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 September 2025

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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 accomplish these goals 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 assessments include 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 services 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 client follow-up and monitoring.

Reassessment. A scheduled in-person, 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 services.

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 at home a client who is unable to visit a local older adult center. The case manager determines that the client is eligible for Supplemental Nutrition Assistance Program (SNAP) benefits to help reduce her food bills, but the client 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. She also expresses feelings of loneliness and needs a Friendly Visitor.
- 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.
- A client has several Instrumental Activities of Daily Living ("IADL"), and Activities of Daily Living ("ADL") needs that are met through a mix of informal and formal supports. However, she is unable to travel to an older adult center and is requesting a Friendly Visitor because she is socially isolated.

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.

NYC Aging 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; legal assistance 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 impracticable." 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 (e.g. a pandemic or earthquake). This exception **does not** eliminate any other program requirements outright but rather provides a degree of flexibility only in instances where strict compliance is impracticable. If the exception involves a timeframe within which some action must be completed (e.g., conducting an assessment or making a home visit), the action must be completed as soon as it becomes practicable. If the exception involves in-person contact, the activity involved must still be completed, through other means not involving in-person contact, such as virtually or via telephone conference.

If the program utilizes a subcontractor, the subcontract must be utilized for the full array of case management services. All subcontractors are subject to NYC Aging's approval. The primary contractor is responsible for ensuring that subcontractors meet NYC Aging expectations in all relevant areas. All NYC Aging-funded Case Management programs and their subcontractors must also adhere to the NYC Aging General Program Standards, found at: https://www.nyc.gov/site/dfta/community-partners/contractor-tools.page.

Target Population/Eligibility

Standard 1: Participant Eligibility

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

Compliance 1.1. To be eligible for case management services, an individual must:

- Be at least 60 years of age or older;
- Be functionally impaired, as shown by a need for assistance of another person in at least one Activity of Daily Living (ADL), or two Instrumental Activities of Daily Living (IADLs). 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 requires other types of case management assistance;
- Have unmet needs for such management assistance;
- Be able to be maintained safely in his or her home environment;
- Be willing to accept assistance from the case management agency (CMA) and providers, and cooperate with the care plan; and
- Not be eligible to receive the same or 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 enrolled directly as a client.

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;
- Have functional limitations, as shown by the need for the assistance of another person with at least one ADL such as bathing, grooming, dressing, washing, feeding, toileting, mobility, and transferring, or two IADLs such as shopping, laundry, meal preparation, reheating meals, and house cleaning;
- Have unmet needs for assistance with ADLs and/or IADLs;
- Are able to be maintained safely in the home if support is provided;
- Are 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
- Have no other resources available to fully assist them. 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 home care 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 complies with limits 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 submit an application for home care through Medicaid within 30 calendar days of the date of determination that the client is eligible for or receiving Medicaid.

- The case manager documents when the application for Medicaid home care (and Medicaid, where applicable) is submitted.
- Prior to NYC Aging-funded home care beginning, the client must agree in writing to apply for Medicaid home care if eligible, and once Medicaid home care is approved and begins, NYC Aging-funded home care will conclude. Such agreement by the client is a condition of the commencement of NYC Aging-funded home care.

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; and/or
    - Are unable to shop or cook.

Note: Clients who have Medicaid (not Medicaid Managed Long Term Care (MLTC)), self-report that they are not receiving meals under Medicaid, and meet the home delivered meals eligibility criteria set forth above in Compliance 2.3, can continue to be assessed and authorized for home delivered meals. However, clients who self-report that they are provided meals through Medicaid or Medicaid MLTC would not meet the eligibility criteria for home delivered meals.

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.

- 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 home delivered meals.

Compliance 2.4. Eligibility and Documentation for Under 60 Non-Case Managed HDM clients.
If a CMA determines that it would be in the best interest of an HDM client, NYC Aging-funded home delivered meals may also be provided to: (1) the client's spouse or domestic partner, regardless of the person's physical condition or age (e.g., even if they are under 60); (2) disabled individuals under 60 years of age living in the same household as the client ("non-case managed HDM client"). Justification for this determination must be documented in case notes.

A case record for the non-case managed HDM client is opened in NYC Aging's client tracking system. The case record forms include the following sections: Client Demographics, Social Demographics, Contacts, CMA/Intake, Meal Delivery Plan, Case Notes, Units Entry, and the NY Client Info section of the Client Profile. 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 conducted with the non-case managed HDM client and is documented in the non-case managed HDM client's case notes. The six-month follow-up can be in the form of a home visit or a telephone contact. Contact can be made directly with the primary client on behalf of the non-case managed HDM client, but documentation of such contact must be recorded in the non-case managed HDM client's record.

For clarity: if the spouse or domestic partner meets every element of the eligibility criteria for home delivered meals, that person is to be considered a case management client, and a separate record is opened for that client.

Compliance 2.5. 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 2.6. Friendly Visiting Eligibility. Friendly Visiting service is provided to older adults who meet the following criteria:

- Are receiving NYC Aging case management services or NYC Aging caregiver services.
- Have few or no informal supports or opportunities for socialization (isolated or at risk for social isolation*).*
- Agree to abide by the Friendly Visiting program rules and the Client Rights and Responsibilities.

Note*: Clients can receive Friendly Visiting service regardless of Medicaid or MLTC status.*
See also Friendly Visiting Standards, Page 36.

Informed Consent

Standard 3: Informed Consent

The program obtains informed consent from each client. (See also the Consent Training Guide, and Section 2 of NYC Aging's General Program Standards)

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 home delivered meal 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.
- If a client leaves the program and returns, the signed consent on record remains in effect.

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

- If a client refuses to sign the Consent to Refer and Share Personal Information form, case management would not be able to make any direct referrals, nor authorize any NYC-Aging funded services. Case Management could only help in limited ways that do not involve contacting other agencies or sharing client information with outside agencies on behalf of the client. For example, case management could help with filling out a SNAP form, but they cannot send the form on behalf of the client. They could share resources with the client, but they could not contact those same resources to advocate on behalf of the client. The only exception would be if case management determines that the client is experiencing a situation that threatens their health or safety, in which case, for example, a referral needs to be made to HRA APS or 911: the Consent to Share and Refer form is not required in cases of emergencies. Otherwise, if there is no other case management or assistance needed, the case can be closed/inactivated.

***Note**: The signed Consent to Refer and Share Personal Information gives the referring program (Home Care, Home Delivered Meals, Friendly Visiting) permission to enroll the client into their program and collect additional data as needed. The Home Care, Home Delivered Meals and Friendly Visiting programs do not need to also obtain consent to collect data from the client.*

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

Compliance 3.4. Documentation of Consent. The program utilizes the NYC Aging approved consent forms. The program uploads **all signed consent forms** aforementioned in Compliances 3.1, 3.2 and 3.3 in the client's record in NYC Aging's client tracking system. The name of the electronic attachment must include the word "Consent" in the file name. Example: "CONSENT to COLLECT signed 2024-07-23."

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.)

