7. The Caregiver Support Plan must include one or more of the following goals:

- Reduce caregiver stress;
- Improve mental health;
- Improve physical health;
- Feel better supported in caregiving role;
- Make more time for self;
- Practice self-care;
- Seek out support;
- Decrease social isolation;
- Improve overall financial well-being;
- Improve understanding of the disease process;
- Maintain care receiver safely in the home environment; and/or
- Other.

Compliance 9.8. The Caregiver Support Plan shall include (a) desired outcome(s) and a plan to achieve the goal(s) and outcome(s), such as:

- Decreased levels of caregiver burden.
- Improved caregiver mental and physical health.
- Improved confidence in caregiving abilities.
- Improved knowledge of community resources.

Compliance 9.9. The program utilizes, when necessary, supplemental tools, including the Loneliness Scale, Patient Health Questionnaire (PHQ-9), Nutrition Screen, Generalized Anxiety Disorder Screening Tool (GAD-7), and the CAGE substance abuse screening tool.

Compliance 9.10. Coordination with Referral Sources. The program communicates and coordinates with referral sources to ensure seamless receipt and continuity of services.

Compliance 9.11. The family caregiver, and care receiver when appropriate, agree to the Caregiver Support Plan.

Standard 10: Supervisory Review
Program supervisors ensure comprehensive casework by workers.

Compliance 10.1. Initial Assessment Supervisory Review Timeframe. The supervisor reviews and signs off on each family caregiver's case, including intake, assessment, assessment summary case notes, and Caregiver Support Plan. Supervisor signs off no later than ten (10) business days after each family caregiver assessment is completed.

Compliance 10.2. Six (6) Months Supervisory Review. The supervisor reviews and signs off on each family caregiver's case file, including case notes since the last assessment, at least once every six (6) months, or more frequently should a need be identified, and the case is discussed during Supervision.

Standard 11: Caregiver Feedback and Quality Assurance

The program provides opportunities for input from clients.

Compliance 11.1. By no later than the end of the 3rd quarter of each fiscal year, the program conducts a quality assurance survey to evaluate the caregiver satisfaction, summarizes the results of the survey, and indicates what steps the program will take to address areas of dissatisfaction and client feedback. (See Attachment B for copy of the quality assurance survey that must be utilized.) A summary of the survey results is provided to NYC Aging no later than May 31 of each year.

Compliance 11.2. The program conducts a review of a sample of participant case records annually. This process is for program to ensure compliance with program standards are being met in preparation for NYC Aging Annual Program Assessments.

Standard 12: Resource Development

The program maintains and updates information on resources for caregivers to support and facilitate its linkage function.

Compliance 12.1. Cultivation of Referral Sources. The program identifies and cultivates appropriate referral sources – e.g., health and social service agencies, home care providers, civic and religious groups, older adult centers, hospital discharge units, NORCs, case management agencies, adult day services, family life centers, libraries, schools, PTA's, elected officials and community boards, retailers, and other entities that have contact with family caregivers. Where necessary, the program educates potential referral sources on how to recognize caregivers in need by conducting informational meetings or public information sessions.

Standard 13: Caregiver Counseling, Support Groups and Training

Caregiver Counseling, Support Groups and Training refer to a range of individual and/or group services that are intended to assist family caregivers in gaining knowledge and skills related to their caregiving role. *(See Service Definition)*

Compliance 13.1. Counseling. This service may be provided on an individual basis or in a group setting. There are many different types of counseling and can include mediation, grief counseling, etc. Units of counseling are captured in increments of 15 minutes in the NYC Aging client tracking system.

Compliance 13.2. Support Groups. Support groups can be short or long-term, and can be in-person, on-line and/or by telephone. Support Groups can be designed for anyone in a caregiving role, be disease-specific, or be based on the caregiving relationship (e.g., spouse, child). They must be structured and provide an agenda, a stated goal and purpose, and a summary. Summary of support group meetings/discussions and notes on participant progress must be recorded and signed off by facilitator and supervisor. Support groups are geared toward caregivers and does not include care receiver participation.

Compliance 13.3. Caregiver Training. Training programs may be delivered in one session or in a series. Training topics are geared toward supporting the family caregiver in their caregiving role. Topics can range from skills related to assisting care receivers with their activities of daily living, legal issues such as powers of attorney or living wills, managing difficult behaviors, stress management, etc.

Standard 14: Respite Services

Respite temporarily relieves family caregivers from their caregiving responsibilities by providing a brief period of rest for caregivers. Respite service may be provided directly by the caregiver program or through a sub-contractor. *(See Caregiver Service Definition)*

Compliance 14.1. Respite Eligibility. In order for the family caregiver to be eligible to receive respite services, the family caregiver must be caring or coordinating care for a care receiver who either:

1. Requires substantial assistance with at least two Activities of Daily Living (ADLs) or
2. Is in need of extensive supervision and/or monitoring resulting from cognitive impairment.

