Department for the Aging

Case Management and Friendly Visiting

Standards of Operation and Scope of Services

Based on standards set by the New York City Department for the Aging and the New York State Office for the Aging.
Effective July 1, 2024

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Case Management

Case Management Introduction

These standards are required and apply to all NYC Aging-funded Case Management programs. Case management services help older persons with functional impairments gain access to appropriate services, benefits and entitlements needed to age safely at home and maintain their quality of life. Case managers do so by developing trusting relationships with clients and their caregivers and engaging them in a collaborative process of problem solving.

The core functions of case management are:
Intake and assessment. Identification of the client's needs and capabilities through intake and comprehensive strength-based in-home initial assessment and regular reassessments. The assessment includes financial assessment of clients who need home care, and, when permitted by the client, financial assessment to determine eligibility for city, state and federal benefits and entitlements.

Care planning. Development of a mutually agreed-upon care plan with clients and caregivers, based on the needs and goals identified during the assessment/reassessment(s) and specifying the interventions that will help the older person to age safely at home.

Implementation of the initial and subsequent care plan(s). Authorizing NYC Aging-funded home care services*, home-delivered meals, and friendly visiting, arranging for other services, linking clients to community resources, coordinating, and negotiating with service providers for the delivery of service identified in the care plan, and coordination and collaboration with providers of counseling and assistance with long-term care planning.
**Note: NYC Aging-funded home care services are homemaker/personal care service and housekeeping/chore service. In these standards they will be referred to as "home care services", unless specified.*

Follow-up and monitoring. Ensuring the client's needs are being met as specified in the care plan through ongoing contact and coordination with service providers and clients. This means direct contact with the client over the phone or through an in-person visit. Although contact with an informal support, such as a family member, can help supplement the follow-up and monitoring, this type of contact must not be the only method of follow-up and monitoring.

Reassessment. An in-person scheduled, or event-based reassessment of the client conducted to identify changes in the client's situation and functioning since the most recent assessment/reassessment and to measure progress toward the service goals.

Services discharge. Discontinuation or termination of case management and other services at the client's request when the client's goals have been met or if the client becomes ineligible for the service.

Examples of case management needs:

- A case manager visits the client at home to conduct a comprehensive assessment and discovers that the client cannot bathe herself or do housework. The client's son, her only relative, lives in Wisconsin.
- A case manager visits the client at home who is unable to visit a local older adult center. The case manager determines that she is eligible for Supplemental Nutrition Assistance Program (SNAP) benefits, which can

help reduce her food bills, but needs help with the application. She also needs assistance paying her utility bills from Con Edison.
- A case manager determines that the client, who can self-direct, needs help linking to Medicaid and Medicaid home care to continue living at home safely.
- A case manager discovers that a client, who called asking for meals, may be a victim of elder abuse and needs case management services coordinated with services from a local elder justice program.
- A client who is a recent immigrant needs home-delivered meals as well as friendly visiting service from an organization that helps immigrants from her country.
- A client who has difficulty leaving home and is recently widowed after 51 years of marriage needs support from the case manager and linkage to grief counseling from a local community center.

The program effectively provides quality case management and performs the above core functions by maintaining extensive information resources and linkages. Information resources include (1) key businesses serving community residents; (2) cultural, religious, and educational institutions; (3) key health care and social service providers, (public and voluntary) including hospitals, ambulatory care clinics, community health centers, nursing homes; older adult centers, social adult day programs, and other NYC Aging-funded service providers; and (5) non-NYC Aging-funded service providers serving the community.

The Department also expects the program to identify, develop and maintain collaborative relationships with Medicaid programs; NY Connects; volunteer organizations; local banks; NYC Aging-funded caregiver programs, elder justice services providers; older adult center programs; Adult Protective Services (APS) and mobile crisis teams; community hospitals and clinics; and key civic and representative offices serving the community.

Throughout these standards, there will be requirements regarding when face to face meetings must take place and corresponding time frames for these meetings to occur. However, where exceptions are permitted, we have noted them using the phrase “unless impractical.” This term is used specifically when a case management agency is unable to meet face to face with the client due to a crisis or disaster. It can also apply when a client is unable to meet due to circumstances beyond their control. For example, they may be in a hospital or rehabilitation facility, or they may be extremely ill or are experiencing a contagious infection. The case manager must document these circumstances in the client’s file. Here are some circumstances where it does not apply:

- The case manager forgot to schedule the home visit or was on vacation.
- The client refuses to cooperate with the case manager to schedule a face-to-face appointment for reasons unrelated to circumstances beyond their control.

Target Population/Eligibility

Standard 1: Participant Eligibility

The program provides case management to individuals who meet case management eligibility requirements.

Compliance 1.1 Individuals eligible for case management meet the following requirements:

- Are 60 years of age or older;
- Have at least one functional Activity of Daily Living (ADL) limitation or two Independent Activities of Daily Living (IADL) limitations as shown by the need for assistance from another person. Note: The client may have a functional need that is being met – e.g., by an informal support, private home care agency or other source – but require other types of case management assistance.
- Need case management assistance;
- Are able to be safely maintained at home;
- Will accept assistance from the case management agency (CMA) and providers and cooperate with the care plan; and

- Are not eligible to receive similar case management services from any other government-funded program.

Note: The case management agency may provide case management services for the older client's caregiver(s) when such assistance enables the client to age safely at home. If the client's caregiver is 60 years of age or older, that caregiver is eligible for case management services and should be considered a client in her/his own right.

Standard 2: Home Care, Home-Delivered Meals and Friendly Visiting Authorization

The program authorizes home care, home-delivered meals, and friendly visiting services for eligible clients.

Compliance 2.1. NYC Aging-funded home care eligibility. Individuals authorized for NYC Aging-funded home care meet the following requirements:

- Are 60 years of age or older;
- Functional limitations, as shown by the need for the assistance of another person with at least (a) one ADL such as bathing, grooming, dressing, washing, feeding, toileting, mobility, and transferring, or (b) two IADLs such as shopping, laundry, meal preparation, reheating meals, and house cleaning (for housekeeping);
- Unmet needs for assistance with ADLs and/or IADLs;
- Able to be maintained safely in the home if support is provided;
- Ineligible for housekeeping or personal care under any other government program, including Medicaid (may receive NYC Aging-funded home care until Medicaid service begins); and
- No other resources are available to fully assist the client. NYC Aging-funded home care services will supplement but not duplicate other services the client is receiving, such as Medicare-funded Hospice or Medicare-funded skilled nursing care following hospital discharge.

Compliance 2.2. NYC Aging Funded home care for clients with Medicaid or eligible for Medicaid. Authorizations of NYC Aging-funded homecare meet the following guidelines:

- The client has been assessed by the case manager to have unmet ADL and/or IADL needs.
- The authorization of home care hours is as specified by NYC Aging.
- When the case manager determines that the client is eligible for Medicaid or is in receipt of Medicaid, the case manager will follow-up with the client to obtain Medicaid home care within a 2-month time frame.
- The case manager documents when the application for Medicaid home care (and Medicaid, where applicable) is submitted.
- Once Medicaid home care is approved and begins, NYC Aging-funded Home Care ends.

Compliance 2.3. Home-Delivered Meal eligibility. Individuals authorized for NYC Aging-funded home-delivered meals meet the following eligibility criteria:

- Are 60 years of age or older;
- Are unable to attend congregate meal sites because of an accident, illness, or frailty;
- Lack formal or informal supports (family, friends, or neighbors) who can regularly provide meals;
- Are able to live safely at home if home-delivered meal services are provided;
- Are unable to prepare meals because of one or more of the following:
    - Lack of adequate cooking facilities.
    - Lack of knowledge or skills to prepare meals.
    - Are unable to safely prepare meals.
    - Are unable to shop or cook.

Examples:

- *The client is 76 years old, lives alone, has difficulty walking, and is struggling to shop for food. She may be eligible for home-delivered meals.*
- *The client is 82 years old, lives alone, has difficulty walking, and is unable to shop for food. She has a family member who provides some meals some of the time, but this does not occur regularly. The family member comes by only a few days during the week to drop-off some food. She may be eligible for home-delivered meals.*

Note: When it is in the best interest of the client that is authorized for home-delivered meals, as documented in case notes, NYC Aging-funded meals may also be provided to: (1) the client's spouse or domestic partner, regardless of the person's physical condition or age (under 60); (2) disabled individuals under 60 years of age living in the same household as the client. A case record for the non-case managed client (the case managed client's spouse or domestic partner, or disabled person under age 60 living in the same household as the client) is opened in NYC Aging's client tracking system, and the NY Client Info section of the Client Profile is completed. A referral is also sent to the home-delivered meal program. A six-month follow-up to determine continued need and eligibility for the service is done with the non-case managed client and is documented in the case notes of this client's case file. The six-month follow-up can be in the form of a home visit or a telephone contact.

However, if the spouse or domestic partner meets all the eligibility criteria for home-delivered meals, that person is considered a case management client and a separate record is opened for that client.

Example:

- *The client is 69 years old and cares for her 40-year-old developmentally disabled son. In addition to her own difficulty in caring for herself, she is struggling to care for her son as well. Both persons may be eligible for meals.*

Compliance 2.4. Home-Delivered Meal ineligibility. Counseling about other resources such as congregate meals and food pantries is provided to clients who are reassessed as no longer eligible for NYC Aging-funded home-delivered meals.

Compliance 2.5. Friendly Visiting Eligibility. Friendly Visiting service is provided to older adult who meet the following criteria:

- Are receiving NYC Aging case management services.

Exception: The Case Management program will close the case if the client is institutionalized, however, if the client is matched with a volunteer at the time of case management closure, Friendly Visiting program will keep it open if the match is active with the same volunteer.

- Have few or no informal supports or opportunities for socialization (isolated or at risk for social isolation*).*
- The client must abide by the program rules and the Client Rights and Responsibilities.

See Friendly Visiting Standards, Page 25

Informed Consent

Standard 3: Informed Consent

The program obtains informed consent from each client. (See also NYC Aging General Program Standards, Section 2)

Compliance 3.1. Consent to Collect Personal Information. The case manager obtains signed consent to collect and record data from individuals seeking the service before any personal identifying information is entered into the NYC Aging client tracking system.

- When initial contact is via telephone, verbal consent is acceptable to proceed with the Intake and PEC authorization. The case manager must obtain signed consent during the initial in-person assessment.
- If the client withdraws from the service before an in-person visit can be made, the case manager enters a note in the client's record in the client tracking system and immediately closes the case.

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

- If a client refuses to sign the consent to share/refer, the client is considered to have refused services. The case manager explains this to the client, and if no other assistance is needed the case is closed/inactivated.

Note: The signed consent to refer and share personal information gives the referring program (Home Care/Home Delivered Meals) permission to activate the client into their program and collect additional data as needed. The Home Care or Home Delivered Meals program does not need to also obtain consent to collect data from the client.

Compliance 3.3. Revocation of Consent. Client consent is in effect until the case is closed or consent is revoked. If a client revokes consent, that client is refusing service. Any client identifying data shared while consent was in effect cannot be rescinded retroactively. No client data files may be deleted from the client tracking system. When a case is closed, the program does not need to obtain a signed revocation of consent from the client.

Compliance 3.4. 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 the client tracking system.

Compliance 3.5. Consent for non-English Speakers. Consent documents are available to clients in the language understandable to them.

- If necessary, the program uses an interpreter fluent in the client's spoken language to aid in the consent process. (See NYC Aging General Program Standards, Standard 9 for more on Language Access requirements.)

Scope of Services

Standard 4: Screening and Intake

The program screens each inquiry to determine whether to conduct an Intake or provide the client with needed information and referral.

Compliance 4.1. The Screening and Intake process typically starts with a phone call to the case management agency from a referral source or an individual, such as an older adult, caregiver, or neighbor. Through screening, if the individual is found appropriate for case management services, an intake is completed within two (2) business days of the initial call. At intake, if the client is found ineligible for case management services, or the client refuses to accept services, the staff conducting the screening should offer other appropriate referrals in the community to the client. If the client is unreachable, or refuses to return the intake calls, or refuses to provide enough information to the staff to complete the intake, the CMA should follow-up and leave a message via phone or send a letter to the client indicating that the CMA can be reached in the future if they are interested in services. The client intake is closed.

Example:

- *The CMA receives an intake call on August 8th, 2022, a Monday, from a neighbor regarding a frail older adult living nearby. Based on the information shared by the caller, the older adult may be eligible for case management services. The CMA has until August 10th, 2022, to reach the older adult and complete the rest of the intake.*

Compliance 4.2. Screening and Intake are staffed daily, Monday through Friday, during the program's regular hours of operation.

Compliance 4.3. Staff that conduct the screening/intake are competent in the main languages spoken by older residents in the program's service area, are knowledgeable about community resources, and skilled in eliciting information and deducing needs. Telephonic interpretation or translation services must be provided if needed.

Compliance 4.4. Screening. The initial inquiry is screened to determine preliminary eligibility for the program in terms of age, functional and/cognitive impairment and need for case management assistance.

- Information and Assistance is provided to persons who do not meet eligibility requirements and documented in NYC Aging's client data system through a Service Ticket. A client case file is not opened.
- An Intake is conducted on persons who appear to meet eligibility requirements (See Compliance 4.5 below).

Compliance 4.5. Intake. An intake is conducted to gather relevant information to register the client.

- Sufficient information is collected during the intake process to register the client in the case management program. Note: If both individuals in a "couple" are to receive services, two Intakes are completed.
    - Sufficient information is also obtained from the client or client's collateral contacts to make a reasonable determination that the client is not at-risk. An in-home assessment is scheduled within five (5) business days if the client's risk status cannot be ascertained. The Intake is then completed during the initial in-home assessment.
- During Intake, the worker asks about whom the client lives with, whether someone with a mental illness is present in the home and whether there is any current substance abuse in the home.
    - If there is reason to suspect safety issues, the assigned case manager calls before making the in-home visit to inquire of the client whether she/he is fearful of anyone who comes into the home; whether the police have ever been called to the home and why; and presence of weapons in the home. The case manager follows their agency's protocols on how to proceed.