Compliance 3.6. HRA Adult Protective Services (HRA APS) clients who were referred to the case management program for home delivered meals are not required to sign any of the aforementioned consent forms in this section. However, if APS closes their case with a client and the client becomes a regular case management client, all consent policies then apply.

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, using NYC Aging's intake form, is completed within two (2) business days of the initial call. At intake, if the client is found ineligible for case management services, or if the client refuses to accept services, the case management staff should offer other appropriate referrals in the community to the client. If the client is unreachable or refuses to return the intake calls after three attempts, or refuses to provide enough information for the staff to complete the intake, the CMA should follow-up with a third phone call 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. All follow up attempts are documented in NYC Aging's client tracking system, and the client intake is then closed.

***Example**:*

- The CMA receives an intake call on August 8, 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 10, 2022, to reach the older adult and complete the rest of the

intake. The CMA should make a total of three (3) attempts to reach the client, starting with the first attempt made within 2 (two) days of the referral.

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 adults residing 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 is documented in NYC Aging's client data system through a Service Ticket. A client case file is not opened.
- A full intake is conducted on persons who meet preliminary eligibility requirements (See Compliance 4.5 below).

***Note**: A client at the screening phase and whose intake has not yet been completed cannot be put on the wait list for any NYC-Aging funded services, including Case Management, Home Care, Home Delivered Meals, and Friendly Visiting.*

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. This includes: Full Name, Address, Phone Number, at least one Emergency Contact, Race, Gender, and Primary Language spoken. The Nutrition Screening Initiative (NSI) Scale in NYC Aging's client tracking system must also be completed. If another member of the household who is 60 years or older is to receive services, or if a dependent who is less than 60 years of age is eligible to receive services, an intake is completed for each person.
    - 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 is high or 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 they are 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.

Compliance 4.6. The intake process results in one of the following actions: (1) scheduling and completion of client's in-home assessment within ten (10) business days, unless impracticable; 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: Once an intake has been completed, a client may be authorized for home delivered meals on the presumption that the client is eligible. However, a client cannot be authorized for home care or Friendly Visiting until an in-home assessment is conducted.

Compliance 4.7. Intake of HRA Adult Protective Services referrals for Home Delivered Meals.

- NYC Aging has an agreement with HRA Adult Protective Services (APS) for all case management agencies to accept requests for home delivered meals. HRA APS and their vendors will use a form approved by both NYC Aging and HRA APS. The case management agency will accept this referral from HRA APS and their vendors if the referral forms have been completed. The case management agency will enter the data into the client's record. The case management agency will have discretion to reject the form if the form is incomplete or if the client does not meet the eligibility for home delivered meals. An APS client whose referral is accepted will not be required to have an assessment performed by the case management agency because APS is considered the lead case manager for this client. However, the case must be assigned to the program's case manager or supervisor for follow up with APS, when necessary.

Compliance 4.8. Current APS clients should not be referred to Friendly Visiting.

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 they have 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 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; and
- 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 assessment/reassessment must take place in the client's home or usual residence, unless impracticable (e.g., pandemic or citywide disaster). If the home visit is practicable and the client declines an in-home assessment or reassessment after being reminded that it is a program requirement, the program terminates the services. This is documented with an explanation in the client's file in NYC Aging's client tracking system.

- If the client is institutionalized or will be temporarily residing in another residence, a home visit is conducted within five (5) business days of the client's return to their usual residence.

Compliance 5.3. Assessment/Reassessment Instrument. The case manager completes (or updates at reassessment) all relevant sections of the Case File and COMPASS forms in the client data system. The case manager must complete the Care Plan, Home 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 immediately brings the situation to the attention of their supervisor.

Compliance 5.5. Client's need for accommodation. The program accommodates clients with communication difficulties (e.g., due to vision or hearing impairment or limited English proficiency). The program clearly documents in the case record what accommodations were provided to the client.

Some examples of accommodation may include:

- Reading documents out loud to an individual with a vision impairment (documents should be in large print);
- Assigning a client to a case manager who speaks their language;
- Using a TTY device for hearing impaired clients;
- Using free, no-cost interpreter services;
- Having a family member or friend present during the assessment to aid in communication; and/or
- Enlisting assistance from another agency that specializes in assisting persons with a special need.

Compliance 5.6. Obtaining information from others. 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 privately). 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 and client consent obtained, 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 their income exceeds the current threshold for contribution status (thresholds are established annually by the NY State Office for the Aging) and will be required to pay a 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.
- Per NYSOFA Program Instruction No. [PI 25-PI-04.], 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.
- Any client who refuses to provide the required financial information for determining their cost share must consent to pay the maximum home care 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 disagree with their determined cost share are informed in writing of their right to request a redetermination. Clients are also informed of their right to a redetermination via a hearing if they do not agree with it.

Note: Case manager determines the cost share based on client documentation; the home care provider collects the cost share.

Compliance 5.8. Assessment/Reassessment Summary. The case manager completes an Assessment Summary (and Reassessment Summaries) of their findings and analysis of the client's situation. The Assessment 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 a brief summary of key milestones and events in 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 conditions;
- Mobility/Falls;
- Housing; and
- 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. In the Case Note section, select "Assessment submitted for review" in the Case Note Type drop-down.

Compliance 5.10. Assessment and Reassessments of Adult Protective Services clients

- If the client originated as a referral from HRA APS because of a request for home delivered meals, this client is not required to have an assessment nor reassessment.

- If the client originated as a case management client, was referred to APS, and APS accepts the client for services, the case management agency does not need to do a reassessment for the client, unless they are receiving NYC-Aging funded home care services, in which case an annual reassessment must be conducted. The case management agency will document the date that APS accepted the client for services and indicate the APS case manager is the primary case manager in the client's NYC Aging record.

- On a bi-monthly basis, the case management agency will follow up with APS to ensure that services are still needed.

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 initial assessment, which should be an in-home visit, occurs no later than ten (10) business days after the initial intake is completed, unless impracticable. If the assessment cannot be performed within ten business days and the client can be safely maintained at home while waiting, the client is placed on a wait 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. For clients who were on the list for an in-home assessment after the intake was completed, once a client is assigned to a case manager, the case manager must perform the in-home assessment within ten (10) business days.

Compliance 7.3. Reassessments. Reassessments are conducted at least every 365 calendar days from the date the client was most recently assessed or reassessed.

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

Compliance 7.4. Event-based Reassessments. An event-based reassessment is conducted within five (5) business days of the precipitating event.

Compliance 7.5. The following assessment categories are completed during the in-home assessment: Client Information, Emergency Checklist, Technology, Health Care, Medical Information, Legal Information, Nutrition, NSI, CAGE, Psycho-Social Status, Medication List, Risk Factors for Falls, IADLs, ADLs, Services Receiving, Informal Support Status, Monthly Income, Benefits/Entitlements. All assessment related forms must be completed and entered into the NYC Aging client data system no later than seven (7) business days after the in-home assessment was conducted.