Compliance 14.2. The program ensures that allocation of respite services is equitable, with particular consideration given to those in greatest social and/or economic need. If costs for respite or supplemental services exceeds the threshold communicated by NYC Aging, the program must obtain prior approval from their NYC Aging program officer before proceeding with the purchase(s).

Compliance 14.3. When the long-term care need will exceed the NFCSP respite capacity, the worker explores with the caregiver other forms of home care such as Expanded In-home Services for the Elderly Program (EISEP) and/or Medicaid eligibility. Note: Respite is a limited time service and thus each family caregiver should be assessed and reassessed to determine the specific level of respite need.

Compliance 14.4. Types of Respite. The program makes available the following types of respite services:

- **In-home Respite**, including but not limited to housekeeping and personal care, provided in the care receiver's home setting, and obtained from a home care program licensed by the New York State Department of Health (DOH).
- **Out-of-home Respite (Day)** for the care receiver, including medical model and social model adult day services provided in a setting other than the family caregiver/care receiver's home, including adult day care, or other non-residential setting (in the case of older relatives raising children, day camps), where an overnight stay does not occur that allows the caregiver time away to do other activities. The program ensures that the social adult day services program to which they will refer the client is registered with NYC Aging pursuant to Chapter 2 of Title 69 of the Rules of the City of New York. Prior to client referral, the program must make a site visit to the social adult day services program in order to determine appropriateness of referral.) Such site visit must be documented in the client's electronic files.
- **Out- of- home Respite (Overnight)** in a DOH-licensed long-term care facility or other New York State certified group setting in which the care receiver resides in the facility (on a temporary basis) for a full 24-hour period (in the case of older relatives raising children, overnight summer camps).
- **Other Respite** for services that do not fall into the previous categories.

Compliance 14.5. Program confirms with clients and documents receipt of respite services in case notes. Support plan indicates length of time the service will be provided.

Compliance 14.6. When Demand Exceeds Availability. With NYC Aging's approval, the program establishes internal written guidelines giving priority to those with greatest social and economic need. The program explores and

implements alternative care options with caregivers when respite demand exceeds availability. If there is a documented need for additional respite care services beyond what is provided to the caregiver by home and community-based waiver programs, Medicaid, or EISEP, the program staff must obtain approval from their supervisor and NYC Aging to authorize the respite. Justification must be documented in the client's electronic file.

Standard 15: Supplemental Services

The program ensures that allocation of this resource is equitable, with particular consideration given to those in greatest economic need. *(See Service Definition)*

Compliance 15.1. Eligibility. The family caregiver must be providing or coordinating care to a care receiver who requires substantial assistance with at least two ADLs and/or is in need of extensive supervision and/or monitoring resulting from cognitive impairment.

Compliance 15.2. Supplemental Services may include:

1. Assistive technology, durable equipment, emergency response systems
2. Consumable supplies
3. Home modifications and repairs
4. Legal and financial consultation
5. Homemaker, chore, and personal care services
6. Transportation
7. Nutrition services (If nutrition services are provided, a short nutrition screening must be completed for the individual(s) receiving the meal, whether it is the family caregiver, care receiver, or both. This is to account for any food allergies and/or dietary restrictions the caregiver and care receiver may have. (See Attachment C:
8. NFCSP Nutritional Screen)
9. Other

Compliance 15.3. The allocation for Supplemental Services does not exceed 30% of the program's budget. The program has an appropriate accounting system to manage expenditures.

Compliance 15.4. The program has written procedures for ordering and purchasing items/services. Documentation supporting the decision to use these funds must be kept. Programs also confirm with clients and document receipt of Supplemental Services in case notes. The case notes must indicate cost and items purchased. In cases where high-cost items are being purchased, programs are required to seek NYC Aging prior approval.

Compliance 15.5. The program ensures sound management of accounts, including clear records of purchases made and timely payment to providers.

Compliance 15.6. The program establishes written internal guidelines to explore and implement alternative options should demand for Supplemental Services exceed funding.

Standard 16: Services Follow-Up, Coordination and Monitoring

The program does follow-ups and monitoring with caregivers within required timeframes and coordinates provision of care.

Compliance 16.1. Linkage Follow-Up. The program follows up with the family caregiver within ten (10) workdays of providing information about resources to inquire if a linkage was made and if the referral was adequate, appropriate,

and satisfactory. If the family caregiver needs referral assistance, the program makes the linkage. Contact with the family caregiver is documented in case notes.