The Intake process results in one of the following actions: (1) scheduling of client's in-home assessment; or (2) client's placement on a wait list for in-home assessment if an in-home assessment cannot be conducted within ten (10) business days; or (3) decision that client does not require an in-home assessment and provision of information and assistance when there are other needs. Note: At intake, a client may be authorized for home-delivered meals on the presumption that the client is eligible.

Standard 5: Assessments and Reassessments

The program conducts an initial in-home assessment and annual (at minimum) in-home reassessment of each client's needs, strengths, and assets.

In conducting an assessment/reassessment, the case manager uses the skills of observation, deduction, exploration, and inquiry to obtain in-depth information about the client's current strengths, resources (including formal and informal support systems), problems, needs, and quality-of-life goals. The purpose of the assessment is not simply to "certify" the client's need for the services that she or he has requested, but to evaluate all aspects of the client's

current functioning and situation to develop a comprehensive care plan. The purpose of the reassessment is to again review all aspects of the client's current functioning to develop a new care plan or continue the existing plan. The case manager also uses the reassessment as a fresh opportunity to engage or re-engage the client in meaningful activities and interests and to measure progress toward care plan goals since the last assessment. To facilitate doing a comprehensive evaluation, the case manager:

- Takes time to get to know the client as a person.
- Explains the purpose for asking personal questions.
- Seeks the client's input and listens to what the client has to say.
- Uses skills of observation and deduction.
- Evaluates all aspects of the client's functioning and situation.

Compliance 5.1. Case Manager assignment. The program assigns a case manager to the client who is, and who remains, the primary contact for the client and who coordinates contact with the client by other agency staff. The client should be informed of how to contact the case manager.

Compliance 5.2. Location of Assessment/Reassessment. The case manager assigned to the client conducts the assessment/reassessment in-person with the client and, if applicable, his/her authorized representative, unless impractical. The assessment/reassessment takes place in the client's home or usual residence, unless impracticable. If in the best interest of the client, the assessment can be completed through a combination of phone or virtual and in-home. The case manager should encourage the client to accept a home visit. For clients who decline a home visit, the program determines the reason for these situations and a reasonable delay can be granted at the discretion of the program. Some examples are if the client is currently ill or is hospitalized. If the client ultimately declines an in-home assessment or reassessment after being reminded that it is a requirement of participation in the program, the program terminates the services, unless a home visit is impracticable. If the case manager is unable to conduct a home visit due to impracticability, this is documented with an explanation in the client's file.

Compliance 5.3. Assessment/Reassessment Instrument. The case manager completes (or updates at reassessment) all relevant sections of the Case File and COMPASS 2019 forms in the client data system. The case manager must complete Strengths and Accomplishment, Care Plan, and Cost Share for clients receiving home care services. The program indicates where the client refuses to provide information.

Compliance 5.4. Elder abuse and imminent risk detection. Where elder abuse is known or suspected, the case manager assesses the client's imminent risk of serious physical harm and brings the situation immediately to the attention of her/his supervisor.

Compliance 5.5. Client need for accommodation. The program accommodates clients with communication difficulties (e.g. due to vision or hearing impairment or limited English proficiency) – for example, by reading documents out loud to the individual with a vision impairment (documents should be in large print); use of a TTY device for hearing impaired elders; use of an interpreter service; having a family member or friend present during the assessment to aid in communication; enlisting assistance from another agency that specializes in assisting persons with a special need.

Compliance 5.6. Obtaining information from others. To obtain as complete of a picture as possible of the client's needs, the case manager seeks information relevant to the client's presenting problems, recent care issues and informal supports from others engaged in the client's care.

- If the client does not object, and if it is feasible, formal and/or informal caregivers are involved in the assessment process (except for questions related to elder abuse and neglect which must be asked of the client in private). If informal caregivers provide assistance with ADLs and/or IADLs, the type of assistance they provide is documented.

Example:

- *The client was recently discharged from the hospital and is being assessed at home. The case manager asks for the most recent discharge package and, if needed, follows-up with the client's physician/social worker/care coordinator.*

Compliance 5.7. Determination of contribution/cost share status for home care clients. If a client is eligible for NYC Aging-funded home care, the client provides documentation of income to enable the case manager to determine whether he/she is above the current threshold for contribution status (thresholds are provided annually by the NY State Office for the Aging) and will be required to pay a cost share. Note: Although the case manager determines the cost share based on client documentation, the home care provider collects the cost share**.**

- A Cost Share Worksheet is completed in NYC Aging's client tracking system for every home care client prior to home care authorization. (See Attachment C, Cost Share Worksheet.) If the client lives alone or with another person who is not willing to divulge financial information (and who is not a recipient of NYC Aging-funded home care), the column for single-person household is completed. If the client lives with a spouse or other party who contributes to expenses and is willing to provide information, the column for couples is completed.
    - The following sources are excluded from income determination: food stamp allotments; income from job programs established to foster employment of lower income elderly or to support volunteer efforts; unearned income from one-time lump sum payments; proceeds from reverse mortgages; war reparations.

- The client consents to pay the maximum home care cost share if she/he refuses to provide the required financial information for determining her/his cost share. Clients who refuse to provide financial information and who refuse to agree to pay the maximum cost share may <u>not</u> receive home care services.

- Clients who will be authorized for home care but who disagree with their designated cost share are informed in writing that they have the right to a redetermination, and to formally contest the re-determination if they do not agree with it.

Compliance 5.8. Assessment/Reassessment Summary. The case manager completes an Assessment Summary (and Reassessment Summaries) of his/her findings and analysis of the client's situation. The Summary is sufficiently detailed to address the client's safety at home and to indicate issues that still need attention. It includes the following information about the client:

- Personal History, including how they spent their life, strengths that they bring, and any other important information about themselves.
- Mental Health and Cognitive Status
- Engagement with others in their life/social isolation
- Elder abuse
- Substance abuse
- Finances/Benefits/Entitlements
- Chronic Physical Health
- Mobility/Falls
- Housing
- Supports (formal and informal)

Examples of Assessment Summary Content:

- *An explanation that the client's strong religious faith helps her face the loss of her spouse and motivates her in other parts of her life.*

- *An explanation that the client has accepted some of the plan offered by the case manager but refused others and a statement that the case manager will continue to review goals with the client.*
- *Statement of steps the case manager will take to obtain missing information when the assessment is incomplete, e.g., obtaining additional medical, nutritional, mental health or housing assessments if need is indicated.*

Compliance 5.9. Assessment/Reassessment Sign-off. The case manager signs off on the initial assessment and subsequent reassessments. For example, "The case manager completed the assessment on this date" is written at the end of the assessment summary in the case notes section.

Standard 6: Event-based Reassessments

The program conducts event-based reassessments when needed.

Compliance 6.1. An event-based reassessment is conducted before the next scheduled reassessment if there is a major change in the client's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the care plan.

Standard 7: Assessment Timeframes

The program follows required timeframes for the initial assessment, subsequent reassessments, and event-based reassessments.

Compliance 7.1. Initial assessment . The assessment occurs no later than ten (10) business days after initial Intake is completed, unless impracticable. If the assessment cannot be performed within ten business days and the client can be safely maintained while waiting, the client is placed on a waiting list for assessment. If the case manager is unable to conduct the assessment within ten (10) business days due to impracticability, this is documented with an explanation in the client's file.

- The assessment occurs prior to authorization for NYC Aging-funded home care or Friendly Visiting. Note: NYC Aging-funded home-delivered meals may be authorized or arranged prior to the assessment when the client is presumed eligible.

Compliance 7.2. Reassessments. Reassessments are conducted at least every 365 calendar days, or more often as appropriate to the client's changing needs (event-based reassessment).

- A reassessment may be temporarily postponed if requested by the client or his/her authorized representative, or if there is a sudden change in her/his condition (e.g., hospital or nursing home stay) which affects the information collected. Circumstances of postponement are noted in the client's file.

Compliance 7.3. Event-based Reassessments. An event-based reassessment is conducted within five (5) business days of the precipitating event.

Standard 8: Care Plan

The program develops comprehensive care plan(s) for each client based on assessment/reassessment findings.

Each client has a current Care Plan that is the product of an active and ongoing process that begins during the initial assessment and that changes over time as client needs change. The case manager involves the client in care plan development to the extent possible by discussing goals and presenting choices and options. The care plan is comprehensive and includes not only services (where needed), but other appropriate interventions and linkages,

including those to health care and to opportunities for the client to engage or re-engage with personal interests and the life of the community.

Compliance 8.1. The initial care plan is developed within six (6) business days of the initial assessment completion date.

Compliance 8.2. The client or the client's authorized representative participates in care planning with (when appropriate) their informal caregivers who provide assistance with activities of daily living or instrumental activities of daily living. The case manager explains the client's choices and elicits the client's preferences.

Compliance 8.3. Care plan(s) include:

- Services and/or needed linkages to address assessed unmet needs, health and mental health care issues, and quality of life issues.
    - Where the client has a need for home care, the type(s) of home care service offered is appropriate to and is consistent with, the client's assessed unmet ADL and/or IADL needs (e.g., housekeeping service when client has only IADL impairments).
    - Supplemental services are offered at the program's discretion when necessary to achieve a care plan goal and the service cannot be obtained through other means. Examples of supplemental services include friendly visiting, support groups, home remediation/services, legal services, medical, dental, and mental health expenses not covered by insurance, and transportation for non-emergency appointments.
- Social work interventions where needed, such as client advocacy and support.
- Supports provided by existing caregivers and interventions to strengthen and support caregivers when possible.
- Entitlements/benefits counseling and application assistance when pertinent to the client's needs.
- Assist clients to connect with providers that provide counseling and assistance with long-term care planning.

Compliance 8.4. Clients are reassessed every 365 days, at which time care plans are also reviewed to ensure clients are receiving appropriate services to address their needs. If a new care plan is required based on the client's needs, a new plan that reflects the updated needs is developed and implemented.
Note: *Interventions specified in the care plan may be for less than 365 calendar days. However, if the client's needs or situation appears to have changed to the point where the care plan needs to be amended, an event-based reassessment is conducted (see Standard 5), and an updated care plan is developed. The care plan may include a plan to reassess the client at an earlier date than 365 calendar days, based on the client's particular needs and level of risk.*

Compliance 8.5. The case manager uses reassessments as opportunities to review/update the care plan with the client.

- Goals are reconsidered. Some may have been achieved, some may still be relevant, some may need to be revisited if they no longer match the client's needs and new goals may need to be formulated, with appropriate referrals/interventions planned.
- Service needs are reviewed. Current services, regardless of funder, may need to be re-authorized or terminated. New services, regardless of funder, may need to be arranged or authorized.
- Goals or services previously rejected or refused by the client are revisited if still relevant to the client's situation. The case manager uses the new care plan as an opportunity to re-introduce them for the client's consideration.

Compliance 8.6. If at reassessment there are no changes to the Care Plan, the case manager indicates in case notes that the Care Plan continues to be in effect and updates the date field.

Compliance 8.7. Completed Care Plans are sent to the supervisor for review within one (1) business day of completion.

Standard 9: Client and Service Provider Rights and Responsibilities.

The program reviews a statement of Client and Service Provider Rights and Responsibilities with each client.

Compliance 9.1. During the initial assessment and each subsequent reassessment, the NYC Aging-issued Client and Service Provider Rights and Responsibilities is reviewed with the client or authorized representative and the client is given a copy.

- The client and the case manager sign the Client and Service Provider Rights and Responsibilities.
- The case manager documents in case notes that the client received a copy.
- Case managers ensure that client rights are protected in all aspects of the program.

Standard 10: Service Agreements

The program obtains signed Service Agreements from clients in receipt of home care, home-delivered meals, and friendly visiting.

The Service Agreement specifies type(s), frequency, and duration of the home care and/or home-delivered meals and/or friendly visiting services that will be provided. It is not required if the client will not receive these services.

Compliance 10.1. As part of the initial assessment and each reassessment process, the case manager and the client (or authorized representative if the client is unable to sign due to medical or mental health reasons) sign and date a current Service Agreement. If the client or her/his authorized representative refuses to sign the Service Agreement, NYC Aging-funded home care, home-delivered meals and friendly visiting may not be authorized.

- A copy of the Service Plan is given to the client or her/his authorized representative and, if requested by the client, to informal caregiver(s).
- A new signed Service Agreement is obtained at each reassessment even if service type, amount, duration, and frequency have not changed.

Standard 11: Supervisory Review

Program supervisors ensure comprehensive casework by case managers.

Compliance 11.1. Initial supervisory review timeframe. The case manager's supervisor reviews and approves each client's case record, including intake, assessment, assessment summary, care plan, service plan (where applicable) and case notes no later than ten (10) business days after receiving the completed initial in-home care plan.

Examples of Supervisory Approval:

- *I reviewed the case record through DATE and approve.*
- *I reviewed the case record through DATE and advised the case manager to follow-up with the client's daughter about a potential referral and linkage to the local caregiver program.*

Compliance 11.2. Subsequent supervisory review timeframe. The case manager's supervisor reviews and approves each client's case record, including case notes since the last assessment, reassessment, reassessment summary, updated care plan, and updated service plan (where applicable) no later than ten (10) business days after receiving the completed reassessment care plan.

Standard 12: Implementation of Interventions

The program implements interventions specified in the client's care plan(s).

Compliance 12.1. The case manager:

- Makes all planned authorizations, linkages, and arrangements;
- Carries out planned social work interventions; and
- Encourages and supports the client in carrying out any actions for which the client has responsibility.

Compliance 12.2. Where linkages are proposed, the case manager works closely with the proposed service provider so the linkages support the client's goals.