Example #1: The case manager visits the client to conduct the in-home assessment on Monday, March 2, 2026. The case manager has until Wednesday, March 11, 2026, to finish completing the assessment related forms.

Example #2: The case manager visits the client to conduct the in-home assessment on Monday, March 2, 2026. The case manager is unable to finish the assessment during the in-home visit because the client is unable to obtain some required information or is too tired to continue. The case manager makes a plan with the client to conduct a phone call with the client on Friday, March 6, 2026, to obtain all the remaining information to complete the assessment. The case manager has until Wednesday, March 11, 2026, to finish completing the assessment related forms.

***Note**: Case Management programs can put into their procedures and protocols steps to complete the assessment forms sooner than seven (7) business days.*

Standard 8: Care Plan

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

Each client must have 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 health care and 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. Best practice is to complete the Care Plan forms and enter this information into the NYC Aging client tracking system simultaneously as the assessment is completed. However, if a CMA needs additional time to complete the Care Plan and enter it into the client tracking system, they have up to six (6) business days to do so.

Example #1: The case manager completed the assessment related forms on Monday, March 2, 2026. She also completed the Care Plan on the same day. That is satisfactory because she completed the Care Plan within six (6) business days.

Example #2: The case manager completed the assessment related forms on Monday, March2, 2026. She completes the Care Plan on Tuesday, March 10, 2026. This is also satisfactory because she has up to six (6) business days to complete the Care Plan.

***Note**: Case Management programs can put into their procedures and protocols steps to complete the Care Plan sooner than six (6) business days after the assessment forms are completed. Programs may also simultaneously complete the Care Plan and the Assessment forms.*

Compliance 8.2. In NYC Aging's client tracking system, the Care Plan will include the forms identified as Care Plan, Service Plan, Meal Delivery Plan, and Home Care Plan. These forms are to be completed based on the needs of the client.

Compliance 8.3. When appropriate, the client or the client's authorized representative participates in care planning with 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 8.4. Care Plan(s) include:

- Services and/or needed linkages to address unmet needs, health and mental health care issues, and quality of life issues identified during the assessment.
    - When 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 support groups, home remediation services, legal services, medical, dental, and mental health expenses not covered by insurance, and transportation for non-emergency appointments. The program provides supporting documentation in the case notes for supplemental services provided.
- Social work interventions when 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.
- Assistance in connecting clients with providers that offer counseling and assistance with long-term care planning.

Compliance 8.5. 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 within six (6) business days.

- If there is no change to the authorization for home delivered meals or friendly visiting service based on the most recent reassessment, there is no need to create a new Care Plan or new Meal Delivery Plan.
- When a client is authorized for home care service, any of the following changes will require the case manager to create a new Service Plan and Home Care Plan, which may include:
    - A change in the number of hours to be provided (i.e., an increase or decrease in hours);
    - The type of service to be provided (e.g., a change from Homemaker/Personal Care to Housekeeping/Chore or vice-versa);
    - A change in the cost share hourly rate (i.e., an increase or decrease);
    - A change in the contribution rate (i.e., an increase or decrease); and/or
    - A change in the contribution method (e.g., from either contribution-only to cost share, or vice-versa).

Compliance 8.6. 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 8.7. 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, or some may need to be revisited if they no longer match the client's needs. 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.

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, the client and case manager sign, and the client is given a copy.

- The client and the case manager sign the Client and Service Provider Rights and Responsibilities. If the client is unable to sign, the client's authorized representative may sign on the client's behalf.
- The case manager documents in case notes the date that the client received a copy.
- Case managers ensure that client rights are protected in all aspects of the program.

Compliance 9.2. A complete copy of the signed Client and Service Provider Rights and Responsibilities must be uploaded into the client's record in NYC Aging's client tracking system.

- HRA APS clients who were referred to case management programs for home delivered meals are not required to sign this form.

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 their 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 their authorized representative and, if requested by the client, to informal caregiver(s).
- A newly signed Service Agreement is obtained at each reassessment even if service type, amount, duration, and frequency have not changed.

Compliance 10.2. A complete copy of the signed Service Agreement must be uploaded into the client's record in NYC Aging's client tracking system after each assessment and reassessment.

- HRA APS clients who were referred to case management programs for home delivered meals are not required to sign this form.

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, approves, and makes recommendations as appropriate, for 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.*

Once the Assessment and Care Plan are completed, the case manager must alert the Supervisor. This should be done immediately as best practice. It is also best practice for the Supervisor to complete their review and approve the case record within five (5) business days of the assessment and care plan completion. However, if a supervisor needs additional time to complete this review and enter their approval in the case record, they have up to 10 business days to complete this activity.

- Example #1: The case manager completed the assessment related forms on Monday, March 2, 2026. She then completed the Care Plan on Wednesday, March 4, 2026. She alerts the Supervisor within the same day, and the Supervisor has 10 business days, or until Wednesday, March 18, 2026, to review and approve the case record. In this example, the supervisor completes and documents approval of the case record in four days on Tuesday, March 10, 2026.

Supervisors can authorize referrals to be sent to NYC Aging-funded providers during the supervisory review period by explicitly documenting that they are authorizing the Care Plan for that service.

The supervisor and case manager can also work simultaneously with one another so that the assessment and Care Plan forms are ready for review by the time those documents are completed.

> Example #2: The case manager assessed the client on March 2, 2026. The case manager worked on completing the assessment-related documents, and the Care Plan forms by March 9, 2026, five (5) business days later. During these five (5) days, the case manager updated the supervisor about the case and made the supervisor aware of the client's assessment and care plan. The supervisor provided some advice on improving the case manager's documentation which the case manager updated. On March 10, 2026, the case manager alerted the supervisor that the record was ready for her review. On March 11, 2026, the supervisor reviewed the record and documented approval.

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.

Compliance 11.3. Case management supervisors shall review the client case records of each case manager at least annually. This criterion can be met when supervisors review the case record as part of the reassessment process, assuming the reassessment is performed and reviewed on time. Otherwise, the supervisor must document proof in the case note that they have reviewed the case record before 365 days have passed.

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, to ensure 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, weekly hours may be temporarily increased to include escort to a medically related appointments 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 any 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.

Compliance 13.1. 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 13.2. 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 (1) business day after the service was scheduled to begin to confirm that the service began. The case manager will also inquire with the client about their satisfaction with the service and address any issues.

Example of adequate documentation: "The case manager contacted the client by phone about her meals today. She confirmed that she received her meals. We also discussed what she thought about them and if there were any complaints. She stated that she enjoyed them. She had no issues with the meals. We informed her that we would follow up again in 15 business days but that she could call us back if she had any issues."

Example of inadequate documentation: "The case manager called, and she got her meal."

Exception: HRA APS clients who were referred to case management programs for home delivered meals are not required to be contacted next day by the NYC Aging case management program.

Compliance 13.3. 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 an NYC Aging-funded service has begun to ascertain adequacy, appropriateness, and satisfaction with the service.

- The 15-day contact is a required 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 with a home visit.

Exception: HRA APS clients who were referred to case management programs for home delivered meals are not required to be contacted with a 15-day follow-up by the NYC Aging case management program.