Compliance 16.2. When the program makes a linkage for a family caregiver, the program follows up with the service provider or other entity regarding: (1) receipt of any required paperwork; (2) determination of eligibility, where applicable; and (3) service start date, if applicable. Follow-up occurs within ten (10) business days of referral. If a family caregiver is on a waitlist for services, staff make regular contact with them to determine if there has been a change in their needs.

Compliance 16.3. Service Coordination. With the caregiver's consent, the program keeps in contact with all of the family caregiver's social service providers and documents in the caregiver support plan when contact was made , to coordinate the provision of care.

Standard 17: Service Discharge/Termination Procedures
The program follows service discharge/termination procedures.

Compliance 17.1. Voluntary termination of services. Reasons for voluntary termination of caregiver program include:

- The family caregiver requests termination of all services.
- The family caregiver no longer needs caregiver program services because goals have been achieved, and client agrees with this determination.
- The family caregiver and/or care receiver has died/moved/is not expected to return home within 90 days from hospital/nursing home/skilled nursing facility, and the caregiver agrees to service termination.
- Medicaid funded home care is in place for the care receiver, or the family caregiver will assist with all the care receiver's needs. No additional caregiver services are needed.
- The client is referred to other services and agrees to discharge from the caregiver program.

Compliance 17.2. Involuntary Termination of Services. The caregiver program service is terminated (client is discharged from the service) without requiring the client's consent when:

- The caregiver is no longer eligible for the program services.
- The caregiver has failed to cooperate with program requirements or has refused to comply with their caregiver support plan.
- Any fraud or misuse of service resources is determined to have occurred.
- The caregiver has failed to respond the program after the program has made at least three (3) attempts to contact him/her.

Compliance 17.3. The program notifies the caregiver to discuss the service termination and documents the discussion. Case termination is reviewed and approved by the program director/program supervisor in the client's electronic file.

Compliance 17.4. The family caregiver's case record in NYC Aging's client tracking system reflects termination of services. Client information will remain closed in the tracking system, but the case can be reopened as needed with a new intake and assessment.

Compliance 17.5. Right to Contest Involuntary Termination. The program notifies the family caregiver of their right to contest the involuntary termination of services and to seek a resolution through a settlement conference and hearing. The client has a right to contest an involuntary termination in the following situations:

- The client has been denied an NYC Aging-funded service based on a determination that they are not programmatically eligible.
- The client has failed to cooperate with program requirements such as permitting a care specialist/worker to visit or refusing to agree to a support plan.

Compliance 17.6. Notification of Termination to Providers. When caregiver program services are terminated, the program sends a notification to providers (Home Care Agency, Adult Day Program, etc.).

Compliance 17.7. Assistance with Service Needs after Termination. If it appears that the caregiver client being discharged is in need of additional services, the caregiver program assists the client in accessing appropriate care and follows up to ensure services are coordinated.

- If the caregiver appears mentally incompetent or at-risk, the program makes a referral to an appropriate agency such as HRA's Adult Protective Services in order to ensure the client's safety.

Section 4: Staffing/Personnel Management

Standard 18: Staffing
Staff and volunteers are appropriately qualified and trained.

Compliance 18.1. Care Manager's Qualification. Care Managers have at minimum, a Bachelor of Social Work or Bachelor of Arts, with at least one year of experience in the field of social service.

Compliance 18.2. Program Director's Qualification. The Program Director has an LMSW or LCSW or an equivalent master's level degree (e.g. human services, social services, public administration, or public health).

- The Program Director does not manage any other programs simultaneously with the Caregiver Program, including non-Caregiving programs within the same agency. Exceptions may be permitted with NYC Aging approval.

Compliance 18.3. The program's staffing corresponds to the levels required by NYC Aging, and as proposed to NYC Aging in program's response to NYC Aging's Caregiver Support Request for Proposals (RFP), or as later approved by NYC Aging.

Compliance 18.4. The program notifies NYC Aging within two (2) weeks when there is a permanent change in staffing and provides a plan for filling the vacant position.

Compliance 18.5. Key positions are filled within three (3) months of becoming vacant.

Compliance 18.6. The program employs an adequate number of staff to meet the needs of the volume of family caregivers the program serves annually. It also makes use of trained volunteers to supplement the provision of caregiver services.

Compliance 18.7. Staff coordinating caregiver services have the following qualifications:

- The knowledge, awareness, and understanding of the biological, psychological, and social aspects of aging; the impact of disabilities and illnesses on aging; caregiver and caregiving supports; respite care;

supplemental services; interviewing principles; community resources; and eligibility requirements for public benefits.
- Skills in establishing and maintaining interpersonal relationships, problem-solving, and advocacy.
- The ability to communicate with individuals of different socio-economic backgrounds and cultures; conduct an effective interview; complete an assessment; arrange and negotiate service referrals; and work independently.