Compliance 12.3. Temporary increase in NYC Aging-funded home care hours. Once the client is receiving home care, s/he may have weekly hours temporarily increased to include escort to a medically related appointment for that week when there is an unmet need. The case manager first consults with the home care provider to determine if there are available hours and if there is enough time to assign an aide to accommodate the request.

- "Medically related appointments" are defined as visits to medical, mental health, physical therapy, and other related providers. CMAs may reach out to their NYC Aging program officer for clarification regarding whether an appointment is "medically related."
- "Unmet need" means there is no one else who can accompany the client to the appointment. If there is someone else who can accompany the client to the appointment, that means the need is met and this client would not be eligible for this service.
- The case manager establishes, with the home care agency, how much notice is required to request additional hours.
- The program sends a referral to the home care agency through the client data system requesting the extra hours. This direct referral does not require prior approval from NYC Aging.

Note: The client's cost share contribution remains the same for this temporary increase in care.

Compliance 12.4. The case manager explains any deviations from the current care plan in case notes.

Standard 13: Ongoing Case Management

The program provides each client with ongoing case management, including services coordination, follow-up, and monitoring of care plan appropriateness.

The case manager is active in the client's ongoing care by following-up on referrals, ensuring that services are coordinated, calling the client to monitor service appropriateness, responding with appropriate interventions to emerging needs, and maintaining ongoing communications with service providers to resolve potential problems or health and safety issues.

Compliance 13.1. Next day follow-up on receipt of home care or home-delivered meals. The case manager either makes a home visit or a phone call to the client one business day after the service was scheduled to begin to confirm service start.

Compliance 13.2. Fifteen (15)-day follow-up on receipt of home care or home-delivered meals. The case manager contacts the client no later than 15 business days after a NYC Aging-funded service has begun to ascertain adequacy, appropriateness and satisfaction with the service.

- The 15-day contact is a home visit if the client is receiving home care, unless impracticable. If the case manager is unable to conduct a home visit due to impracticability, this is documented with an explanation in the client's file.
- The 15-day contact for home-delivered meals can be made by phone or it can be a home visit.

Compliance 13.3. Follow-up on Entitlement/Benefit application. The case manager follows up with the appropriate government office to ensure receipt and status of client's benefits application until a decision is reached. The case manager also keeps the client informed.

Compliance 13.4. Client care plan monitoring. The case manager or a staff person under the case manager's direction, monitors the client's care plan via phone or home visit as often as needed but at least once every two (2) months (60 calendar days). When clients have complex needs, the case manager makes as many contacts (either by phone or home visit) as needed to adequately address them, beyond the minimum requirement.

- Monitoring involves active inquiry, coordination, and follow-up to ensure that:
  - Services are being implemented as authorized;
  - Client's needs are being addressed;
  - Progress is being made to reach the client's goals;
  - New issues/needs are brought to the case manager's attention so they can be addressed;
  - Problems with the care plan are identified and addressed with the service provider; and
  - Client remains safe at home.

Note: Case managers are not expected to review all the above items in a single monitoring contact, but rather the item(s) most relevant at the time of the contact.

- Case management needs that come to the case manager's attention between assessments are followed up appropriately and documented in the case record.

Examples:

- *The case manager is helping the client to apply for SNAP benefits. She has already linked the client with NYC Aging-funded home-delivered meals. During her monitoring call, the case manager informs the client that she has just mailed the completed SNAP application. As the conversation continues, the client informs the case manager that she missed her doctor's appointment because she is experiencing worsening problems with her gait. The case manager and client agree that the case manager should help the client apply for Access-A-Ride.*

- *The case manager contacted the client for a monitoring call. The client has NYC Aging-funded home care. She informs the case manager that while she likes the aide who has been helped her over the past two months, she does not like her cooking and wants to change the aide. As the discussion continues, it becomes clearer that there may be some personality conflict between the client and the aide. The case manager and client agree that a follow-up discussion and review with the home care agency is the next step to determine how to resolve this situation.*

Compliance 13.5. Severe or imminent threats.

- The case manager reports to his/her supervisor as soon as possible any situations posing possible severe or imminent threats to the health or safety of the client or any indications of elder abuse, mistreatment, or neglect. The case manager's actions are documented in the client case record.
- The supervisor investigates reported serious client health and safety issues and reports these instances to NYC Aging and other appropriate government agencies such as APS, police, NYC Department of Health and Mental Hygiene (DOHMH), as needed. The supervisor's actions are documented in the client's record.

Compliance 13.6. "No answer" when a client does not answer the door for the home-delivered meals deliverer, the case management program may respond in any of the following ways within one (1) business day from receiving notification from the HDM:

- The case manager may follow-up beyond reaching out to the emergency contacts until client safety has been verified.

- The case manager may maintain a list of clients deemed high risk. If a client on that list is a No answer, the case manager must conduct follow-up beyond the emergency contacts until client safety has been verified.
- For clients assessed to be low risk, the case manager may call or email the emergency contact and await a response. However, if a client who is deemed low risk is a No Answer on two consecutive days, the case manager must follow-up beyond the emergency contacts until client safety has been verified. A home visit may be required as a last resort based on the known risk factors to the client.
- All follow-ups must be documented.

Compliance 13.7. Documentation in the case record. Service coordination, follow up, monitoring contacts and collateral phone calls are documented in the case record.

- The case manager provides sufficient detail when documenting monitoring or follow-up contacts to demonstrate that steps taken and information obtained were relevant to the client's situation, and that the client's needs and/or safety were addressed.

Examples of Adequate Documentation:

- *A client is receiving meals and has no other need. The client has remained stable during the past few months without any crisis. The case manager wrote the following about the monitoring contact: "We reviewed her current living situation and meal service from Totally Awesome HDM. I determined there were no major changes needed in her care plan and she continues to remain safely at home with the meals."*

- *The client has meals, but the case manager introduced the topic of SNAP because the client had refused to apply for this benefit when they last spoke. He wrote: "The client continues to appreciate the hot kosher meals. I encouraged her to reconsider her refusal of SNAP because it will help stretch her current budget. Client remains unsure if she wants to do it, said she doesn't need government help even though she complains that she doesn't have enough money to buy new shoes."*

- *The client has a daughter who lives in another state. The client begins to exhibit unusual behavior during a monitoring call. The case manager wrote: "The client was very confused during the call. She mentioned that she was expecting her husband to return home today even though her husband has been deceased for the past two years. She was also confused about which day it was. This is unlike this client who generally has a good memory and had never displayed any signs of disorientation. After talking with her, I contacted the client's daughter. The daughter mentioned that she had taken her mother to the doctor last week and that her medication had been changed. The daughter stated that she will follow-up with mother's physician."*

Example of Inadequate Documentation:

- *The case manager wrote: "The client was contacted today, and everything was fine. No further assistance was needed."*

Procedures and Methods

Standard 14: Service Authorizations and Referrals

The program follows required procedures for service authorizations and referrals.

Compliance 14.1. Referrals for home care, home-delivered meals, and friendly visiting. The case manager authorizes and sends referrals for home care services (homemaker/personal care and housekeeping services), home-delivered meals and friendly visiting through NYC Aging's client tracking system.

- Referrals for home care, home-delivered meals, and friendly visiting are consistent with the Service Agreement signed by the client regarding the types, amounts, frequency and duration of services and the assessed home care cost share amount, where appropriate.
- On a monthly basis, the home care vendor will advise the CMA how many referrals they can send. The CMA uses the wait list priority report to guide them in their selection of the allotted number of clients to refer to home care. Only clients that are truly ready to begin services should be referred to home care. It is essential that the CMA maximizes their allotment of referrals each month and sends their full number of clients to the home care provider in a timely way.
- Referrals that include 6th and 7th home-delivered meals specify Citymeals as the funder.
- Referrals specify special instructions for the provider when needed, including indication of high-risk clients to home-delivered meals providers.
- Referrals specify when there are other clients attached/linked to this case who will be receiving home-delivered meals (see Compliance 2.3) or a secondary client in the home who will indirectly benefit from having housekeeping tasks performed.

Example:

- *Mr. John Doe is authorized for 12 hours of home care and related housekeeping tasks. Mrs. Jane Doe, the client's spouse, is a secondary client because she will benefit from having the couple's apartment cleaned.*

Compliance 14.2. Timing of reauthorization referrals.

- The case manager sends a reauthorization referral through NYC Aging's client tracking system for homemaker/personal care or housekeeping/chore service if the client will continue to need the service.
    - This reauthorization is sent within ten (10) business days of the reassessment.
- The case manager sends a referral for ongoing home-delivered meals service only if there will be a change in the client's meal delivery, for example, if the client requested a change from hot kosher to frozen kosher meals.

Compliance 14.3. Referrals for other services. The program links clients to other services or resources that the client requests.

- It is best practice to link a client to the other service they want and need. This includes a referral and follow-up to ensure that the client is connected to the service and that their needs are being met. When services are complementary to what CMA provides, it is best practice to communicate updates to the provider and coordinate service provision.
- For NYC Aging funded services such as Caregivers, Elder Justice, and PROTECT and Counseling for Home Bound (PACS-HB), referrals can be sent directly through NYC Aging's client tracking system.
- The case manager documents other referrals in the client's case notes.

Examples of linkage and case coordination:

- *A client is waiting for homemaker/personal care and has an overwhelmed caregiver who is feeling stressed by the care needs of the client. With the caregiver's consent, the CMA refers the caregiver to the local Caregiver program, and they provide access to a support group and in-home respite services. The CMA remains in communication with the Caregiver program, advising them when homemaker/personal care will be available for the client.*
- *A client is a victim of elder abuse and with the client's consent, the CMA refers the client to the local Elder Justice program for counseling. The client reaches out to the CMA to let them know that she will be in the hospital for a scheduled surgery and then rehab. The client also tells the CMA that their grandchild, who was demanding money from the client, has moved out. The CMA lets the Elder Justice program know about the pending hospitalization and rehab as well as the change with the client's grandson.*

Standard 15: Wait Lists

The program maintains required wait lists and manages all wait lists.

Compliance 15.1. The program maintains wait lists for case management assessments, home care and home-delivered meals regardless of number of clients on the list or length of wait.

- Case management wait list for clients for whom the in-home assessment* cannot be conducted within ten (10) business days of the completion of Intake: Clients are only placed on a wait list under these conditions: (1) the Intake has been completed; (2) they can be safely maintained on the wait list; (3) they are deemed eligible for case management; and (4) they are informed about other possible community resources/options but would still benefit from case management. Clients authorized for HDM should be assessed within ten (10) business days of initiating the service, unless impracticable. When this occurs, the case manager will follow Compliance 13.1 and 13.2 as they relate to the next day and 15-day follow up contact, respectively.
- Wait list for NYC Aging-funded home care services (personal care and housekeeping) are established after an in-home assessment has been completed on the client, the client found eligible, a cost share/contribution worksheet is completed, and the service provider has indicated that they are at capacity and cannot accept additional clients.
- Wait list for NYC Aging-funded home-delivered meal services is established after an intake is completed, client found to be eligible for the service, there are no diet types available and the service provider has indicated they are at capacity and cannot accept additional clients. It is important to note that if a client has been offered one diet type option and declines because they have a personal preference for a different diet type that is currently not available, this client would not be eligible to be on the wait list for home-delivered meals. The one exception to this protocol is if a client needs a particular diet type due to religious observation (i.e., kosher, halal) or they are unable to handle or store frozen meals.

Compliance 15.2. Counseling on options. The case manager documents the discussion with the client of all possible community resources and other options occurred before the client was placed on the wait list.

- The program does not place clients who cannot be safely maintained while waiting for the service on a wait list. The case manager works with the client who cannot be safely maintained without service to ensure alternatives are found and put in place.

Compliance 15.3. Prioritization. Clients on the wait list for assessment and for home care or home-delivered meals services are prioritized on the Wait List Prioritization Form in the NYC Aging client tracking system.

- The client is advised of the approximate wait for the service s/he needs and that her/his priority may change because other clients with higher needs may rank higher.
- The client with the highest priority on the wait list is referred first when service becomes available.
- If the service becomes available but the client is not able to accept the service, the case manager documents in the case notes:
    - *The date the service became available to the client.*
    - *The date the client was offered the service.*
    - *The reason why the client did not or could not accept the service.*

Compliance 15.4. Interim services. Clients for whom interim or gap-filling services have been arranged (e.g., private pay home care) may continue on the wait list until service becomes available.

Compliance 15.5. Monitoring of clients on the Wait List. Clients on the wait list for a service receive a monitoring call every two months to review their status, including any changes in their need for the service.
Examples:

- *The case manager calls the client on the wait list for personal care and learns that her daughter no longer can assist the client intermittently with bathing. The case manager and client agree that she needs more immediate help with her personal care. The client is referred for homemaker/personal care and an end date is put on the wait list.*

- *The case manager contacts the client to monitor status. The client informs the case manager that she will pay for private housekeeping with some financial help from her son who lives in another state. Because of this change in the client's situation, the case manager removes the client from the wait list for housekeeping service.*

Compliance 15.6. Six-month review of clients on the Wait List. After the client has been on a wait list for six months, the case manager calls the client (3rd monitoring call) to evaluate the situation and again explore the possibility/feasibility of other service arrangements. The case manager documents discussion of alternatives with the client.

- If other arrangements cannot be made, the case manager determines whether to visit the client for a reassessment of her/his priority on the waiting list or whether to continue the client at the same priority.

Standard 16: Collection of Past Due Cost Share Amounts

The program follows required procedures for collection of past due cost share amounts.

Compliance 16.1. Timing of cost share collection procedures. The program begins past-due collection procedures when it receives a copy of the Late Payment Notice that was sent to the client and the CMA by the home care provider. The case manager has 30 calendar days from the day of receipt of the Late Payment Notice to resolve the late payment issue with the client.

Note: The NYC Aging-funded home care provider is required to send the client a Late Payment Notice when no payment or a lesser amount than invoiced has been received from the cost share client by the due date. The provider is also required to send a copy of the Late Payment Notice to the case management agency.