Compliance 13.4. Follow-up on Entitlement/Benefit application. The case manager follows up with the appropriate government office to ensure receipt and to check on the status of client's benefits application until a decision is reached. The case manager also keeps the client informed.

Compliance 13.5. 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.

For clients who were referred for meals by HRA APS, the case manager or a staff person under the case manager's direction will also contact the APS office at least once every two (2) months (60 calendar days) to ensure that the client is still active with APS and continues to need meals.

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 on appropriately and documented in the case record.

Examples:

- *The case manager is helping the client to apply for SNAP benefits and 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 helping 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 13.6. Severe or imminent threats.

- The case manager reports to their 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
- An Incident/Accident Report Form is completed within 72 hours of the occurrence. See Incident/Accident Report Form at: https://www.nyc.gov/assets/dfta/downloads/pdf/community/Incident-Accident-Report_Form-Final_12-2024.pdf

Compliance 13.7. "No answer" to a meal deliverer. When a client does not answer the door for the home delivered meals deliverer, the case management program responds in any of the following ways within one (1) business day of receiving notification from the HDM provider:

- The case manager may first follow up with the client. Thereafter, the case manager may reach out to the emergency contacts until client safety has been verified.
- The case manager must maintain a list of clients deemed high risk. If a client on that list is a No answer, the case manager must follow up with the client and 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 contacts and await a response. However, if a client who is deemed low risk is a No Answer on two (2) consecutive days, the case manager must follow up with the client and the emergency contacts until client safety has been verified.

- A home visit may be required as a last resort based on the client's known risk factors.
- For a client who receives meals through an HRA APS referral and is reported as a No Answer, the case manager must inform the client's HRA APS case manager, supervisor, and program director of this event as APS is the primary case manager. These notifications must be documented in the client's case record.
- All communications must be documented.

Compliance 13.8. 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 [name of 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."*

- *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: Contributions

The program gives clients an opportunity to contribute to the cost of their service.

Compliance 14.1. The CMA must provide an opportunity for clients to voluntarily contribute toward the cost of their case management.

Compliance 14.2. Clients must be informed that all contributions are kept confidential, and services will not be denied if they cannot or choose not to contribute.

Compliance 14.3. The CMA has written procedures to safeguard and account for all voluntary contributions towards case management.

Standard 15: Service Authorizations, Referrals, and Linkages

The program follows required procedures for service authorizations and referrals.

Compliance 15.1. 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.
- For home care, on a monthly basis, the home care vendor will advise the CMA on 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 who 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 timely sends their full number of clients to the home care provider.
    - For Home Care services, the Service Plan/Care Plan will be completed to define the service type (Homemaker/Personal Care or Housekeeping/Chore), units/hours per week, and authorization date. Following that, the case manager then fills out the Home Care Plan, the cost share rate and monthly maximum, or contribution rate. The referral is then sent to the Home Care Agency for them to process as they will need the Home Care Plan to process the referral. If any information is missing from the Home Care Plan, the referral will be rejected.
    - Referrals specify when there is a secondary client in the home who will indirectly benefit from having housekeeping tasks performed. *For example: Mrs. Jane Doe is the spouse of the primary client, Mr. John Doe who is authorized for housekeeping. She is the secondary client and will benefit from having housekeeping performed.*
- For Home Delivered Meals, the case manager should consult with the home delivered meal partner to determine what variety of meals are available. Clients must be referred for either HOT or FROZEN weekday meals. HOT meals are delivered daily, while FROZEN meals are delivered twice a week.
    - Referrals for weekday HOT meals must be for no less than five (5) days a week unless there is an exceptional reason for fewer days. Not all home delivered meals programs can accommodate this exception, and the case manager must confirm that the program can deliver less than five (5) weekday meals. If the home delivered meal program accepts the referral, then it is the responsibility of the case manager to monitor and determine if the situation changes. The case manager must then send an updated referral to inform the home delivered meal provider.
    - For FROZEN meal delivery, home delivered meal programs are required to make two face-to-face deliveries per week. The case manager can only make an exception for a once-a-week delivery referral for out-of-home medical treatments that make it difficult for the client to be home coinciding with the FROZEN meal delivery schedule. It is the responsibility of the case manager to monitor and determine if the situation changes. If the client no longer requires the out-of-home medical treatment and can be home to accept the twice a week FROZEN meal delivery, the case manager must then send an updated referral to inform the home delivered meal provider.
    - Referrals specify special instructions for the home delivered meals provider when needed, including indication of high-risk clients.
    - Referrals specify when there are other clients attached/linked to this case who will be receiving home delivered meals (see Compliance 2.4).

Compliance 15.2. Reauthorization referrals for ongoing needs.

- Case managers use reassessments to determine whether clients have ongoing needs and submit reauthorization referrals as needed.
    - For clients determined to need ongoing homemaker/personal care or housekeeping/chore services, the case manager sends a reauthorization referral through NYC Aging's client tracking system within ten (10) business days of the reassessment.
    - For home delivered meal clients who wish to change their meal delivery (e.g., from hot kosher to frozen kosher meals), the case manager sends a reauthorization referral for ongoing home delivered meals service. Otherwise, the case manager does not need to send a reauthorization for ongoing home delivered meals.
    - The case manager does not need to send a reauthorization for ongoing Friendly Visiting.

Compliance 15.3. Nutrition Counseling
The NSI is performed at each assessment and reassessment. The Case Manager will offer Nutrition Counseling through NYC Aging if the client scores a rating of 6 or higher on the NSI. The case manager will document the offer and the client's response. A referral will be sent upon written consent from the client.

Compliance 15.4. Building and maintaining Linkages. The program links clients to other services or resources that the client requests. Given the range of needs of case management clients, it is imperative to build a web of linkages with other service providers in the community to tap into the wealth of services and programs that can benefit clients, such as businesses and social service providers, cultural, faith based, and educational institutions, health care providers, hospitals, nursing homes, elder abuse service providers, and Adult Protective Services (APS).

- It is expected that the CMA will maintain an ongoing working relationship with the corresponding catchment area's home delivered meals program, friendly visiting program and the borough's NYC Aging funded home care providers, as well as programs that provide supplemental services (home remediation services, legal services, medical, dental, mental health expenses not covered by insurance).
- It is best practice to link a client to the other services 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 most NYC Aging-funded services such as Caregivers, Elder Justice, and Geriatric Mental Health, referrals can be sent directly through NYC Aging's client tracking system.
- The case manager documents other referrals in the client's case notes.
- The CMA monitors whether linkages and referrals to NYC Aging programs and to services offered in the community result in meaningful outcomes.

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 16: Wait Lists

The program maintains and manages required wait lists.

Compliance 16.1. 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 will waitlist 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 the following 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) is established after an in-home assessment has been completed on the client, the client is 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, the client is 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 16.2. Counseling on options. The case manager documents the discussion with the client of all possible community resources and other options before the client was placed on the wait list.