Compliance 18.8. The program adopts and maintains written job descriptions for all paid and volunteer positions funded with NFCSP funds. Job descriptions must include scope of work, duties, responsibilities, and minimum entry-level standards for each position.

Compliance 18.9. The Caregiver Coordinator and Care Managers participates in all NYSOFA required trainings.
- A minimum of 10 hours of training per year is completed.
- It is expected that the training be related to working with informal caregivers.
- All records of Caregiver Coordinator and care managers attendance at trainings must be submitted to NYC Aging.
- The Caregiver Coordinator extends any knowledge learned to all staff and volunteers of the program through in-service training.

Compliance 18.10. The program also provides staff and volunteers with:
- An orientation on agency policies and procedures, participants' rights, community characteristics and resources, as well as a written job description, program service definitions, and NYC Aging's Caregiver Standards.
- Procedures for conducting the allowable activities under this program.
- In-service training that relates to working with informal caregivers based on the need for professional growth and increasing knowledge, skills, and abilities.

Compliance 18.11. **References**. The program obtains and verifies at least two professional references for potential employees.

Compliance 18.12. Case aides do not conduct assessments, do not develop caregiver support plans, and do not terminate caregivers from the program. MSW interns may conduct assessments and develop support plans with qualified supervision.

Compliance 18.13. **Training Requirements**. All persons performing screening/intake/assessment functions are trained on interviewing skills and resources. The program maintains documentation of training in each staff person's personnel file.

Compliance 18.14. **Mandated Trainings**. The program abides by all NYC Aging mandated training requirements.
- All staff and volunteers participate in trainings as required by NYC Aging and NYSOFA.
- Program Directors and Care Managers complete a minimum of ten (10) hours of trainings per year.
- For each staff member, the program maintains a log and/or list of trainings, number of hours, topics, trainings completed, training certificates and/or training confirmation documentation.
- All newly hired staff complete the earliest available "Elder Abuse Detection and Response Protocols" training as required by City law and receive a supplemental refresher training regarding the same at least once every three (3) years.

Compliance 18.15. Supervision. Staff/students/volunteers receive appropriate and regularly scheduled individual and/or group supervision, which includes a discussion of their responsibilities, as well as discussion of caregiver and care receiver cases, concerns, and questions. Consultation and supervision are available to all staff and volunteers to ensure quality service provision.

Compliance 18.16. Equal Employment Opportunity Requirements. The program has written procedures to address equal employment opportunity complaints and provides employees with a list of types of discrimination prohibited by law. The program will explain the complaint procedure for employees who believe they have been discriminated against in the workplace.

Standard 19: Background Checks

Compliance 19.1. Background Checks for All Staff. The program conducts criminal background checks on all potential employees and volunteers in compliance with the guidelines set forth in its contract with NYC Aging.

Compliance 19.2. Background Checks for Respite Care Workers. The program screens all current and future respite care workers using the New York State Division of Criminal Justice Services (DCJS) Sex Offender Registry *prior* to that volunteer or staff member being offered a respite care paid or volunteer opportunity.

Compliance 19.3. The program prohibits any individual listed on the State's Sex Offender Registry from providing direct respite care services under the NFCSP.

Compliance 19.4. If the program conducts a background check that is more comprehensive and includes a check of the DCJS Sex Offender Registry, the program may continue to use its own background check process.

Compliance 19.5. If there is uncertainty about an individual's status on the Sex Offender Registry, program must verify that the individual is not listed on the Sex Offender Registry before offering them a paid or volunteer position.

Compliance 19.6. The program may conduct a background check by telephone on up to five (5) prospective employees or volunteers by calling the Division of Criminal Justice at: 518-457-5837 or 1-800-262-3257.

Compliance 19.7. Documentation of Background Check. Copies of background checks are kept on file.

Section 5. Language Accessibility and Cultural Competence

Standard 20: Language Access and Cultural Competence
The program ensures barrier-free access to services.

Compliance 20.1. The program complies with the requirements outlined in NYC Aging's General Standards of Operation, Standards 1 and 9.

Section 6. Procedures and Methods

Standard 21: Emergency Policies and Procedures
The program has written emergency protocols and procedures.

Compliance 21.1. The Caregiver program has protocols and procedures for handling emergencies and conditions or circumstances that may endanger caregivers, care receivers, other participants, workers, or volunteers. (See also General Standard of Operation, Standard 27).

Standard 22: Incident /Accident/Data Breach Reporting
The program adheres to NYC Aging's policy for recording and reporting accidents and incidents. (See General Standards of Operation, Standard 27.4)

Compliance 22.1. The program utilizes NYC Aging's form to report incidents, accidents and data breaches. The fillable form can be found at: https://www.nyc.gov/assets/dfta/downloads/pdf/community/Incident-Accident-Report_Form-Final_12-2024.pdf

Standard 23: Contributions
The program provides family caregivers with the opportunity to voluntarily contribute to the cost of the services that they receive.