- The Late Payment Notice is kept in the client's file.

Compliance 16.2. Case manager actions.

- The case manager tries to reach the client by phone to discuss the payment problem. If the client or the client's representative cannot be reached by phone, the case manager documents efforts and sends a follow-up letter to both. Note: Clients or their representatives may not be harassed for payment. Reminder phone calls can only be made during normal business hours. Caregivers or authorized representatives may be called after normal business hours only if necessary to establish contact.
- Within the 30-day timeframe, the case manager obtains the client's agreement to one of the following:
    - The client agrees to pay the assessed cost share in the future and to make specified pro-rated payments on the past-due amount until the entire amount past-due is paid off (Option One). Note: The case manager may conduct a new Financial Assessment and recalculate a new cost share going forward if it appears that the client's income and allowable expenses have changed.
    - The case manager obtains an agreement from the client to pay the assessed cost share in the future and to pay off the past-due amount before or upon receipt of the next bill (Option Two).

Note: A client may be permitted to continue to make lesser payments and still receive services where the case manager determines that the client is acting in good faith and has sudden or temporary personal or family expenses not included in the cost share formula.

- If within the 30-day timeframe a payment plan (Option One or Option Two) cannot be agreed upon, the case manager sends a Termination Notice to the client with information about the client's right to contest termination. (See Standard 17 and NYC Aging's Termination Procedures).

- The case manager continues to work with the client and the client's informal supports to make long term care plans. The case manager documents discussion and planning with the client in case notes.

Compliance 16.3. Coordination with home care provider. Within 30 calendar days of the date of receipt of the Late Payment Notice, the case manager informs the home care provider about the specific details of the negotiated payment plan with the client, or sends the home care provider a copy of the Termination Notice sent to the client.

- The case manager informs the home care provider if the client requests a Fair Hearing and suspends the Termination Notice pending the Hearing outcome.

Standard 17: Service Discharge/Termination Procedures

The program follows required service discharge/termination procedures.

Compliance 17.1. Voluntary termination of services.

- Reasons for voluntary termination of case management service are as follows:
  - Client requests termination of all services including case management.
  - Client no longer needs case management because service goals have been achieved and client agrees with this determination.
  - Client has died/moved/is expected not to return home within 90 calendar days from hospital/nursing home/skilled nursing facility and client or family representative agrees to service termination.
  - Medicaid funded home care or the client's caregivers will assist with all the client's needs. No additional NYC Aging services are needed.
  - Client is referred to APS and APS will take over the case (client or client's designated representative agrees to discharge from the case management program).
- Reasons for voluntary termination of home care services or home-delivered meals service or Friendly Visiting service are the same as those for voluntary case management termination, with this exception: The client may request termination of home care or home-delivered meals or Friendly Visiting services but continue to receive case management if s/he still has case management needs.
- If the home care client will not be relocating, the case manager conducts a reassessment to determine if the service can be safely discontinued.
  - If the client will not allow the reassessment, the agency sends a letter to the client stating its recommendation for a reassessment and documenting its attempts to schedule the reassessment.

Compliance 17.2. Assistance with service needs. If it appears that the client being discharged has further need of services, the case manager assists the client in accessing appropriate care.

- If the client appears mentally incompetent or at-risk, the agency makes a referral to an appropriate agency such as NYC Department of Social Services' (DSS) / Human Resource Administration's (HRA) HRA's Adult Protective Services to ensure the client's safety.

Compliance 17.3. Involuntary Termination of Services. (*See Attachment D, Involuntary Termination of EISEP Services*)

- Case management service is terminated (client is discharged from the service) without requiring the client's consent when:

  - Client is no longer eligible for the service.
  - Client has been in a hospital/nursing home/skilled nursing facility for more than 90 calendar days or is not expected to return home.
  - Client has failed to cooperate with program requirements or has refused to comply with his/her care plan.
- Home care services and home-delivered meals service are terminated without the client's consent for any of the reasons that apply to case management involuntary termination. In addition, home-delivered meals are terminated when the case manager determines that the client's need for meals is being met or can be met by the home care provider.

Compliance 17.4. The program follows NYC Aging's policy for involuntary termination of services and notification to the client of her/his right to contest the involuntary termination and seek a resolution through a Settlement Conference and/or a Hearing. *(See Attachment E "Policy for Hearing Requirements for EISEP-Funded Services")*

- The client has a right to contest involuntary terminations in the following situations:
  - The client has been denied a NYC Aging-funded service (home care, home-delivered meals) based on a determination that he/she is not functionally or programmatically eligible. (See attachment G)
  - The client contests the amount of assessed cost share.
  - The client has failed to make cost share payments or to make negotiated payments on a past-due amount.
  - The client has failed to cooperate with program requirements such as permitting a case manager to visit or refusing to agree to a care plan.
  - The client remains unavailable to receive services after 90 days of service suspension.

Compliance 17.5. If only home-delivered meals service is being terminated and case management services continue, then the client can only contest the involuntary termination and seek a resolution through a Grievance Procedure, not through a Settlement Conference nor a Hearing. (See Attachment H, "Template for Terminating Home Delivered Meals" and Attachment I, " Client Grievance Form."**).**

Compliance 17.6. Grievance Procedure. The program must have a Grievance Procedure in place. At a minimum, the grievance procedures must include:

1. Methods for notifying clients or service applicants of their right to file a grievance.
2. The steps to be followed in filing a grievance.
3. Reasonable timeframes for filing a grievance, investigating the grievance, reaching a decision, and having that decision communicated in writing to the grievant.
4. An opportunity for the grievant to present her/his grievance, along with any pertinent information or documents relating to the issues, to a clearly identified individual or group of individuals that has the authority to make a binding decision.
5. The criteria to be used for making a decision on the grievance.
6. A process by which a program participant may appeal an initial decision made by your agency.

Compliance 17.7. Notification to providers. When case management and other NYC Aging-funded services (home care, home-delivered meals) are terminated, the case manager sends a termination referral to providers through NYC Aging's client tracking system.

Service Levels

Standard 18: Budgeted Units

The program provides its budgeted annual units.

Compliance 18.1. The case management agency meets its service level requirement.

Compliance 18.2. The program uses the correct unit definition in documenting case management service units. A unit of case management represents one hour spent on direct client service as follows:

- Intake interview
- Assessment
- Care Plan Development
- Collateral contacts on behalf of the client
- Contact with the client by telephone (client monitoring)
- Follow-up/coordination/discussion of the client's services with client's service providers
- Entering case notes on the client
- Maintaining the client's case record in NYC Aging's client tracking system and the client's paper file (if applicable). This includes inputting client data.
- Travel time to the client's home
- Discussing the client's case during a case conference or during supervision (only that portion of the case or supervisory conference devoted to the client may be counted toward a case management unit). Note: Either the client's case manager or the case manager's supervisor counts the time, not both.
- Supervisory review of the case record

Example of case conference/supervisory conference unit calculation.

- *The case manager meets her/his supervisor for 1 hour. They spend 30 minutes discussing Client A's alcohol problem and the supervisor provides the case manager with guidance on the case. The supervisor spends 15 minutes with the case manager reviewing the case notes and other documentation on Client A and another 15 minutes with the case manager reviewing case notes on Client B. Units attributable to Client A: .75 hour. Units attributable to Client B: .25 hour. Either the case manager or the supervisor enters the time spent on the case. The program has a policy about whether the case manager or the supervisor claims the unit.*

- *Client A's alcohol problem has worsened. The case manager meets with her supervisor and a co-worker who is a certified alcohol counselor to discuss Client A. For an hour, they discuss Client A and how to proceed with the case. One (1) unit (one hour of service) is attributed to the client. Although three staff participated in the conference, only one staff person enters the time spent on Client A's case.*

- *While a case manager typically works a seven or eight hour day, this does not mean that each day he/she will generate seven or eight hours of case management units.*

- *Time spent in administrative, educational, or general activities cannot be counted as units of service. Units may not be counted for time spent traveling to and participating in professional development activities such as trainings, time spent developing a new form, or time spent informing the public/other providers about the service.*

Compliance 18.3. The program uses the correct unit definition in documenting supplemental services units. (*See Attachment A: Definition of Units*)

Compliance 18.4. Case management units in NYC Aging's client data system match 100% with invoiced units.

Staff Appropriateness and Continuity

Standard 19: Staff and Supervisor(s) Qualifications

Staff and supervisor(s) meet required qualifications.

Compliance 19.1. Cultural Competency. All direct service staff:

- Speak one or more of the three predominant languages in the program's catchment area and know how to access interpreter services when needed.
- Are knowledgeable about and sensitive to the diverse needs, preferences, and characteristics (including religious and cultural expectations and communication styles) of older persons in the program's catchment area.
- Are knowledgeable about and sensitive to socioeconomic, health care and other issues of minority and immigrant populations.
- Are sensitive to issues of gender identity and sexual orientation.
- Are knowledgeable about linguistically and culturally competent service providers in the community.
- Are knowledgeable about the communication needs of persons with visual and/or hearing impairments.

Compliance 19.2. Case Manager Qualifications. Case managers meet or exceed the following qualifications:

- MSW or related Master's degree (e.g., social services, public administration, nursing, or public health) preferred when practicable and budget allows); or
- Bachelor's level degree; or
- High school diploma or Associate degree with four years or more of casework experience in a community social service or social action program; or
- Registered nurse with one year of satisfactory full-time paid experience as a nurse.

Compliance 19.3. Case Management Supervisor Qualifications. Supervisors meet or exceed the following qualification:

- MSW degree or related Master's level degree (e.g., social services, public administration, nursing, or public health).

Compliance 19.4. Case Management Program Director Qualifications. The case management program director (Director) meets or exceeds the following qualification:

- MSW degree or related Masters level degree (e.g., social services, public administration, nursing, or public health). In addition, Directors meet the following qualifications:
    - At least three years of full-time experience in social services or related field;
    - At least two years of supervisory experience;
    - Experience working in the field of aging;
    - Proven leadership experience;
    - Crisis-management skills; and
    - Excellent communication skills.

Compliance 19.5. Intake Staff Qualifications.

- Staff who perform the screening and/or intake function have at least the same qualifications as case managers, and, preferably (though not required), the same qualifications as supervisors.
- Staff who perform the screening and/or intake function have received training on interviewing skills and on the range of available resources to meet client needs.
- Staff who perform the screening and/or intake function are able to:

- Elicit and evaluate the client's presenting problem;
- Determine preliminary eligibility;
- Make necessary referrals to resources/services;
- Provide program information;
- Provide callers with a positive impression of the program and types of assistance available.

Standard 20: Use of Case Aides, Undergraduate and MSW students

The program uses case aides, undergraduates and MSW students appropriately.

Compliance 20.1. Case Aides and Undergraduates. The program ensures that Case Aides and undergraduates are only permitted to perform administrative tasks. They assist case managers to whom they are assigned only with these duties: pre-screening calls; arranging services; two-month monitoring calls and follow-up calls to "no answers; assisting with data entry and other administrative tasks. They may not conduct assessments or reassessment; may not do care planning; may not authorize services; may not terminate clients from the program.

- Case Aides and undergraduates receive appropriate training for their duties.
- The program ensures a regular flow of communication from the case aides/students and the case managers with whom they work.

Compliance 20.2. Master of Social Work (MSW) Students. MSW interns do assessments and care planning, under the supervision of an MSW supervisor. The supervisor is responsible for the case(s) managed by the MSW intern.

Standard 21: Case load average and Full-Time Equivalent staff

Compliance 21.1. The CMA employs a strategy to assist in the management of clients based on presenting and varied needs, which range from simple to complex and that meets the program case load average of 1 case manager to 65 clients. The average program caseload ratio is computed by taking the number of budgeted staff performing core program functions divided by the number of active clients at one given point in time. (Clients who are at Intake and are on the wait list for an in-home assessment are not counted towards the ratio. Clients who are at the intake stage but not on the wait list for an in-home assessment are counted towards the ratio.)
For purposes of determining the case load average, NYC Aging accounts for the following based on your budgeted staff:

- A case manager who is employed either 35 or 40 hours and 100% allocated to the contract will represent 1.0 CM FTE. For case managers who work less than full time, their FTE is pro-rated.
- If the intake worker is a case manager or has a different title though similar salary to a case manager, they are counted in the caseload average.
- A staff member who functions partially as a case manager and partially as a supervisor or other role will have a CM FTE that is pro-rated based on the number of hours they spend in the case manager role.
- A supervisor who is allocated to the contract and functions exclusively as a supervisor will not be counted towards the CM FTE.
- Clerks who only do administrative work and do not do any of the case aide related work will not be counted towards the CM FTE.
- MSW students will not count towards the CM FTE.
- Directors will not count towards the CM FTE.

Compliance 21.2. NYC Aging expects that one case manager, supported by a supervisor and case aides, will generate at least 1,573 client units per fiscal year.

Compliance 21.3. When caseloads are less than 65 per case manager, the CMA will develop a plan and implement such plan within 3 months of the average dropping below 65 per budgeted FTE case manager. Plans may include recruitment for a vacant line, temp worker while staff on extended leave or outreach when case load averages are below 65 and there is not a waiting list for services. Outreach emphasis should be placed on reaching underserved communities in the program's catchment area when compared existing program caseload (e.g., diverse populations and subgroups, cultures, languages).

Compliance 21.4. The program notifies NYC Aging within two (2) weeks when there is a permanent change in staffing. Permanent staffing is defined as a significant change in leadership or staffing pattern, such as the retirement of a director, significant number of staff turnover, or a reduction/addition of budgeting lines.

Standard 22: Background Checks

The program conducts background checks on all employees.

Compliance 22.1. The program conducts background checks on all employees and complies with requirements of the case management contract with regard to the screening of staff, obtaining of references and compliance with applicable Federal, State and city laws.

- Copies of background checks are kept on file.

Standard 23: Staff Orientation

The program orients all staff.