- Clients who cannot be safely maintained while waiting for the service may not be placed 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 16.3. Prioritization. Clients on the wait list for assessment, 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 they need, and that their priority may change because other clients with higher needs may rank higher.
- If a client is reached on the wait list and that client is not able to accept the service, the case manager must document the following in the client tracking system:
    - The date the service became available to the client.
    - The reason the service could not be accepted:
        - Service offered – client asked to postpone
        - Service offered – client unavailable
        - Service offered – client not able to be reached

Compliance 16.4. 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 16.5. Monitoring of clients on the Wait List. Clients on the wait list for a service receive a monitoring call every two (2) 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 16.6. Six-month review of clients on the Wait List. After the client has been on a wait list for six (6) 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 their priority on the wait list or whether to continue the client at the same priority.

Standard 17: Collection of Past Due Cost Share Amounts

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

Compliance 17.1. 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 17.2. 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 18 and NYC Aging's Termination Procedures that are included as an addendum).

- 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 17.3. 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 18: Service Discharge/Termination Procedures

The program follows required service discharge/termination procedures.

Compliance 18.1. 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).
  - APS sends a home delivered meal termination referral to the case management agency.
- Reasons for voluntary termination of home care, home delivered meals or Friendly Visiting services are the same as those for voluntary case management termination, with one exception: The client may request termination of home care, home delivered meals or Friendly Visiting services but continue to receive case management services if they still have 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 program sends a letter to the client stating its recommendation for a reassessment, and documenting its attempts to schedule the reassessment.

Compliance 18.2. 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) Adult Protective Services to ensure the client's safety.

Compliance 18.3. Involuntary Termination of Services. (*See also Attachment D, Involuntary Termination of EISEP Services*)

- Prior to involuntarily terminating a client, the program will do due diligence to work with the client to modify or correct any behaviors or actions that would violate the client's eligibility for services. For example, if a client behaves contrary to the Clients' Rights and Responsibilities, or is refusing to adhere to program requirements, such as agreeing to the annual reassessment in-home visit, then the program will document efforts to engage the client to behave properly going forward or accept the home visit, respectively. In another example, the program may also consider working with the client to sign an

agreement to behave properly going forward, with the agreement that repeated behaviors in the future will lead to an involuntary termination of services.

- Case management, home care, and/or home-delivered meals may be terminated 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; and/or
  - Client has failed to cooperate with program requirements or has refused to comply with their care plan.
- In addition to the above, home-delivered meals may be 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 18.4. The program follows NYC Aging's policy for involuntary termination of services and notifies the client of their 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 failed to make cost share payments or to make negotiated payments on a past-due amount.
  - The client has failed to comply with program requirements such as permitting a case manager to visit or refusing to agree to a care plan.
  - The client is not expected to need services within the next ninety (90) days.

Compliance 18.5. 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."**).**

Use the table below to determine which Termination Letter to use.

Service being terminated	Documents to use and send
Only Home Delivered Meals is being terminated?	Use Termination of HDM Letter and send along the Grievance Form
Are Home Delivered Meals and any other service (Case Management, Home Care, or Friendly Visiting) being terminated simultaneously?	Use Termination of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Case Management being terminated?	Use Termination of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Home Care being terminated?	Use Termination of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Friendly Visiting being terminated?	Use Termination of EISEP Services Letter and send along the Client Rights to a Hearing form

Compliance 18.6. Denial of Services

The CMA determines eligibility of services before services begin. If the CMA determines that a client is not eligible for services, the CMA will then complete and send to the client one of the following letters that is appropriate to their denial:

- The Denial of HDM Letter (see Attachment G) is used when the CMA is determining eligibility for home-delivered meals services only and finds that the client is ineligible. CMAs must provide the Client Grievance Form (see Attachment I) to the client along with the denial letter.

- The Denial of EISEP Services Letter (see Attachment F) is used when the CMA is determining eligibility for Case Management, Home Care, Home Delivered Meals, and/or Friendly Visiting and determines that the client is found ineligible for one or more EISEP-funded service. When denying EISEP service(s), the CMA must include the Client Rights to a Hearing (see link in Attachment E) along with the denial letter.

Use the table below to determine which Denial Letter to use.

Service being denied	Documents to use and send
Only Home Delivered Meals is being denied?	Use Denial of HDM Letter and send along the Grievance Form
Are Home Delivered Meals and any other service (Case Management, Home Care, or Friendly Visiting) being terminated simultaneously?	Use Denial of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Case Management being terminated?	Use Denial of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Home Care being denied?	Use Denial of EISEP Services Letter and send along the Client Rights to a Hearing form
Is Friendly Visiting being denied?	Use Denial of EISEP Services Letter and send along the Client Rights to a Hearing form

Compliance 18.7. 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 their 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 the program provider.

Compliance 18.8. 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 19: Budgeted Units

The program provides its budgeted annual units.

Compliance 19.1. The case management agency meets its service level requirement.

Compliance 19.2. 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

Examples of case conference/supervisory conference unit calculation.

- *The case manager meets with their 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: 0.75 hour. Units attributable to Client B: 0.25 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 they 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 19.3. The program uses the correct unit definition in documenting supplemental services units. (See Attachment A: Service Definitions)

Compliance 19.4. Case management units in NYC Aging's client data system match 100% with invoiced units.

Compliance 19.5. Case management units entered in NYC Aging's client data system must be supported by case notes.

Staff Appropriateness and Continuity

Standard 20: Staff and Supervisor(s) Qualifications

Staff and supervisor(s) meet required qualifications.

Compliance 20.1. 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 20.2. 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 20.3. Case Management Supervisor Qualifications. Supervisors meet or exceed the following qualifications:

- MSW degree or related Master's level degree (e.g., social services, public administration, nursing, or public health).
- A waiver may be requested if the candidate for this position does not meet the above qualification. The waiver requested must describe why the candidate's experience is at least equivalent to or can substitute the above qualifications.

Compliance 20.4. Case Management Program Director Qualifications. The program has a Full Time Equivalent case management program director (Director) that meets or exceeds the following qualifications:

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

A waiver may be requested if the candidate for this position does not meet the above qualifications. The waiver requested must describe why the candidate's experience is at least equivalent to or can substitute the above qualifications.

Compliance 20.5. 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 21: Use of Case Aides, Undergraduate and MSW students

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

Compliance 21.1. 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"; data entry and other administrative tasks. They may not: conduct assessments or reassessments; conduct care planning; authorize services; or 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 21.2. Master of Social Work (MSW) Students. MSW interns may conduct 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 22: Case load average and Full-Time Equivalent staff

Compliance 22.1. 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 or exceeds the threshold by no more than 10% of the program case load ratio average of 1 case manager to 65 clients, assuming the program maintains standards for providing services to clients. The program will meet a supervisor to case manager ratio of 1:5 to ensure that case managers are adequately supported in their work.

- Clients who are at the intake stage 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.