Compliance 23.1. The program has written procedures for collecting and documenting client contributions. These procedures adhere to NYC Aging's contribution guidelines in the General Standards of Operation, Standard 14.

Section 7. Documentation and Record Keeping

Standard 24: Documentation
The Caregiver program maintains required documentation of services.

Compliance 24.1. The program maintains current, complete, and accurate caregiver, care receiver, and service information. Support Plan, intake, check-in and assessment information are entered in the client tracking system within ten (10) business days of completion.

Compliance 24.2. The program uses the correct service and unit definitions. (See Attachment A: Standard Service Definitions for Caregiver Programs)

Compliance 24.3. The program maintains caregiver and care receiver data, paperwork and supporting documents in accordance with its contract with NYC Aging.

Compliance 24.4. The program keeps track of respite and supplemental services utilization by each care receiver or caregiver referred for the service. The program ensures that it receives notice of respite and supplemental delivery from the provider.

Compliance 24.5. The program makes records and documentation available to NYC Aging upon request.

Standard 25: Recordkeeping

Compliance 25.1. The program retains the following records in accordance with its contract with NYC Aging:

1. Caregiver assessments;
2. Caregiver education programs, surveys, and units of service;
3. Caregiver counseling participant files and units of service; and
4. Participant surveys and evaluations.
5. Caregiver participant registration;
6. Contribution collection and deposit records;
7. All income and expense records;
8. Contract, budget, and payroll/timesheet documents;
9. Monitoring reports of contracted NFCSP service providers and directly provided caregiver support services;
10. Caregiver Coordinator training record; and
11. Participant, staff, and volunteer service records (e.g., sign-in sheets).

Attachment A: Service Definitions

Standard Service Definitions for Caregiver Programs

NOTE: Clients should NEVER be given a prospective unit of service as a practice. Units are to be attributed to a client AFTER the service has been provided. No units of service should be attributed to care receivers.

NYC Aging Contracted Services	Service Definition	Unit Type
Public Information	A planned effort to provide caregivers information about services, resources, and entitlements. Activities include the distribution of newsletters, flyers, pamphlets, and brochures, the use of mass media for news, features, public activities, and public presentations by a service representative. A table at a health event can be counted as Public Information when providers distribute and inform caregivers and general public of caregiver services. **Reporting Clarification:** Each instance or event is to be counted as the unit. This is recorded as an aggregate event with an estimated audience size.	**Event**
Assistance: Information and Assistance	Providing an individual with information on a one-to-one basis about available services and opportunities in the community which enables them to locate and obtain needed resources on their own. Assistance provided on a one-to-one basis to caregivers on obtaining access to available services and resources in their community. Includes assisting the caregiver in defining problems/needs and capacities, linkage to services to address the problems/identified needs. When appropriate, assistance may also involve worker intervention, negotiation, and advocacy with providers on the caregiver's behalf to ensure the delivery of needed services and benefits. Also included is follow-up.	**Contact**
Assistance: Case Management (Caregiver)	A service provided to a caregiver, at the direction of the caregiver: • by an individual who is trained or experienced in the case management skills that are required to deliver the services and coordination described below; and • to assess the needs, and to arrange, coordinate, and monitor an optimum package of services to meet the needs of the caregiver; and Includes services and coordination such as— • comprehensive assessment of the caregiver (including the physical, psychological, and social needs of the	**Hour** (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)

NYC Aging Contracted Services	Service Definition	Unit Type
	individual); • development and implementation of a service plan with the caregiver to mobilize the formal and informal resources and services identified in the assessment to meet the needs of the caregiver, including coordination of the resources and services— o with any other plans that exist for various formal services; and o with the information and assistance services provided under the Older Americans Act; o coordination and monitoring of formal and informal service delivery, including coordination and monitoring to ensure that services specified in the plan are being provided; o periodic reassessment and revision of the status of the caregiver; and o in accordance with the wishes of the caregiver, advocacy on behalf of the caregiver for needed services or resources.	
Counseling	A service designed to support caregivers and assist them in their decision-making and problem solving. Counselors are service providers that are degreed and/or credentialed, who are trained to work with older adults and families and specifically, to understand and address the complex physical, behavioral, and emotional issues and challenges related to their caregiver roles. This includes counseling to individuals or group sessions. Counseling is a separate function apart from support group activities or training (see definitions for these services.	**Hour** (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)
Support Group	A service that is led by a trained individual, moderator, or professional, to facilitate caregivers to discuss their common experiences and concerns and develop a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online. Caregiver support groups would not include "caregiver education groups," "peer-to-peer support groups," or other groups primarily aimed at teaching skills or meeting on an informal basis without a trained/credentialed facilitator.	**Session**