Compliance 23.1. All staff members are provided with an orientation that includes:

- Name of person who will supervise the staff member.
- Provision of a kit containing program policies and procedures, personnel policies; a written job description; NYC Aging's standards; the narrative section of the RFP response; and Client and Service Provider Rights and Responsibilities.
- A review of:
    - Specific program components;
    - Staff roles and responsibilities;
    - Client Rights and Responsibilities and Code of Conduct;
    - Emergency procedures;
    - Elder Abuse protocols;
    - Worker Safety Practices and Protocols including agency safety systems (e.g., dedicated emergency phone line, "buddy systems" for joint visits on potentially dangerous home visits); safety information to be obtained prior to the home visit from the client; safety preparations prior to the home visit; getting to the home visit safely; and safety measures to follow at the home visit;
    - Demographics of the community served, including but not limited to socioeconomic data, languages spoken, number who live-alone, major health issues (data available from NYC Aging).

Compliance 23.2. Staff member orientation is documented and new staff sign a statement that they have reviewed the orientation kit.

Standard 24: NYC Aging Training Requirements

Staff meet NYC Aging training requirements.

Compliance 24.1. Case management staff, including directors, supervisors, case managers, and sub-contracted staff who function as the primary case manager for clients, must attend annual trainings as required by NYC Aging.

Compliance 24.2. All newly hired case management staff attend NYC Aging's multi-day "Introduction to NYC Aging-Funded Case Management: Theory and Practice" training before the first anniversary of their date of employment.

Compliance 24.3. All newly hired or promoted supervisors and directors attend NYC Aging-conducted training specifically for case management supervisors and directors before the first anniversary of their date of employment or promotion.

Compliance 24.4. All newly hired or promoted case management staff attend NYC Aging's "Elder Abuse Detection and Response Protocols" training as required by City law before the second anniversary of their date of hire or promotion

Compliance 24.5. After the first anniversary of the start date, and after completing NYC Aging's 8-day introductory case management training or the 7-day supervisory training, all case management staff annually attend sixteen hours of training relevant to case management practice or program administration. Attendance at non-NYC Aging trainings may be used to satisfy this requirement. Staff may also be required to attend mandated trainings as per NYC Aging policy.

- The case management agency maintains documentation of training in each worker's personnel file. This includes topic, date, trainer's name and organization, and number of hours in attendance.

Standard 25: Supervision of Case Managers

Case managers are adequately supervised.

Compliance 25.1. The program has a written staff supervision policy, which includes regularly scheduled individual and/or group supervision of case managers.

Compliance 25.2. When practicable and the budget allows, no more than five case managers report to a supervisor to ensure effective supervision. Where appropriate, the Director of the program may also supervise case managers.

Compliance 25.3. The Program Director provides monthly scheduled individual and/or group supervision to supervisors. Such supervision includes a discussion of the oversight and support of case managers. If a supervisor also carries a caseload, the Program Director supervises their cases.

Compliance 25.4. The case management agency sponsor provides regularly scheduled supervision with the Program Director. Such supervision includes discussion of staff oversight, program performance, related budgetary issues, and other items that have a direct impact on client service and safety.

Compliance 25.5. All case management staff who provide direct service to clients have an annual performance review conducted by their supervisor.

Language Access and Cultural Competence

Standard 26: Linguistic Cultural and Competence

The program is linguistically and culturally competent. (See also Standard 19.1, page 21 and NYC Aging General Standards of Operation, Standard 9)

Compliance 26.1. Language Access. The program provides language assistance free of charge to persons with limited English proficiency (LEP). At minimum, the program has a telephonic interpretation service contract or similar community arrangement with a language interpretation services provider to assist LEP individuals.

Compliance 26.2. Cultural Competence. Services are provided with respect for cultural differences, preferences, and styles of communication, and with skill in assisting individuals in overcoming cultural and linguistic barriers.

Documentation and Recordkeeping

Standard 27: Documentation

Interactions with clients are documented in case notes.

Compliance 27.1. Case notes are entered in the NYC Aging client tracking system within three (3) business days of the event date. An event is defined as any type of work or activity performed by the staff, such as a home visit, a phone call, sending a referral, etc., that is being documented as part of the case record. Supervisors review for compliance during scheduled supervision.

Compliance 27.2. Case note entries include the date, identity of person with whom there was contact, type of contact, (e.g., home visit, phone call), a brief summary of the contact, a summary of actions to be taken and the identity of persons responsible for taking those actions.

Standard 28: Recordkeeping

Accurate client and service information is maintained in NYC Aging's client tracking system.

Compliance 28.1. Programs with sub-contractors monitor entry into the NYC Aging's client tracking system of all required information as well as maintenance of other required records.

Compliance 28.2. Each client has a case record that is maintained in NYC Aging's client tracking system. Any client data, paperwork, or documents should be kept by the organization for six (6) years after the final payment or expirations or termination of the program's agreement to provide case management services with NYC Aging. Example: If an Agreement ends March 15, 2023, the contractor must keep all documents related to this Agreement until March 15, 2029. After March 15, 2029, if documents are not otherwise needed, the contractor is free to responsibly dispose of them. The following are maintained in the client tracking system:

- Intake
- Case File
- COMPASS 2019
- Assessment and Reassessments
- Strengths and Accomplishments
- Care Plans and Service Plans
- Cost Share Worksheet (where applicable)
- Service Authorizations/Referrals (NYC Aging-funded)

  - Documentation of provision of emergency services
  - Case notes
  - Documentation of supervisory review
  - Signed Consent Form (s)

- The following may be maintained in paper files (unless scanned in):
  - Form signed by the client indicating she/he has been informed of, understands, and has received a copy(ies) of the NYC Aging Client and Service Provider Rights and Responsibilities.
  - Service Agreement.
  - Correspondence and other documents pertinent to the client record.

Compliance 28.3. The program may save required records in either paper or electronic form. The program needs to ensure that any conversion they attempt complies with N.Y. Civil Practice Law and Rules governing the conversion of paper documents into electronic ones. NYC Aging encourages all contractors to consult with their organization's counsel before attempting a conversion.

Emergency Preparedness and Response

Standard 29: Emergency Preparedness and Procedures

The program has current plan and procedures for responding to emergencies. (See also NYC Aging General Program Standards, Standards 27 and 28)

Compliance 29.1. The program engages in emergency preparedness planning and exercises and works with NYC Aging to ensure the provision of services and continuity of car as directed by NYC Aging in an emergency and/crisis.

Compliance 29.2. The program provides any requested information (including phone numbers, data, reports, etc.) to NYC Aging related to an ongoing emergency situation preferably by Close of Business on the date requested, but no later than 10:00 a.m. EST the following morning.

Compliance 29.3. The program submits a Service Provide Provider Emergency Preparedness and Response Plan to NYC Aging's Office of Emergency Preparedness and Response and updates the Plan every two years. This plan should detail how the program would continue to provide critical services to clients in the event of an emergency.

Compliance 29.4. In the event of a public health emergency, the program adheres to any additional guidance issued by NYC Aging.

Friendly Visiting

Friendly Visiting Introduction

Friendly Visiting is a scheduled visiting service provided on a regular basis to older persons in their homes to (1) help reduce isolation, and (2) monitor the older person's safety, well-being and need for additional services. Friendly Visiting is not a one-time service.

These standards are applicable to all NYC Aging-funded Friendly Visiting Programs. Friendly Visiting Programs are also required to comply with NYC Aging's General Standards of Operation.

Eligibility

Standard 1. Eligibility

The program serves eligible older persons who need Friendly Visiting service.

Compliance 1.1. The program provides Friendly Visiting service to persons who meet the following criteria:

- Are receiving NYC Aging Case Management services or NYC Aging Caregiver services.
  Exception: The Case Management program will close the case if the client is institutionalized; however, if the client is matched with a volunteer at the time of case management closure and institutionalized in New York City, the Friendly Visiting program will keep it open if the match is active with the same volunteer.
- Have few or no informal supports or opportunities for socialization (isolated or at risk for social isolation*).*
- The client must abide by the program rules and the Client Rights and Responsibilities.

Procedures and Methods

Standard 2. Screening and Assessment

The program screens clients to confirm eligibility and assess needs.

Compliance 2.1. If the client is a case management client, the client's case manager screens the request for Friendly Visiting service to make a preliminary decision about eligibility, and if the case manager deems the client is appropriate for the program, makes a referral to the Friendly Visiting Program. The Case Management Assessment is completed prior to making the referral to the Friendly Visiting Program.

If the person is a caregiver or care receiver aged 60 or over in an NYC Aging Caregiver program, the Caregiver Program must conduct an in-home assessment to the caregiver and/or care receiver's home depending on who is being referred to the Friendly Visiting Program, to make a preliminary decision about eligibility. If the Caregiver Program deems the caregiver or care receiver is appropriate for Friendly Visiting, they make a referral to the Friendly Visiting Program. If the caregiver or care receiver is not amenable to the Friendly Visiting in-home assessment, the assessment can be completed on the phone or virtually. Case notes should reflect the client's request. Caregivers or

care receivers who are not willing to accept an in-home assessment cannot be authorized for in-person visits by a volunteer. They can be authorized for telephone calls and virtual visits only.

Compliance 2.2. The Friendly Visiting Coordinator visits the client in the home or usual residence to confirm eligibility and complete the program assessment in person. If in the best interest of the client, the assessment can be completed through a combination of phone or virtual and in-home. The Coordinator should encourage the client to accept a home visit. If a client is not amenable to the Coordinator visiting them in their home, the assessment can be completed on the phone or virtually. Case notes should reflect the client's request. Clients who are not willing to accept an in-home assessment cannot be authorized for in-person visits by a volunteer. They can be authorized for telephone calls and virtual visits only. The authorized method of visit (in-person, telephone or virtual) should be noted in the assessment. If the client was initially authorized for telephone calls and virtual visits only and then wants an in-person visit with a volunteer, the Friendly Visiting Coordinator must visit the client in their home prior to authorizing the client for in-person visits. This visit and change in method must be documented.
The Coordinator:

- Collects information about the client's interests, hobbies and preferences for a volunteer and documents in the assessment.
- Reviews program structure, volunteer role and program policies.
- Gives/sends the client a copy of the program's policies.
- Obtains signed program agreement. If the assessment is completed on the phone, verbal agreement is acceptable.

Compliance 2.3. The Friendly Visiting Coordinator completes the Social Isolation Assessment with the client within one (1) week of completing the Program Assessment. If the Social Isolation Assessment could not be completed at the home visit, it can be completed on the phone. If the client is unable to answer due to cognitive decline or hospitalization, the Social Isolation Assessment should be marked as 'refused' on the form and the reason documented in the case notes. Proxy members, such as family members or friends, cannot substitute and answer for the client.

Compliance 2.4. If the client needs additional services, the Friendly Visiting staff informs the client's case manager.

Compliance 2.5. Coordinator Assignment. The program assigns a Friendly Visiting Coordinator to the client in NYC Aging's database. Cases may not be assigned to a Program Assistant.

Standard 3. Visiting Schedule

The program develops a visiting schedule with the client.

Compliance 3.1. The program establishes a visiting schedule with the client to ensure the client will be available once per week for an hour.

- The schedule specifies the days of the week and timeframe the client is available.
- When a volunteer has been identified, the program will confirm the client's availability and ensure it coincides with the volunteer's availability.

Standard 4. Client and Volunteer Agreements

The program obtains signed agreement from client and volunteer.

Compliance 4.1. A Client Agreement is signed by the client and Coordinator during the Program Assessment. (See Attachment J)

Compliance 4.2. A Volunteer Agreement is signed by the volunteer and the FV staff person prior to the match. (See Attachment K)

Standard 5. Service Delivery – Individuals

Visitors provide companionship and engage in conversation and activities with their assigned client/s.

Compliance 5.1. The Friendly Visiting Program matches clients and volunteers based on schedule, shared interests, compatibility, and geography.

Compliance 5.2. The program provides the volunteer with information about the client's interests and availability. If the volunteer agrees, the program provides the client with information about the volunteer's interests and availability. If the volunteer also agrees, the program schedules the match visit.

Compliance 5.3. The Friendly Visiting Coordinator or Assistant Coordinator attends the first match visit. This is documented in the case file as the match date. If the client is authorized for telephone calls or virtual visits only, the Friendly Visiting Coordinator or Assistant Coordinator will schedule and facilitate the telephone call or virtual visit. If, due to client or volunteer schedule, the first visit is to be held in the evening or on the weekend, the Friendly Visiting staff will speak with both parties on the first business day following the match visit or call. The reason for the off-hours match visit must be documented in a case note.

Compliance 5.4. The program ensures that within one (1) week following the match, the Friendly Visiting staff will speak with both the client and the volunteer separately to follow up on the match and ensure both parties agree to be matched. If both agree, the date they first spoke or met is logged as the match date and the date and length of the visit are documented as a unit of service. Every match date must have a unit.

Compliance 5.5. The program ensures that volunteers provide socialization and do not do tasks such as shopping, errands, cleaning, escorting to a medical appointment or financial services (bill paying), etc.

Compliance 5.6. The program ensures that each matched client and volunteer are contacted by the program by telephone or video call at least once every three (3) months to ensure the match is going well and address any concerns. If the client is not matched, the program contacts them once every three (3) months to ensure they are still interested in the program. Text messages and emails are not considered contact for this purpose. If the client or volunteer does not answer, the program should follow best practice and make at least three (3) attempts over the next five (5) business days to reach them. These actions must be documented in the case file. The program should continue to attempt to contact the volunteer and client until contact is made with each party.

Compliance 5.7. The program ensures that if a client is matched six (6) months or longer, the Friendly Visiting Coordinator completes the Social Isolation Assessment at the 6-month date. For example, if the client was matched on July 2, the Social Isolation Assessment should be completed on January 2. If the Social Isolation Assessment cannot be completed on the due date, the Program ensures it will be completed within one (1) week of the due date. If the client does not answer, the program should follow best practice and make at least three (3) attempts within five (5) business days to reach them. If the program is unable to complete the Social Isolation Assessment, the program will mark the Assessment as 'refused'. These actions must be documented in the case file.