The average program caseload ratio is computed by taking the number of staff performing core program functions divided by the number of active clients at one given point in time, taking the following into consideration:

1) Neither the program director nor the supervisor is counted in the caseload average. When determining supervisor to case manager ratio, assistant directors are included in the supervisory count, directors are not included in the supervisory count;
2) It is at the program's discretion to have supervisors carry cases. As best practice, this would occur if they are supervising fewer than five (5) case managers.
3) 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.
4) A supervisor who is allocated to the contract and functions exclusively as a supervisor will not be counted towards the CM FTE.
5) 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.
6) If the intake worker is a case manager or has a different title though similar salary, then the intake worker is counted in the caseload average. If the intake worker has a similar salary to a supervisor, they are counted as a supervisor.
7) Case aides are meant to perform administrative tasks and are to assist their assigned case manager with pre-screening calls, arranging services, two-month monitoring calls, and follow up calls. They are not permitted to conduct assessments, provide care planning, authorize services, or terminate clients. (Case aides are not counted towards the CM FTE.)
8) 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.
9) MSW students will not count towards the CM FTE.

Note: NYC Aging will send periodic reports to the CMAs to indicate the active, wait list, and caseload average count based on data from the NYC Aging client tracking system and budgeted CM staff.

Compliance 22.2. 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 22.3. When the program caseload ratio falls below the minimum average, the program should conduct outreach to ensure steady onboarding and a referral stream of clients in need of case management. The program will develop and implement a plan to ensure improvements are made within two (2) months. 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 22.4. 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.

Compliance 22.5. Vacancies are filled within three (3) months.

Standard 23: Background Checks

The program conducts background checks on all employees.

Compliance 23.1. The program conducts background checks on all employees and complies with requirements of the case management contract regarding the screening of staff, obtaining of references, and compliance with applicable Federal, State, and city laws.

- The program provides NYC Aging with an attestation that background checks have been administered on all employees.
- Copies of background checks are kept on file.

Standard 24: Staff Orientation

The program orients all staff.

Compliance 24.1. 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;
    - Incident/Accident reporting; (The program must NYC Aging's Incident/Accident form found at: https://www.nyc.gov/assets/dfta/downloads/pdf/community/Incident-Accident-Report_Form-Final_12-2024.pdf)
    - 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 24.2. Staff member orientation is documented, and new staff sign a statement that they have reviewed and understand the orientation kit.

Standard 25: NYC Aging Training Requirements

Staff meet NYC Aging training requirements.

Compliance 25.1. 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 25.2. 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 25.3. 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 25.4. All newly hired or promoted case management staff attend the earliest available NYC Aging "Elder Abuse Detection and Response Protocols" training, as required by City law, and receive a supplemental refresher training regarding the same at least once every 3 years.

Compliance 25.5. 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 26: Supervision of Case Managers

Case managers are adequately supervised.

Compliance 26.1. The program has a written staff supervision policy, which includes at least monthly scheduled individual and/or group supervision of case managers.

Compliance 26.2. No more than five case managers report to a supervisor to ensure effective supervision.

Compliance 26.3. Where appropriate, the Director of the program may also supervise case managers. Note: It is at the program's discretion to have supervisors carry cases, provided they are supervising fewer than 5 case managers.

Compliance 26.4. 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 26.5. 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 26.6. 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 27: Linguistic and Cultural Competence

The program is linguistically and culturally competent. (See also Standard 20.1, page 28 and NYC Aging General Standards of Operation, Standard 9)

Compliance 27.1. The program adheres to the requirements outlined Standard 20.1 and Standard 9 in the General Standards of Operation.

Documentation and Recordkeeping

Standard 28: Documentation

Interactions with clients are documented in case notes.

Compliance 28.1. 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 28.2. Case notes include the date, identity of the 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 29: Recordkeeping

Accurate client and service information are recorded in NYC Aging's client tracking system.

Compliance 29.1. The program updates client information in the NYC Aging client tracking system weekly.

Compliance 29.2. 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 29.3. Each client has a case record in NYC Aging's client tracking system. All client data, paperwork, or documents must 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
- 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 29.4. 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 legal counsel before attempting a conversion.

Compliance 29.5. Client's case records are subject to review only by the client, the client's authorized representative, designated case manager, case manager supervisor, NYC Aging's authorized staff, or authorized program or fiscal monitoring agents.

Incident/Accident Reporting

Standard 30: Incident /Accident Reporting

The program has a written policy for recording and reporting incidents and accidents, including data breaches.

Compliance 30.1. The program adheres to NYC Aging's policy for recording and reporting accidents and incidents. (See General Standards of Operation, Standard 27.4)

Compliance 30.2. The program must utilize NYC Aging's Incident/Accident form to report incidents found at: https://www.nyc.gov/assets/dfta/downloads/pdf/community/Incident-Accident-Report_Form-Final_12-2024.pdf)

Emergency Preparedness and Response

Standard 31: 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 31.1. The program adheres to requirements outlined in the General Program Standards, Standards 27 and 28 and as stated below. In the case of any conflicts between the General Standards of Operation and that included below, the General Standards of Operation shall take precedence.

Compliance 31.2. The program engages in emergency preparedness planning and exercises and works with NYC Aging to ensure the provision of services and continuity of care as directed by NYC Aging in an emergency and/or crisis.

Compliance 31.3. 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 31.4. The program submits a Service 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 31.5. In the event of a public health emergency, the program adheres to any additional guidance issued by NYC Aging.

Client Satisfaction Survey

Standard 32: Client Satisfaction Surveys

The Program conducts client satisfaction surveys and ensures that the views of older persons are solicited and considered as to the operation of the program.

Compliance 32.1. The program conducts a client satisfaction survey each contract year to allow clients an opportunity to share their experiences and can demonstrate that they reviewed and used the data collected to enhance their services.

Compliance 32.2. Surveys are conducted no later than six (6) months after the start of the contract year and results sent to the Program Officer no later than nine (9) months after the start of the contract year. NYC Aging will share a survey tool with the program no later than one (1) month after the start of the contract year.

Friendly Visiting

Friendly Visiting Introduction

Friendly Visiting is a scheduled visiting service provided on a regular basis to older persons in their homes to: help reduce isolation; and 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, found at: Contractor Tools - NYC Aging

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.
- 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 In-home Assessment is completed prior to making the referral to the Friendly Visiting Program.

Compliance 2.2. 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 and they will be authorized for telephone calls and virtual visits only. Caregivers or care receivers who are not willing to accept an in-home assessment by the NYC Aging Caregiver Program and the Friendly Visiting Program cannot be authorized for in-person visits by a volunteer. Case notes should reflect the client's request.

Compliance 2.3. 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 and they will be authorized for telephone calls and virtual visits only. Clients who are not willing to accept an in-home assessment by the Friendly Visiting Coordinator cannot be authorized for in-person visits by a volunteer. Case notes should reflect the client's request. 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 in-person visits 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 in the case file.

Compliance 2.4. The Coordinator conducts the following steps as part of the program assessment:

- Collects information about the client's interests, hobbies and preferences for a volunteer and documents these 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 and should be noted on the Agreement.

Compliance 2.5. 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 cannot 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 2.6. If the client needs additional services, the Friendly Visiting staff informs the client's case manager.