NYC Aging Contracted Services	Service Definition	Unit Type
	Reporting Note: For a support group session to count as a group, more than one caregiver must be in attendance. If only one caregiver attends, the service should be entered as a counseling session and not a support group session.	
Training	A service that provides informal caregivers with instruction to improve knowledge and performance of specific skills relating to their caregiving roles and responsibilities. Skills may include activities related to health, nutrition, and financial management; providing personal care; and communicating with health care providers and other family members. Training may include use of evidence-based programs, be conducted in-person and/or on-line and be provided in individual or group settings. Reporting Note: The Caregiver must attend the training session in order for a unit of service to be captured.	**Hour** (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)
In-home Respite (Individual Respite-Home Care)	A respite service provided in the home to the caregiver or care receiver and allows the caregiver time away to do other activities. During such respite, other activities can occur, which may offer additional support to either the caregiver or care receiver, including homemaker or personal care services. Respite services may include cognitive engagement offered virtually to the care receiver and allows the caregiver to have respite while care receiver is engaged virtually in activities.	**Hour** (Excludes travel time) (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)
Out-of-Home Respite (Overnight)	A respite service provided in residential settings such as nursing homes, assisted living facilities, and/or family type homes (or in case of older relatives raising children, summer camps) in which the care receiver resides in the facility (on a temporary basis) for a full 24-hour period of time. The service provides the caregiver with the time away to do other activities.	**Hour** (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)
Out-of-home Respite (Day) /Group Respite (Adult Day)	A respite service provided in settings other than the caregiver/care receiver's home, including adult day care or other non-residential setting (in case of older relatives raising children, day camps and/or afterschool programs), where an overnight stay does not occur and allows the caregiver time away to do other activities. **Reporting Note:** Do not report meals.	**Hour** (Partial hour may be reported to two decimal places, e.g., 0.25 hours.)
Respite – Other Respite	A respite service provided using NYC Aging funds in whole or in part, that does not fall into the previously defined respite service categories.	**Hour** (Partial hour may be reported to

NYC Aging Contracted Services	Service Definition	Unit Type
		two decimal places, e.g., 0.25 hours.)
Supplemental Services	Supplemental Services complement the care provided by caregivers and addresses the needs of the caregiver. These are not the traditional caregiver services. Supplemental Services has a funding cap. No more than 30% of a program's funding can be spent on supplemental services. All funds expended on supplemental services must be associated with a client. These funds may NOT be expended on giveaways. To be eligible for supplemental services, a caregiver must be caring for an older person who is defined as frail under Section 102(22) (A) and (B) of the Older Americans Act: (22) The term "frail" means, with respect to an older individual in a State, that the older individual is determined to be functionally impaired because the individual – (A)(i) is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing or supervision; or […] (B) due to a cognitive or mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. **Reporting Note:** Supplemental services may be provided to the caregiver, to the care receiver, or to meet the need of both. However, all units must be captured under the caregiver.	**See each Supplemental Service type below:**
Supplemental - Transportation	Escorting a person who has difficulties (physical or cognitive) with using vehicular transportation. Includes transportation to medical appointments, transportation to social adult day program, or transportation for a family caregiver to get to the care recipient's home to provide care.	**One-Way Trip**
Supplemental – Legal Assistance	Provision of legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney. This may include tax assistance.	**Hour**
Supplemental – Other	A service that complements the care provided by the caregiver that does not fall into any of the assigned domains for supplemental services. This category is meant to be flexible. This may include laundry services, bill paying,heavy duty cleaning/trash removal, and other items.	**Each Item**

NYC Aging Contracted Services	Service Definition	Unit Type
Supplemental – Personal Emergency Response System (PERS)	A service which utilizes an electronic device to alert appropriate people of the need for immediate assistance in the event of an emergency in an older person's home.	**One Unit per Month**
Supplemental Assistive Tech	Assistance with door locks, and or alarms, tablets, smoke detectors etc.	**Each item**
Supplemental Consumable Supplies	Provision of incontinence supplies, adult diapers, groceries, gym membership, nutritional supplements.	**Each item**
Supplemental Home Modification and Repairs	Includes installations of grab bars, minor bathroom remodel, ramp.	**Each Item**
Supplemental Chores	Includes lawn care, snow removal, room clean out so the care recipient can move in with the caregiver	**Each Item**
Supplemental - Durable Equipment	Provision of bathtub chairs, bathtub benches, pill dispensers, etc.	**Each Item**
Supplemental Nutrition Services	Includes services such as congregate meals and nutrition education. Congregate meals may be provided in a stopgap situation. For example, if a caregiver needs a brief, interim break and would benefit from socialization.	**Each Meal**

Note:

- All Respite and Supplemental service categories, Training, Support Group and Public Information units are captured via Event Profile.
- Information and assistance, assistance case management and counseling are captured through Client Profile unit entry in the NYC Aging Client Tracking System.
- CTL services, such as Training and Support group can be captured via Client Enrollment units and not via the Event Profile.