Compliance 5.8. If a client's case is closed for any reason, the program will complete a new Program Assessment and Social Isolation Assessment when they return to the program.

Compliance 5.9. If the match dissolves, the program ensures that the Friendly Visiting staff will speak with both the client and the volunteer within two (2) weeks following the dissolution date. Text messages and emails are not considered contact for this purpose. If the client or volunteer does not answer, the program should follow best

practice and make at least three (3) attempts within five (5) business days to reach them. After three (3) unsuccessful attempts, the program will send a letter informing the client or volunteer of match dissolution and closure of case, if applicable. Attempts must be sufficiently documented in the case record.

Compliance 5.10. Clients and volunteers may only be in one NYC Aging-funded Friendly Program at a time without prior approval from NYC Aging. If a client transfers to a new NYC Aging-funded Friendly Program (i.e.: they moved), the new program will complete new assessments. If a volunteer transfers, the new program will conduct new background and reference checks.

Standard 6. Service Delivery - Groups

Volunteers facilitate a virtual group with the goal(s) of providing companionship and engaging assigned clients in conversation.

Compliance 6.1. The Friendly Visiting Program may recruit volunteers to facilitate telephone or virtual socialization groups. Group topics are developed by the program. Volunteer group facilitators are held to the same standards as one-on-one volunteers.

Compliance 6.2. The program provides the client with information about the group topic and schedule. If the client is interested in joining the group, the program provides the volunteer group facilitator with information about the client. If the volunteer group facilitator thinks the client would be a good fit for the group, the program informs the client and invites the client to attend the next group session. The Friendly Visiting Coordinator or the Assistant Coordinator must attend the client's first group session. If the group is held in the evening or on the weekend, the Friendly Visiting staff will speak with the client and the volunteer group facilitator on the first business day following the group call.

Compliance 6.3. The program ensures that within one (1) week following the client's first group session, the Friendly Visiting staff will speak with both the client and the volunteer group facilitator separately to follow up on the group and ensure the client wants to join the group and the volunteer thinks the client is a good fit for the group. If both agree, the date of that group session is logged as the match date and the date and length of the session are documented as a unit of service. This match date must have a unit. If more than one volunteer facilitates the group, clients are matched with only one of the volunteers.

Compliance 6.4. The program ensures that the volunteer and group clients provide socialization only and no one performs tasks for another, such as shopping, errands, cleaning, escorting to a medical appointment or financial services (bill paying), etc.

Compliance 6.5. The program ensures that each group client and volunteer group facilitator are contacted by telephone or video call at least once every three (3) months to ensure the match is going well and address any concerns. Text messages and emails are not considered contact for this purpose. If the client or volunteer does not answer, the program should follow best practice and make at least three (3) attempts over the next five (5) business days to reach them. These actions must be documented in the case file. The program should continue to attempt to contact the client and volunteer until contact is made.

Compliance 6.6. The program ensures that if a client is active in the group for six (6) months or longer, the Friendly Visiting Coordinator completes the Social Isolation Assessment at the 6-month date. For example, if the client first attended the group (and was matched) on July 2, the Social Isolation Assessment should be completed on January 2. If the Social Isolation Assessment cannot be completed on the due date, the program ensures it will be completed within one (1) week of the due date. If the client does not answer, the program should follow best practice and make at least three (3) attempts over the next five (5) business days to reach them. If the program is unable to complete the Social Isolation Assessment, the program will mark the Assessment as 'refused'. These actions must be documented in the case file.

Compliance 6.7. If the client decides to leave the group, the program ensures that the Friendly Visiting staff speak with both the client and the volunteer group facilitator within two (2) weeks following the dissolution date. Text messages and emails are not considered contact for this purpose. If the client or volunteer does not answer, the program should follow best practice and make at least three (3) attempts over the next five (5) business days to reach them. These actions must be documented in the case file. After three (3) unsuccessful attempts, the program will send a letter informing the client or volunteer of match dissolution and closure of case, if applicable. Attempts must be sufficiently documented in the case record.

Standard 7. Monitoring Client Safety, Training and Supervision

The program trains and supervises volunteers. Volunteers monitor clients' safety and welfare.

Compliance 7.1. All new volunteers receive formal orientation on topics pertinent to the service they will be providing. Examples include but are not limited to: roles and responsibilities; relationship-building; boundary-setting; services and activities that can be performed by the volunteer; situations that should be reported to staff; how to "read" clues to a client's needs; confidentiality; response to urgent situations; record keeping.

Compliance 7.2. Volunteers document and report any concerns that arose during the visit to the Friendly Visiting staff within 24 hours of the visit or call.

Compliance 7.3. The Friendly Visiting staff follows up as necessary on all reported concerns (for example, informing the case manager and/or addressing it with the client directly).

Compliance 7.4. Volunteers report the date and length of each visit to the Friendly Visiting Program weekly or monthly, depending on program policy.

Compliance 7.5. Friendly Visiting staff speak with each matched volunteer at least once every three (3) months to ensure the match is going well and address any concerns. If the volunteer does not answer, the program should follow best practice and make at least three (3) attempts within five (5) business days to reach them. These actions must be documented in the case file. The program should continue to attempt to contact the volunteer until contact is made.

Standard 8. Re-Evaluation of Service Needs

The program re-evaluates the client's need for the service on an ongoing basis.

Compliance 8.1. The client's need and appropriateness for the service is re-evaluated on an ongoing basis, with feedback provided from the volunteer and the case manager. This feedback must be documented in the case file.

Compliance 8.2. The match is dissolved if the need no longer exists and/or the client is no longer appropriate for the service, due to behavior and/or cognitive decline. If the match has not had a unit for three (3) months, the match should be dissolved. The reason must be documented in the case file.

Compliance 8.3. The program conducts a client satisfaction survey annually to allow clients an opportunity to share their experiences. The program shall demonstrate that they reviewed and used the data collected to enhance their service.

Standard 9. Volunteer Recognition and Outreach
The Program holds a volunteer recognition event and conducts volunteer outreach in the community.

Compliance 9.1. The program holds a Friendly Visiting Program volunteer recognition event at least once per fiscal year.

Compliance 9.2. The Friendly Visiting staff presents at an outreach event or attends a community event to recruit volunteers for the program at least once per fiscal year.

Staff Appropriateness and Continuity

Standard 10. Staff Qualifications
Staff meet required qualifications.

Compliance 10.1 Cultural Competency. All direct service staff:

- Speak one or more of the three predominant languages in the program's catchment area and know how to access interpreter services when needed.
- Are knowledgeable about and sensitive to the diverse needs, preferences, and characteristics (including religious and cultural expectations and communication styles) of older persons in the program's catchment area.
- Are knowledgeable about and sensitive to socioeconomic, health care and other issues of minority and immigrant populations.
- Are sensitive to issues of gender identity and sexual orientation.
- Are knowledgeable about the communication needs of persons with visual and/or hearing impairments.

Compliance 10.2 Friendly Visiting Coordinator qualifications. Friendly Visiting Coordinators meet or exceed the following qualifications:

- MSW or related Master's degree (e.g., social services, public administration, nursing, or public health) preferred when practicable and budget allows); or
- Bachelor's level degree and one year experience in social services provision; or
- High school diploma or an AA degree and two years social service provision;
- or four years of direct social service experience.

Compliance 10.3 Supervision of Friendly Visiting Coordinator. Supervisors meet or exceed the following qualification:

- The Friendly Visiting Coordinator is supervised by the Case Management Director, a Case Management Supervisor, or another Master's-level manager within the department. The Friendly Visiting Coordinator is not supervised by a case manager.

Compliance 10.4 Assistant Friendly Visiting Coordinator qualifications. If the program has an Assistant Friendly Visiting Coordinator, they meet or exceed the following qualifications:

- Bachelor's level degree and one year experience in social services experience; or
- High school diploma or an AA degree and two years social service experience;
- or four years of direct social service experience.

Compliance 10.5 Friendly Visiting Program Assistant. The program ensures that Program Assistants are only permitted to perform administrative tasks. They assist the Friendly Visiting Coordinator with administrative tasks only, such as: pre-screening calls; scheduling assessments; client and volunteer check-in calls and follow-up calls; reference checks; assisting with data entry and other administrative tasks, including outreach. They may not conduct assessments or terminate clients from the program. Program Assistants may not have cases assigned to them.

- Program Assistants receive appropriate training for their duties.

Compliance 10.6 Master of Social Work (MSW) students. MSW interns are permitted to conduct assessments under the supervision of an MSW supervisor. The supervisor is responsible for the case(s) managed by the MSW intern.

Standard 11. Program Staffing

Staffing is appropriate and adequate for the service.

Compliance 11.1. The number of full and/or part-time personnel (including volunteers) providing this service is sufficient to meet contracted service levels**.**

Compliance 11.2. Volunteers who provide the service:

- Must be 18 years old or older.
- Commit to visiting for one hour per week for six (6) months or longer.
- Are consistently available at the agreed-upon visit time.
- Have been screened and interviewed to establish reliability and interest by the Friendly Visiting Program.
- Have provided at least two (2) non-familial references. The program completes both reference checks prior to the volunteer being matched with a client and documents reference responses on the provided reference check form.
- Have completed and passed a criminal background check prior to match.
- Have a visiting schedule on file.
- Have completed orientation/training on the program's policies and procedures.
- Have signed the Program Agreement.
- Are prohibited from accepting gifts and/or money.
- Are prohibited from providing services of any kind to the client, including chores, errands, medical care, and financial advice.
- Must meet with the program staff in person to be approved for in-person visits with a client.

Compliance 11.3. Friendly Visiting staff, including MSW interns, have completed and passed a criminal background check prior to employment. MSW Interns are not required to complete a reference check.

Compliance 11.4. All Friendly Visiting staff attend 4 hours of training annually on issues related to older adults and/or managing volunteers, including but not limited to isolation and loneliness. Training is provided by reliable sources (e.g., NYC Aging, SOFA, ACL or other non-profit or mayoral agency, with NYC Aging's approval). Note: Part-time staff members attend training hours in proportion to their annual work hours**.**

Compliance 11.5. All Friendly Visiting Program staff attend and complete NYC Aging's "Elder Abuse Detection and Response Protocols" training as required by City law.

Compliance 11.6. The program maintains documentation of training in each worker's personnel file. This includes topic, date, trainer's name and organization, and number of hours in attendance.

Standard 12. Information Sharing

The program facilitates information sharing among clients and volunteers.

Compliance 12.1. There are demonstrable procedures and communication channels for communicating information about the client to the volunteer/s and case manager.

- Procedures protect the client's confidentiality while maximizing the ability of each volunteer to be helpful.

Service Levels and Reported Units

Standard 13. Definition of Unit

The correct unit definition is used in documenting service provided to the client (See Attachment A).

Compliance 13.1. A unit is each visit with a client with documented need for this service. A visit is defined as either an in-person visit, telephone call, or virtual visit. An in-person visit, telephone call, or virtual visit must be 15 minutes or longer to be considered a unit. Visits/calls over 15 minutes are to be rounded to the nearest quarter-hour. Text messages or emails are not considered contact for this purpose. Units are entered for visits conducted by volunteers only.

Compliance 13.2. Units are counted only for completed visit contacts (in-person visit, telephone call, virtual visit) by a volunteer with clients, whose need for in-home support is documented in NYC Aging's client data system.

Compliance 13.3. If more than one volunteer visits a client together, the program may only enter units for one of the volunteers and not both.

Compliance 13.4. Units for groups are entered per client and for only one volunteer facilitator (if more than one volunteer facilitates the group). For example, if 4 clients participate in a group session with group facilitators A and B, a unit would be entered for each of the 4 clients matched with volunteer group facilitator A, equaling 4 units.

Compliance 13.5. Units are entered into NYC Aging's client database at least once monthly. The Program must maintain back up documents to substantiate the units inputted each month, such as a Microsoft form.

Standard 14. Budgeted Units

The program provides its budgeted units.

Compliance 14.1. The program serves its number of annually contracted units and unduplicated matched clients, which NYC Aging provided to each contractor at the time of the award. The annual contract deliverables for each catchment area were determined based on client need in that area at the time of the RFP. NYC Aging recommends a staffing pattern based on the annually contracted deliverables. If the program does not follow the recommended staffing pattern or there are staff vacancies, the contracted deliverables will remain the same.

The methodology for NYC Aging's recommended staffing pattern based on units is as follows:

- It is expected that one Friendly Visiting Coordinator will support at least 1,420 volunteer units within the fiscal year.

- It is expected that each Program/Case Assistant will support at least 710 volunteer units within the fiscal year.

The methodology for NYC Aging's recommended staffing pattern based on unduplicated clients is as follows:

- It is expected that one Friendly Visiting Coordinator will serve at least 75 unduplicated clients served/matched within the fiscal year.
- It is expected that each Program/Case Assistant will serve at least 37 unduplicated clients served/matched within the fiscal year.

Recordkeeping

Standard 15. Recordkeeping

The program maintains required records.

Compliance 15.1. Client records are entered into NYC Aging's client tracking system within one week of the event date (unless noted otherwise below). These records include:

- Program Assessment in NYC Aging's client tracking system.
- Social Isolation Assessments.
- Date of match.
- Date of dissolved match and/or case closure if client is no longer receiving the service and reason for termination.
- Case notes documenting contacts with the client, case managers, volunteers, and collateral contacts. Case notes must be entered within three (3) business days of the event.
- Signed Program Agreement.

Compliance 15.2. Volunteer records are entered into NYC Aging's client tracking system within one week of being approved as a volunteer. Volunteer records include:

- Name, address, contact information and family and emergency contact(s).
- Record of screening interview, background check and references.
- Case notes documenting contacts with Friendly Visiting staff. Case notes must be entered within three (3) business days of the event.
- Signed Program Agreement.