Compliance 2.7. Coordinator Assignment. The program assigns a Friendly Visiting Coordinator to the client in NYC Aging's client tracking system. Cases may not be assigned to a Program Assistant. Cases should only be assigned to the Friendly Visiting Coordinator.

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 aligns with the volunteer's availability.

Standard 4. Client and Volunteer Agreements

The program obtains signed agreement from the client and the volunteer.

Compliance 4.1. A Client Agreement is signed by the client and the Coordinator during the Program Assessment. If the assessment is completed on the phone, verbal agreement is acceptable and should be noted on the Agreement. (See Attachment J)

Compliance 4.2. A Volunteer Agreement is signed by the volunteer and the FV staff person prior to the match. If the agreement is reviewed on the phone, verbal agreement is acceptable and should be noted on the Agreement. (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 attends the 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 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 Coordinator is not required to attend the first match visit but must follow up 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 continue with the match. 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 monitor the match. Monitoring involves active inquiry, coordination, and follow-up to ensure that:

- Friendly Visiting service is being implemented as authorized (the client and the volunteer are meeting in the mode that the program has approved them for, the client and the volunteer have not entered into a financial relationship, the volunteer is not doing worker tasks, etc.);
- The client's needs for social connection are being addressed (via the volunteer's visiting and/or calling the client at least once a week, getting feedback from the client as to how they feel about the match, etc.); and
- Any concerns about the match are addressed.

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. The program alerts the client's assigned Caregiver or Case Management program staff of the above.

Compliance 5.7. If the client is not matched, the program contacts them at least once every three (3) months to ensure they are still interested in the program and to review their preferences for a volunteer and availability. 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 until contact is made.

Compliance 5.8. 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 Coordinator ensures it will be completed within one (1) week of the due date. If the client does not answer, the Coordinator should follow best practice and make at least three (3) attempts within five (5) business days to reach them. If the Coordinator is unable to complete the Social Isolation Assessment, the Coordinator will mark the Assessment as 'refused'. These actions must be documented in the case file.

Compliance 5.9. 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 5.10. If the match dissolves, the program ensures that the Friendly Visiting staff 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. If the program is unable to reach the client, the program alerts the client's assigned Caregiver or Case Management program staff of the above.

Compliance 5.11. 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 different NYC Aging-funded Friendly Program (e.g., they moved), the new program will complete new assessments. If a volunteer transfers to another program to volunteer, the new program will conduct new background and reference checks. If a volunteer leaves a Friendly Visiting Program and then returns to the same Friendly Visiting Program within one (1) year, the Program does not need to conduct new background and reference checks. If a volunteer leaves a Friendly Visiting Program and then returns to the same Friendly Visiting Program after more than one (1) year, the 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 must attend the client's first group session. If the group is held in the evening or on the weekend, the Friendly Visiting Coordinator is not required

to attend the first group session but must 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 matched group client and volunteer group facilitator are contacted by the program by telephone or video call at least once every three (3) months to monitor the match. Monitoring involves active inquiry, coordination, and follow-up to ensure that:

- Friendly Visiting service is being implemented as authorized (the client and the volunteer are meeting in the mode that the program has approved them for, the client has not entered into a financial relationship with anyone in the group, the volunteer is not doing worker tasks, etc.);
- The client's needs for social connection are being addressed (via the client attending the group once a week, getting feedback from client as to how they feel about the group, etc.); and
- Any concerns about the group are addressed.

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. If the program is unable to reach the client, the program alerts the client's assigned Caregiver or Case Management program staff of the above.

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 Coordinator ensures it will be completed within one (1) week of the due date. If the client does not answer, the Coordinator should follow best practice and make at least three (3) attempts over the next five (5) business days to reach them. If the Coordinator is unable to complete the Social Isolation Assessment, the Coordinator 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. If the program is unable to reach the client, the program alerts the client's assigned Caregiver or Case Management program staff of the above.

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; and record keeping.

Compliance 7.2. Volunteers document and report any concerns that arise during a 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) within three (3) business days.

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. The program ensures that each volunteer is contacted by the program by telephone or video call at least once every three (3) months to monitor the match.

Monitoring involves active inquiry, coordination and follow-up to ensure that:

- Friendly Visiting service is being implemented as authorized (the client and the volunteer are meeting in the mode that the program has approved them for, the client and the volunteer have not entered into a financial relationship, the volunteer is not doing worker tasks, etc.);
- The client's needs for social connection are being addressed (via the volunteer's visiting and/or calling the client at least once a week, getting feedback from volunteers as to how they feel about the match, etc.); and
- Any concerns about the match are addressed.

Text messages and emails are not considered contact for this purpose. If the 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 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 in accordance with Compliance numbers 5.10 and/or 6.7. The reason must be documented in the case file.

Compliance 8.3. The program conducts a client satisfaction survey each contract year 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.

- NYC Aging will share a survey tool with the program no later than 1 month after the start of the contract year.

- Surveys must be conducted no later than 6 months after the start of the contract year and results sent to the Program Officer no later than 9 months after the start of the contract year.

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. The program has a Full Time Equivalent Friendly Visiting Coordinator that meets or exceeds 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;
- Bachelor's level degree and one year of direct social service experience;
- High school diploma or an AA degree and two years of direct social service experience; 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.
- The supervisor provides regularly scheduled (at least once monthly) supervision to each Friendly Visiting Coordinator. If the Friendly Visiting Coordinator supervises staff, such supervision includes a discussion of the oversight of the program and support staff.

Compliance 10.4. 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 and follow-up calls; reference checks; and 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 10.5 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. If the Program has more than one Friendly Visiting Coordinator, one is designated as the lead coordinator. The lead coordinator must be 1 full-time equivalent (FTE).

Compliance 11.3. In order to provide Friendly Visiting services, Volunteers must:

- Be 18 years old or older*;*
- Commit to visiting for one hour per week for six (6) months or longer;
- Be consistently available at the agreed-upon visit time;
- Have been screened and interviewed by the Friendly Visiting Program to establish the Volunteer's appropriateness, reliability, and interest;
- Have provided at least two (2) non-familial references the volunteer has known for at least one year (see below);
- 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; and
- Meet with the Friendly Visiting Coordinator in person to be approved for in-person visits with a client. This meeting should occur prior to the match visit being scheduled.

Compliance 11.4. The program completes both non-familial reference checks prior to the volunteer being matched with a client, documents reference responses on the provided reference check form, and uploads the completed forms into NYC Aging's database.

Compliance 11.5. 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 11.6. 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, NYSOFA, ACL, or other non-profit or mayoral agency). Note: Part-time staff members attend training hours in proportion to their annual work hours**.**

Compliance 11.7. All newly hired or promoted Friendly Visiting staff complete the earliest available "Elder Abuse Detection and Response Protocols" training as required by City law and receive a supplemental refresher training regarding the same at least once every 3 years.

Compliance 11.8. 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.