Attachment B: Quality Assurance Survey

National Family Caregiver Support Program (NFCSP) Quality Assurance Survey

The National Family Caregiver Support Program (Caregiver Program) provides a range of supports that assist family and informal caregivers with caring for their loved ones at home for as long as possible.

The Caregiver Program provides the following services:

- Information to caregivers about available services.
- Assistance to caregivers with gaining access to available services.
- Caregiver counseling, support groups, and training.
- Respite care (in-home, out of home, overnight).
- Supplemental services (e.g., home delivered meals, transportation, personal. emergency response systems, home modifications, etc.).

[Organization Name] is pleased to be able to provide you with assistance through the Caregiver Program. Please take a moment to complete this survey. Your feedback will help us improve the quality of the Caregiver Program and continue to effectively provide services to other families and informal caregivers. We appreciate your response to the survey.

1. **How did you hear about the Caregiver Program, and the caregiver services offered by our agency?**

☐ Friend/Family	☐ Newspaper
☐ Newsletter	☐ Radio/TV
☐ Brochure	☐ Hospital
☐ Case/Care Manager	☐ Other

If other, please specify:

_____

2. **What is your relationship to the person you are caring for?**

☐ Husband	☐ Grandparent
☐ Wife	☐ Parent
☐ Domestic Partner (including civil union)	☐ Sister
☐ Son/Son-in-law	☐ Brother
☐ Daughter/Daughter-in-law	☐ Non-Relative

☐ Declined to Answer ☐ Other

If other, please specify your relationship:

_____

3. Was the information about the Caregiver Program made clear to you?

☐ Yes ☐ No

4. Below is a list of services and resources available through the Caregiver Program. Please tell us whether you utilized any of these services, and, if so, please indicate your level of satisfaction with the services you received.

Service	Did you use this service?			If yes, how would you rate the services you received?			
	Yes	No		Excellent	Good	Fair	Poor
Caregiver Case/Care Management							
Caregiver Counseling							
Caregiver Support Groups							
Caregiver Training							
Respite Care (A break from caregiving responsibilities)							
Other:							

If other, please state what other service(s) you received:

_____

_____

5. If you are not satisfied with a service or rated any of the above as "poor," please tell us about your experience:

_____

_____

_____

_____

6. Were services arranged in a timely manner?

☐ Yes ☐ No

7. **Was the staff member you worked with helpful, and did they assist you with arranging service(s) to meet your needs?**

☐ Yes ☐ No

8. **As a result of the service(s) you have received through the NFCSP:**

	YES	NO	UNSURE
Do you have a better understanding on how to access services?			
Do you feel more confident as a caregiver?			
Do you believe the service(s) you received allowed you to provide care for a longer period of time?			
Do you feel that your level of stress has decreased?			
Do you take more time for your personal health and overall well-being?			

9. **If you were to seek help with your caregiving responsibilities again, would you come back to our program?**

☐ Yes ☐ No

10. **Do you have any suggestions that would help us improve our program?**

_____
_____
_____
_____
_____

11. **What workshops or information could we provide that are of interest to you or you feel would be beneficial in your role as a caregiver?**

_____
_____
_____
_____

Do you have any additional comments about the service(s) you received or your role as a caregiver in general?

_____
_____
_____
_____

If you would like to be contacted regarding this survey, please provide the following information:

Name: _____

Mailing Address: _____

_____

_____

Telephone Number: ( ) ____-_____

If you have any questions about this survey, please contact (Organization Contact Information).

Thank you for taking the time to complete this survey. Your feedback is very important to us!

Please mail the completed survey to [Organization Address].

Attachment C: National Family Caregiver Support Program (NFCSP) Nutritional Screen

This form should be used when providing nutrition services to caregivers and/or care receivers as a Supplemental Service using Title III-E funds.

Meal Recipient Information

First Name:
Last Name:

Nutrition Service

Is there a modified therapeutic diet prescribed by a physician?

☐ Yes

☐ No

If *yes*, check all that apply:

☐ Texture- Modified	☐ Calorie controlled diet	☐ Sodium restricted
☐ Fat restricted	☐ High Calorie	☐ Renal
☐ Diabetic	☐ Liquid nutritional supplement	☐ Other

If other, please specify:

If *no*, check all that apply:

☐ Regular	☐ Special Diet
☐ Vegetarian	☐ Ethnic/Religious
☐ Food Allergies	

If Ethnic/Religious, please specify:

Does the meal recipient have a physician-diagnosed food allergy?