Compliance 15.3. Methods for unit collection and documentation must be approved by NYC Aging. Documentation of collected units must be maintained and made available upon request.

Attachment A. Service Definitions

Case Management – Unit of Service = Hour (including travel time)

Friendly Visiting – Unit of Service = Scheduled in-person visit, telephone call, or virtual visit.

Supplemental Services

- **Supplemental Service - Home Remediation – Unit of Service = Item** (such as):
  - Heaters in the winter.
  - Bed bug remediation such as extermination, mattress replacement, new furniture replacement, temporary lodging when apartment being exterminated and cost to clean/replace clothing.
  - Pay Con Ed bill during peak season.
  - Heavy duty cleaning of apartments.
  - Air Conditioners in the summer.
  - Portable fire extinguishers.
  - Handy man services such as minor home repairs and move furniture so client can have apartment painted.
  - Household Items such as carpeting, benches, microwave ovens.

- **Supplemental Service – Legal – Unit of Service = Hour**
  - Services such as setting up a Medicaid supplemental trust fund.

- **Supplemental Service – Health – Unit of Service = Item** - Medical, dental, and mental health expense not covered by insurance (such as):
  - Hearing aides
  - Dental work
  - Co-payment for Mental Health treatment
  - PERS installation
  - Ensure
  - Diapers
  - Eyeglasses
  - Devices for those with visual or hearing impairments
  - Adaptive devices not covered by insurance such as chair lift, grab bars, etc.
  - Social Adult Day Services
  - Nurse to make home visits.

- **Supplemental Service – Transportation – Unit of Service = One Way Trip.** Transportation for non-emergency appointments.

- **Supplemental Support Group – Unit of Service = Group Session**. One hour of a support group

- **Supplemental Service – Nursing –** Unit of Service = Hour

- **Supplemental Service – Snow Removal –** Unit of Service = Contact

- **Supplemental Service – Other**

Attachment B. Client Rights & Responsibilities and Code of Conduct

Client Rights & Responsibilities and Code of Conduct

A. Each individual client has the following basic rights:

1. Be informed of your rights in writing when you are admitted into the program.
2. You have a right to voice complaints and to seek protection from mental, physical, and financial abuse, mistreatment, or neglect.
3. You have a right to receive services without regard to race, creed, color, national origin, gender, age, disability, sexual orientation, gender identity, marital and/or familial status, political affiliation, military status, arrest or conviction record, status as a victim of domestic violence, predisposing genetic characteristics, or any other protected characteristics under relevant Federal, New York State, and New York City civil rights laws and regulations (except that all program eligibility requirements are met before services can be provided).
4. You have the right to be treated with consideration, respect, and dignity in the delivery of services. This shall include: (a) being treated in a respectful manner compatible with your cultural and religious beliefs, practices, and preferred language; (b) respect for your wishes regarding your home environment, furnishings, and possessions, as long as your wishes are not contrary to the operations of the service provider or violate the service provider's staff right to privacy and safety; (c) any person coming into your home will exhibit appropriate standards of behavior; and (d) being free from exploitation, abuse (verbal, emotional, physical or financial), and discrimination.
5. You have the right to: (a) participate in the development, revision, and termination of your care plan; (b) be informed of all services to be provided and of when and how services will be provided. Your case manager and other service providers are responsible for giving you and/or your designated representative sufficient information about your service options so that you can make informed choices.
6. You have a right to refuse or end any portion of the plan (such as home care, home delivered meals, bill paying or friendly visiting), except for case management, without loss of other services, after being fully informed of and understanding the consequences of refusal. **Case management is a requirement for program participation and cannot be refused if other services are desired.**
7. You will be given a copy of your signed Service Agreement.
8. You have the right to be shown proper and current identification by any person coming to your home to provide a service.
9. You have the right to the name, address, and phone number(s) of your designated case manager so that you may ask questions, express complaints, report absences of workers, and seek aid in emergencies. You have the right to contact your designated case manager if you have questions or concerns.
10. You have the right to review your case record.
11. You have the right to be assured of confidential treatment of your records.
12. NYC AGING-funded meal and home care providers are required to ask for voluntary contributions. Although you are not required to pay any money beyond the NYC Aging-funded home care cost sharing amount, your voluntary contributions help support and strengthen the program's ability to deliver services to you.
13. You have the right to be informed both verbally and in writing of the agency's grievance procedures and of the right to be assisted by outside representatives of your choice to resolve complaints, free from interference, coercion, discrimination, or reprisal.
14. You are entitled to recommend changes in policies and services to any agencies providing you with services to the New York City Department for the Aging and/or to the New York State Office for the Aging. Your case manager can tell you how to contact these agencies.

B. Each individual client has the following basic responsibilities:

1. Your case management agency and other services providers will choose the staff who will assist you. You have a responsibility to treat agency staff, your case manager, and any other service provider with respect,

consideration, and dignity. You shall not threaten, harass, discriminate against, abuse, nor mistreat anyone who is assigned to assist or provide services to you.

2. You are responsible for cooperating with your care plan and service arrangements and to work with your care providers to keep your service plan up to date.
3. You are responsible for communicating any cultural and religious beliefs, practices, and/or preferred language to your case management agency so that arrangements can be made to accommodate your needs.
4. You are responsible for letting your service provider(s) know if you will not require services on a scheduled day.
5. You are responsible for paying your cost share for NYC Aging-funded home care, if any. You may contest your assessed cost-sharing amount to determine if the amount is accurately determined.
6. You are responsible for telling your service providers and your case manager about any problems with your care and services. You may file a grievance if you are dissatisfied with the service you have received. You are responsible for working in good faith with your case management agency to reach a resolution to your grievance.

C. Discharge from the program:

1. Clients may be discharged from the program if:

(a) you or your authorized representative requests discharge; or
(b) your case management agency determines that you:

i. no longer meet the eligibility requirements identified in state regulations at 9 NYCRR § 6654.15;
ii. have not cooperated with the program requirements, including a refusal to undergo an assessment, to agree to a care plan, to allow for in-home visits by the case manager or other staff under the direction of the case manager, to agree to validate income information if requested to do so for purposes of determining Medicaid eligibility or cost sharing, or to provide cost sharing as required pursuant to 9 NYCRR § 6654.6; or
iii. are not expected to need services within the next 90 calendar days.

2. If you received NYC Aging-funded home care, you will not be discharged for failure to pay cost sharing without first receiving:
   (a) written notification of your failure to pay the required cost sharing amount; and
   (b) an opportunity to be heard on whether the cost sharing amount was paid, or the reasons why it was not paid.
3. If you are being involuntarily discharged from the program, you will be informed in writing of the reason at least 30 calendar days prior to termination of services. The written notice will include information regarding how to file a grievance or obtain a local hearing regarding the decision to discharge you from the program.
4. If you are being discharged and it appears that you have a need for continued services, you will be assisted in seeking appropriate care.

I received this form during my assessment / reassessment (circle one) on this date, _____ and understand my Client Rights and Responsibilities.

I understand that any violation of this Client Rights & Responsibilities and Code of Conduct might result in suspension or termination of my NYC Aging-funded services.

Client Signature: _____

Who We Are
[Case Management Agency Logo HERE]

Contact Us
Phone: Email:
Web site address:

(*This case management program is sponsored by the NYC Department for the Aging)*

Attachment C. HMPC and HSCH Cost Share Simple Worksheet

HMPC AND HSCH COST SHARE SIMPLE WORKSHEET

THRESHOLDS EFFECTIVE : April 1, 2024

Complete only if client(s) income is above the threshold on line 9 below.

Client Name(s) _____ _____ **Client ID#**_____

A. HOUSING ADJUSTMENTS		**INDIVIDUAL**	**COUPLE**
1. Monthly Housing Expenses.		_____	_____
2. Subtract Housing Adjustments Threshold.	**-**	___753_____	__1,022___
3. Excess Housing Expenses.	**=**	_____	_____
4. Maximum Adjustment.		___753____	___1,022____
5. Adjustment (enter the smaller of lines 3 and 4)	**–**	_____	_____
B. INCOME ADJUSTMENT			
6. Monthly Income.		_____	_____
7. Enter Adjustment from line 5.	**–**	_____	_____
8. Subtract line 7 from line 6.	**=**	_____	_____
9. Income Threshold.	**–**	**___1,883____**	**____2,555___**
10. ADJUSTED INCOME & MAXIMUM MONTHLY FEE (SUBTRACT LINE 9 FROM LINE 8)	**=**	_____	_____

C. COST SHARE RATE (Compare line 10 with Fee Rate Schedule against the Individual Column or Couple Column)

11. ( ) Fee Rate = 0%. $ _____ per hour suggested contribution. (Use Lowest Fee)
Skip to Service Agreement.

12. ( ) Fee Rate = _____ %. Rate per hour = _____.
Complete Section D and Service Agreement.

D. Service(s) Recurring Monthly
AVERAGE MONTHLY COST TO CLIENT

Weekly Units	x 4.3 =	Monthly Units	x	Maximum Rate Per Hour	x	Cost Share Fee Rate (decimal)	Average Monthly Cost to Client
13. _____	x 4.3 =	_____	x	_____	x	_____	= _____

BiWeekly		Monthly		Maximum Rate		Cost Share Fee	Average Monthly

Units	x 2.15 = Units	x Per Hour	x Rate (decimal)	Cost to Client
14. _____	x 2.15 = _____	x _____	x _____	= _____

Home care recipients will be monthly at the above rate per hour for service received.
The monthly bill can never exceed the Maximum Fee.

_____ _____

Prepared By **Date**

Addendum Page

Guidelines on filling out the **HMPC AND HSCH COST SHARE SIMPLE WORKSHEET:**

1. For **Section A**, you will be putting in the total Housing Expenses.
    a. Remember to put in ONLY those countable Housing Expenses.
    b. You are required to fill in each Housing Expense in STARS.

2. For **Section B**, you will be putting in the total Income.
    a. Remember to put in ONLY those countable sources of Income.
    b. You are required to fill in each source of income in STARS for both the client and the spouse.
    c. If the spouse is not applying or receiving DFTA-funded home care, and has some income for mutual needs, that income must be included in the total on this Simple Worksheet. HOWEVER, if the spouse reports that a part or all of his/her income is not available for their mutual need, do not include that part or all of his/her income in the total. You will be REQUIRED to document the spouse's income STARS, both the countable and uncounted income, but for purposes of this Simple Worksheet, you do not have to put it in for calculation purposes.

3. For **Section C**, the Suggested Contribution is set at the lowest Fee on the Fee Rate Schedule. In this case, use the 5% Fee Rate.

4. For **Section D**, here are the definitions each of the fields:
    a. Weekly units = the authorized hours of weekly home care the client will receive
    b. Monthly units = the authorized hours of monthly home care the client will receive
    c. Maximum Rate per Hour = you must put in the HIGHEST RATE PER HOUR from the Rate Threshold Schedule. That will be at 100%.
    d. Cost Share Fee Rate (decimal) = Convert the percentage of the Cost Share Fee Rate to a decimal. For example, if the Rate is 15%, you will convert that number to a decimal, 0.15.

    Example: Weekly Units (12) x 4.3 = 51.6 Monthly Units x Maximum Rate Per Hour (if $28.50 were the Highest rate on the schedule) x Cost Share Rate Fee (15% or 0.15) = $220.59 is the Average Monthly Cost to Client.

5. Remember that the MAXIMUM FEE RATE, line 10, is the most that the client will be asked to pay. The "Average Monthly Cost to Client" is only an average, an estimate of the average monthly cost.

Medicaid

You are expected to do the Medicaid Pre-screen if the client receives SSI or if you believe the client may be eligible for Medicaid.

The 2024 Medicaid income and resource levels established by the New York State Department of Health (NYSDOH) for determining Community Medicaid eligibility income and resource levels are as follows:

• Income levels are $1,732.00 and $2,351.00 per month for an individual and couple, respectively; and

• Resource levels are $31,175.00 and $42,312.00 for an individual and couple, respectively.

Attachment D: Involuntary Termination of EISEP Services

Involuntary Termination of EISEP Services
[Involuntary Termination Letter Template for Case Management Agencies]
CMA: Delete the header and add your Logo/Letterhead

Date:

Dear [Client's Name],

We have reviewed your eligibility for services and have determined that you are no longer eligible for services funded by the New York City Department for the Aging ("NYC Aging") services because; [*select all that apply*]

□ You have not had or needed NYC Aging-funded services in that last 90 calendar days;
□ You have not complied with your service plan; [*agency can specify details*]
□ You have failed to pay your agreed cost share amount, after numerous attempts and reminders to do so;
□ You have violated the Client's Code of Conduct. [*agency can specify details*]

If you agree to with these findings and do not object to the termination, you do not have to respond to this letter.

However, if you disagree and do not want your NYC Aging-funded service terminated, you have 30 days from the date of this letter to request a hearing to appeal of the determination. If you request a hearing, a Settlement Conference will be hosted by NYC Aging to state your case and dispute this determination. If a settlement is not reached at the NYC Aging Settlement Conference, your appeal will be referred to the New York City Office of Administrative Trials and Hearings for a hearing and determination.

To request a hearing, please reach out to your Case Manager within 30 days from the date of this letter and NYC Aging will contact you to arrange a Settlement Conference within 15 days of receiving notice from your Case Manager of your appeal request.

Reminder, if **we do not hear from you within the next 30 days**, please be aware that your services will be discontinued.

Yours,

[Signature of Case Manager]
cc: CMA Supervisor
cc: CMA Director

Attachment E: Policy for Hearing Requirements for EISEP-Funded Services

Policy for Hearing Requirements for EISEP-Funded Services

I. Purpose

As the Area Agency on Aging ("AAA") for New York City, the Department for the Aging ("NYC Aging") and the case management agencies ("CMA") it funds must comply with Program Instructions issued by the New York State Office for the Aging ("NYSOFA").

CMAs that receive Expanded In-Home Services for the Elderly Program ("EISEP") funds must comply with Program Instruction No. 19-PI-15, entitled "EISEP Hearing Standards," issued by NYSOFA on June 13, 2019. This NYC Aging policy complies with the minimum requirements of 19-PI-15, EISEP Hearing Standards.

II. Policy

A CMA providing services funded by EISEP must comply with the hearing procedures outlined below for the following three actions/determinations made by the CMA[1]:

(i) where a CMA denies an applicant[2] for EISEP services (including case management and/or home care) based on its determination that the applicant is not functionally eligible for EISEP;
(ii) where a client disputes the amount of their cost share for home care as assessed by the CMA; or
(iii) where a client is involuntarily discharged from one or more EISEP-funded service(s) for:
   a. failure to pay the cost share amount (home care);
   b. refusing to cooperate with the EISEP requirements;
   c. refusing to sign their Service Agreement; or
   d. is not expected to need services within the next ninety (90) calendar days.

Clients do not have a right to a hearing based upon any other decision or determination about services made by a CMA, or for dissatisfaction with services received.[3]

III. Procedure

[1] Since NYC Aging contracts with its CMAs to operate the EISEP program services, for purposes of this policy, any references in 19-PI-15 to an Area 010 determination also encompasses determinations made by the contracted CMA.
[2] If a client is presumed eligible for home-delivered meals while awaiting an in-home assessment and it is later determined that they are ineligible, this hearing policy would apply.
[3] For any other determination made by a CMA, clients may file a grievance or complaint pursuant to NYSOFA Program Instruction No. 17-PI-04, "Grievance Procedures for Programs operated under Title III of the Older Americans Act."

A. Client Rights to a Hearing. CMAs must provide to each EISEP client a copy of "Client Rights to a Hearing," (https://aging.ny.gov/system/files/documents/2019/10/19_pi_15_eisep_and_cse_client_rights_to_a_hearing_english.pdf), either at the time the CMA determines that an individual is not eligible for EISEP services and/or at the time that the CMA enrolls the client into the EISEP program.

B. Notice to Client of Determination. CMAs must provide written notice to the EISEP client of its determination, which must include instructions for how to request a hearing. CMAs may use and adapt the attached template letters for this purpose, included as Attachment B to this Policy. Each ESIEP client who is involuntarily discharged shall be informed in writing of the reasons for such discharge at least five (5) business days prior to discharge.

C. CMA Notice to NYC Aging and Participation in Settlement Conference.

1. Once the CMA receives a response from a client who wishes to exercise their right to a hearing, the CMA must immediately notify their NYC Aging Program Officer and provide all relevant records.
2. The Program Officer will work with the client and the CMA to schedule a Settlement Conference, and the CMA must participate in the Settlement Conference hosted by NYC Aging.

D. NYC Aging Settlement Conference.

1. NYC Aging will notify the client of the scheduled Settlement Conference. NYC Aging's notice to the client of the Settlement Conference will inform the client that:
   a. Participation in a Settlement conference does not affect the client's right to a hearing;
   b. Choosing to participate in a Settlement Conference suspends the sixty (60) day deadline by which the determination must be made (from the date that a Settlement Conference is agreed to through the date on which the Settlement Conference is held);
   c. If a resolution is reached during the Settlement Conference, no EISEP hearing will be held; and
   d. The client may be represented in the Settlement Conference by a competent adult of their choosing.
2. If a Settlement Conference is held, NYC Aging will prepare a Settlement Conference Report, briefly describing the nature of the dispute and the results of the Settlement Conference.
3. If the Settlement Conference results in a resolution of the dispute and no hearing is necessary:
   a. The CMA and EISEP client must enter into a Settlement Agreement; and
   b. The Settlement Conference Report and Settlement Agreement will become part of the client's CMA case file and provided to the client or to the client's representative. The CMA must maintain copies of both in the client's case file according to the records retention requirements outlined in its contract with NYC Aging.
4. If the Settlement Conference does not result in a resolution, and a subsequent hearing is held, then:
   a. The Settlement Conference Report shall become part of the client's CMA case file, and a copy of the Report shall be provided to the client or to the client's representative. The CMA must maintain a copy of the Report in the client's case file according to the records retention requirements outlined in its contract with NYC Aging.

b. The Settlement Conference Report shall become part of the EISEP hearing record.

5. NYC Aging shall ensure that the Settlement Conference adheres to all language access requirements required by NYSOFA for clients with limited English proficiency.

E. OATH Hearing. EISEP hearings are adjudicated before the NYC Office of Administrative Trials and Hearings ("OATH"). The procedure for referring matters to OATH for hearings and for NYC Aging, the CMA, and the client to participate are outlined in this section.

1. NYC Aging will send the Settlement Conference Record to OATH.
2. OATH will provide at least 14 business days' notice to the client and NYC Aging of the scheduled hearing date, time, and place, unless the client agrees to a shorter notification period. NYC Aging will notify the CMA of the scheduled hearing.
3. OATH shall hold the hearing and issue a written decision ("Report & Recommendation") within sixty (60) business days of the date that the request for hearing was received from NYC Aging. If the Report & Recommendation upholds the CMA's determination, OATH's Report & Recommendation will inform the client that they have thirty (30) business days to ask NYSOFA to conduct a review of the Report & Recommendation, if the client desires such a review.
4. NYC Aging will send a copy of OATH's Report & Recommendation to NYSOFA within five (5) business days of receipt of OATH's Report & Recommendation. NYC Aging will send a copy of the EISEP Hearing Record to NYSOFA within thirty (30) business days of the issuance of OATH's Report & Recommendation.

F. Review by NYSOFA. If the client requests a review of OATH's Report & Recommendation, NYSOFA will complete its review of the EISEP Hearing Record within sixty (60) business days of receipt of the EISEP Hearing Record from NYC Aging.

Attachment F: Template for Denial of EISEP Services

CMA Template for Denial of EISEP Services

[Determination of Ineligibility Template for Case Management Agencies providing EISEP Services]
[Source: NYSOFA 19-PI-15: EISEP Hearing Standards]

CMA: delete the header and add your Logo/Letterhead

Date:

Dear [Client's Name],

We have determined that you are not eligible for the following services funded by the New York City Department for the Aging ("NYC Aging") services: [*CMA: select all that apply*]

☐ Case Management
☐ Home Care
☐ Home Delivered Meals [*CMA: if this is the ONLY service being denied, do NOT use this letter – use OAA Grievance Letter*]
☐ Friendly Visiting

This determination is based on the following reasons: [*CMA to insert reasons for denial of services*].

If you agree with these findings and do not object to the determination, you do not have to respond to this letter.

However, if you disagree, you have 30 business days from the date of this letter to request a hearing to appeal of the determination. If you request a hearing, a Settlement Conference will be hosted by NYC Aging to state your case and dispute this determination. If a settlement is not reached at the NYC Aging Settlement Conference, your appeal will be referred to the New York City Office of Administrative Trials and Hearings for a hearing and determination.

To request a hearing, please reach out to your Case Manager within 30 business days from the date of this letter and NYC Aging will contact you to arrange a Settlement Conference within 15 business days of receiving notice from your Case Manager of your appeal request.

Yours,

[Signature of Case Manager]
cc: [Name], CMA Supervisor
cc: [Name], CMA Director

Attachment G: Template for Terminating Home Delivered Meals

CMA Template for Terminating HDM

*[Involuntary Termination Letter Template for Case Management Agencies terminating JUST **home-delivered meals**]*

[Source: NYSOFA 17-PI-04: Grievance Procedures for Programs operated under Title III of the Older Americans Act]

Add your Logo/Letterhead

Date:

Dear [Client's Name],

We have reviewed your eligibility for services and have determined that you are no longer eligible to receive home-delivered meals because: [*CMA: select all that apply*]

☐ You have not had or needed this service in the last 90 calendar days;
☐ You have not complied with your service plan; [*agency can specify details*]
☐ You have violated the Client's Rights & Responsibilities and Code of Conduct. [*agency can specify details*]

If you agree with these findings and do not object to the termination, you do not have to respond to this letter and your home delivered meal service will be concluded in 30 business days.

However, if you disagree and do not want your home-delivered meals terminated, you have 30 business days from the date of this letter to file a grievance by filling out the attached Grievance Form and submitting it to the Director of *[Case Management Agency]*. If you need help completing the Grievance Form, please request assistance from your Case Manager. Your Case Manager can also arrange for language assistance if needed.

Your completed Grievance Form must be submitted to the Director of *[Case Management Agency]* within 30 business days from the date of this letter. You may be contacted by a representative of *[Case Management Agency]* designated to investigate and make a decision regarding your grievance. You will receive a determination of your grievance within 15 business days of submission to the Case Management Agency.

Reminder, if **you do not submit a completed Grievance Form to the Director of *[Case Management Agency]***, please be aware that your home delivered meals will be discontinued on [*CMA: insert effective date of termination*].

Yours,

[Signature of Case Manager]
cc: CMA Supervisor
cc: CMA Director

Attachment H: Client Grievance Form

CLIENT GRIEVANCE FORM

Instructions:

The entire grievance process, including any written materials, will be treated in a confidential manner by the Case Management Agency (CMA) and any other involved parties.

Please complete the entire form on the following page, including all of the contact information required by the form.

If you need assistance completing this form, including language access assistance, you may contact your Case Manager at [enter phone number] or by contacting the CMA Program Director at [CMA main phone number].

This form must be submitted via email or postmarked within thirty (30) calendar days of the event or action.

The completed form should be sent to:

CMA Program Director's Name
[Address 1
Address 2
Address 3]
Or via email: [xxx@yyy.org]

Form

I am requesting a review of the following grievance:

- ☐ I was denied service.
- ☐ I am not satisfied with the quality of service, or an activity provided by your agency or by your service provider.
- ☐ I have a grievance detailed below.

Provide a detailed description of your concern, as checked above:

Tell us what you want to happen now:

_____

_____

Name (please print here): _____

Name (please sign here:) _____

Date: _____

Address: _____

Phone number: _____

Email address: _____

Attachment I: Friendly Visiting Client Agreement Template

NYC Aging Friendly Visiting Program Client Agreement

Client Name:_____

A. I have spoken with the Friendly Visiting Program Coordinator and reviewed the policies and procedures below.

B. I have been provided with my own copy of the policies and procedures to review before my first visit or phone call.

C. I agree to call the Friendly Visiting Coordinator if I do not understand any of my responsibilities while enrolled in the program.

D. I have been made aware that pivotal to my receiving maximum benefit of the program, the Friendly Visiting staff and my assigned volunteer will be communicating with each other regularly and I will be receiving regular contact from the Friendly Visiting staff regarding my participation in the program.

E. To ensure the safety and well-being of all volunteers and clients, I agree to adhere to the below standards of behavior when engaged in Friendly Visiting activities.

F. I understand that the Friendly Visiting Program may terminate my participation at any time for any reason, including for failure to follow these standards.

Standards of Behavior

- The role of the volunteer is to provide companionship and engage in conversation and activities with the client.
- Volunteers are prohibited from providing services of any kind to the client, including chores, errands, medical care, financial advice, or services (bill paying), cleaning, escorting to a medical appointment, etc.
- Clients are prohibited from providing services of any kind to the volunteer, including medical or financial advice or services.
- Volunteers and clients are prohibited from assuming legal responsibilities for the other, such as power of attorney, status of executor/executrix, or designee on a healthcare proxy.
- Volunteers may not accept gifts or money.

Date: _____

Client Signature: _____

Program Coordinator Signature: _____

Attachment J: Friendly Visiting Volunteer Agreement Template

NYC Aging Friendly Visiting Program Volunteer Agreement

Volunteer Name:

A. I have met with the Friendly Visiting Program Coordinator and reviewed the Volunteer Guide.

B. The policies of the Friendly Visiting Program have been explained to me and I have been provided with my own copy of the policies to review before my first visit.

C. I agree to call the Friendly Visiting Coordinator if I do not understand any of the responsibilities I am undertaking.

D. I understand that my volunteer file and its contents, including the criminal background check, will be shared with NYC Aging and stored in NYC Aging's database.

E. To ensure the safety and well-being of all volunteers and participants, I agree to adhere to the below standards of behavior when engaged in Friendly Visiting activities and understand that the Friendly Visiting Program may terminate my volunteer engagement at any time, for any reason, including for failure to follow these standards.

Standards of Behavior

- I will participate in required training programs, read required Friendly Visiting materials and follow the recommended policies and procedures.
- I will accept supervision and support from the Friendly Visiting Coordinator and/or Friendly Visiting Program support staff.
- I will preserve the confidentiality of information about program participants.
- I will maintain a respectful and professional relationship with my Friendly Visiting match/es and during all related activities.
- I will not engage in any discriminatory or harassing behavior based on a person's race, age, gender, sex, sexual orientation, national origin, religion, disability, or any other category protected by law and will immediately report any such conduct to the Friendly Visiting Coordinator.
- I understand that my primary role as a Friendly Visiting volunteer is to provide social engagement in the form of in-person visits, telephone calls or virtual visits with my assigned older adult. I will not compromise the health, safety or financial security of my assigned older adult by overstepping my role as a volunteer.
- Volunteers are prohibited from providing services of any kind to the client, including chores, errands, medical care, financial advice, or services (bill paying), cleaning, escorting to a medical appointment, etc.
- Clients are prohibited from providing services of any kind to the volunteer, including medical or financial advice or services.
- Volunteers and clients are prohibited from assuming legal responsibilities for the other, such as power of attorney, status of executor/executrix, or designee on a healthcare proxy.
- Volunteers may not accept gifts or money.
- During my volunteer activity, should I observe that my client is experiencing any serious issues or problems I will report my observations to the Friendly Visiting staff as soon as possible.
- I will avoid use of my Friendly Visiting volunteer status for personal, business, or financial gain.
- I will follow all the Friendly Visiting Program rules and procedures regarding appropriate contact and relationships with its older clients and other volunteers.

Date: _____

Volunteer Signature: _____

Program Coordinator Signature: _____