☐ Yes

☐ No

If yes, please specify:

Please indicate the meal recipient's meal preference:	
☐ Hot	☐ Chilled
☐ Frozen	☐ Other

Nutritional Health

Responses to this section will indicate whether the individual might benefit from consultation with a Dietitian.

Note for Assessor: *Assist individuals at high nutritional risk with identifying a professional they can talk to about their nutritional health. If individual is 60+, the AAA's Dietitian may be an option, ask the individual if you can make a referral.*

Please also note that the values assigned to the "Yes" column in the chart below are prescribed and should not be modified.

	Yes	**No**
I have an illness or condition that made me change the kind and/or amount of food I eat.	2	0
I eat fewer than two meals a day.	3	0
I eat few fruits or vegetables, or milk products.	2	0
I have three or more drinks of beer, liquor, or wine almost every day.	2	0
I have tooth or mouth problems that make it hard for me to eat.	2	0
I don't always have enough money to buy the food I need.	4	0
I eat alone most of the time.	1	0
I take three or more different prescribed or over-the-counter drugs a day.	1	0
Without wanting to, I have lost or gained ten pounds in the last six months.	2	0
I am not always physically able to shop, cook and/or feed myself.	2	0
TOTAL		

Nutritional Health Score

0-2 = Low Nutritional Risk

3-5 = Moderate Nutritional Risk 6

or more = High Nutritional Risk

If you are at High Nutritional Risk, you are encouraged to share this information with your health care provider, dietitian, or other qualified health or social service professional. Ask them for help to improve your nutritional health.

Have you been referred to a dietitian in the past?	
☐ Yes	☐ No
If yes, when:	

Nutrition Plan

How often will meals be provided:

How long are meals authorized for:

If Home Delivered Meals will be provided, please complete the following information:

Emergency Contact Information
Primary **Secondary**

Are there any pets that would be a barrier to service provision?

If applicable, food security assistance/referrals (including pet food):

If applicable, referral to a dietitian:

Attachment D: Timeline Guide

Category	Standard		Timeframe
Initial Assessment	Standard 8	The Caregiver program conducts an initial assessment.	Within ten (10) business days of the intake interview.
Consent	Standard 3	Signed consent is required for all services that will require an intake or assessment.	Obtained ten (10) business days of an initial assessment.
Documentation	Standard 24	The program maintains current, complete, and accurate caregiver, care receiver, and service information. Support Plan, intake, check-in and assessment information are entered in the client tracking system.	Within ten (10) business days of completion.
Supervisory Review	Standard 10	The supervisor reviews and signs off on each family caregiver's case, including intake, assessment, assessment summary case notes, and Caregiver Support Plan.	No later than ten (10) business days after each family caregiver assessment is completed.
Services Follow-Up	Standard 16	Linkage Follow-Up. The program follows up with the family caregiver within ten (10) workdays of providing information about resources to inquire if a linkage was made and if the referral was adequate, appropriate, and satisfactory. If the family caregiver needs referral assistance, the program makes the linkage. Contact with the family caregiver is documented in case notes.	Within ten (10) workdays.
Services Follow-Up	Standard 16	When the program makes a linkage for a family caregiver, the program follows up with the service provider or other entity regarding: (1) receipt of any required paperwork; (2) determination of eligibility, where applicable; and (3) service start date, if applicable.	Within ten (10) business days of referral.
Monitoring Calls	Standard 8	Periodic check-ins are conducted to discuss status of support plan and any new needs for the caregiver and care receiver. On-going check-ins are conducted until the case is closed.	Every three (3) months.
Case Notes	Standard 8	Case notes are completed by staff after conducting each check in.	Within five (5) business days.

Category	Standard		Timeframe
Reassessment	Standard 8	The program conducts a reassessment using the required assessment tool, until the case is closed.	Every six (6) months.
Supervisory Review	Standard 10	The supervisor reviews and signs off on each family caregiver's case file, including case notes since the last assessment or more frequently should a need be identified.	Every six (6) months.
Caregiver Feedback	Standard 11	The program conducts a quality assurance survey to evaluate the caregiver satisfaction, summarizes the results of the survey, and indicates what steps the program will take to address areas of dissatisfaction and client feedback.	By no later than the end of the 3rd quarter of each fiscal year.
Caregiver Feeback Results	Standard 11	A summary of the survey results is provided to NYC Aging.	No later than May 31st of each year.
Staffing	Standard 18	The program notifies NYC Aging when there is a permanent change in staffing and provides a plan and timeline for filling the vacant position.	Within two (2) weeks.
Staffing	Standard 18	Key positions are filled.	Within three (3) months of becoming vacant.