Language Access and Cultural Competence

Standard 13. Linguistic and Cultural Competence

The program adheres to the requirements outlined in Standard 9 in the General Standards of Operation, and as stated below. In the case of any conflicts between the General Standards of Operation and that included below, the General Standards of Operation takes precedence.

Compliance 13.1. The program is linguistically competent.

- The program has a language access plan that includes these provisions:
    - The program will provide on-demand language assistance free of charge to persons with limited English proficiency (LEP). At minimum, the program will have a telephonic interpretation service contract or similar community arrangement with a language interpretation services provider to assist LEP individuals.
    - The program will inform persons with limited English proficiency of the availability of free language assistance at its location. The notice will be in writing designed to be understood by LEP individuals.
    - The program will train staff that have contact with the public in the timely and appropriate use of these and other language services.
    - The program includes information on its website in the languages of the communities it serves, in addition to English.
    - The program has visible signage about the availability of free interpretation services.
    - Vital documents are translated into the non-English language of regularly encountered LEP groups eligible to be served or likely to be affected by the program or activity. Examples of vital documents include applications, consent, and complaint forms; notices of rights, and notices advising LEP persons of the availability of free language assistance.

Compliance 13.2. The program is culturally competent.

- All service activities reflect (1) understanding of the needs, characteristics, cultural expectations and preferences of different ethnic groups residing in the community; (2) sensitivity and responsiveness to issues relating to culture, religion, socioeconomic status, gender identity, sexual orientation and immigrant adjustment; (3) sensitivity to cultural barriers impeding service utilization, including but not limited to language barriers; and (4) knowledge of linguistically and culturally competent service providers in the community and City, and ability to refer individuals to these providers when needed.

- All 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.
- As appropriate to the type of services provided, cultural preferences are respected – e.g., through foods served, holiday celebrations, social activities and program communications.

Service Levels and Reported Units

Standard 14. Reporting Units

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

Compliance 14.1. 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 made by a volunteer. 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 14.2. 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 14.3. If more than one volunteer visits a client together, the program may only enter units for one of the volunteers and not both.

Compliance 14.4. 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. Units would not be entered for volunteer group facilitator B.

Compliance 14.5. Units are entered into NYC Aging's client tracking system at least once monthly. The program must maintain back up documents to substantiate the units inputted each month, such as a Microsoft form.

Standard 15. Budgeted Units

The program provides its budgeted units.

Compliance 15.1. 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 for service 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 Assistant will support at least 710 volunteer units within the fiscal year.

The methodology for NYC Aging's recommended staffing pattern for 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 Assistant will serve at least 37 unduplicated clients served/matched within the fiscal year.

Recordkeeping

Standard 16. Recordkeeping
The program maintains required records.

Compliance 16.1. The following client records are entered into NYC Aging's client tracking system within one week of the event date:

- Program Assessment;
- 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; and
- Signed Program Agreement.

Compliance 16.2. Case notes documenting contacts with the client, case managers, volunteers, and collateral contacts must be entered within three (3) business days of the event.

Compliance 16.3. The following volunteer records are entered into NYC Aging's client tracking system within one week of approving a volunteer:

- Name, address, contact information, and emergency contact(s);
- Record of screening interview, background check and references; and
- Signed Program Agreement.

Compliance 16.4. Case notes documenting contacts with Friendly Visiting staff must be entered within three (3) business days of the event.

Compliance 16.5. Methods for unit collection and documentation must be approved by NYC Aging. Documentation of collected units must be maintained and made available upon request.

Compliance 16.6. Personnel and other records are properly maintained for six years from the end of the fiscal year in which the client last received services.

Attachment A. Service Definitions

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

Friendly Visiting: Unit of Service = Completed in-person visit, telephone call, or virtual visit by a volunteer that is 15 minutes or longer.

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

- **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: Unit of Service = Depends on the type of service**
  - Emergency food/groceries: Unit of Service = Item
  - Coats/Clothing: Unit of Service = Item
  - Air purifier/dehumidifier/Air Conditioner/Fan: Unit of Service = Item

Where there is a question about how to count individual items, please use the following guidance:

- A purchase of groceries should be counted as 1 item, regardless of the number of food products and bags.
- Like items that come in a box or package should be counted by box or package. For example, a box of 12 Ensures will count as 1 item.

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. You have the right to 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, 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 to the New York City Department for the Aging and/or to the New York State Office for the Aging changes in policies and services to any agencies providing you with services. 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 section 6654.15 of title 9 of the New York Codes, Rules, and Regulations (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 Worksheet

Thresholds Effective: April 1, 2025

	Income	**Individual** [not married, married but not living with their spouse, or married and living with a spouse who is not participating in EISEP]	**Spouse** [who lives with applicant but not participating in EISEP]	**Married Couple** who are both participating in EISEP
1a.	Social Security			
1b.	Supplemental Security Income			
1c.	Pension/Retirement Income			
1d.	Interest Income (Monthly)			
1e.	Dividends Income (Monthly Average)			
1f.	Salary/Wages			
1g.	Other			
	Comment on Other:			
2	Total **Monthly Income** of Individual, and Total Monthly Income of Spouse, or **Net Income of Married Couple**			
3	Total Monthly Income of **Individual** and **Spouse** [Add Total Monthly Income of Individual and Spouse together. If no Spouse, enter 0]			[redacted]
4	Amount of non-client Spouse's income not available for mutual needs [If no Spouse, enter 0)			
	Specify why income is not available:			
5	**Net Monthly Income for Individual** [Subtract Line 4 - from Line 3, if applicable]		[redacted]	

	Housing Expense	**Individual**	**Married Couple**	
6	Monthly Rent or Mortgage Payment			
7a.	Electricity			
7b.	Other heating & Cooking fuels			
7c.	Telephone installation & local usage			
7d.	Water & Sewage			
7e.	Property Taxes			
7f.	School Taxes			
7g.	Other			
	Specify Other:			
8	Total Housing Expenses =			
9	Housing Adjustment Threshold [subtract]	**-783**	**-1058**	
10	Excess Housing Expenses =			
11	Maximum Adjustment	**-783**	**-1,058**	
12	**Housing Adjustment: Enter the lesser of Line 10 or 11**			
	Income Adjustment	**Individual**	**Married Couple**	
13	Net Monthly Income			
14	Enter Housing Adjustment from Line 12			
15	Subtract Line 14 from Line 13			
14	Income Threshold	**-1,956**	**-2,644**	

15	**Adjusted Income & Maximum Monthly Fee** [Subtract Line 14 from Line 15: if the difference is zero or less, there is no Cost Share and only a Voluntary Contribution is requested]			Compare this number with the Fee Rate Schedule against either the Individual Column or Couple Column)
	CONTRIBUTION ONLY			
16	If Line 15 is 0 or less, the Fee Rate is 0% and the client is Contribution Only.			
	The Suggested Contribution will be calculated at 5% of the Fee Rate.			
	Enter here the Contribution Rate =			
	COST-SHARE			
17	If Line 15 is greater than 0, determine the % rate and rate per hour			
	Fee Rate =		%	
	Rate per hour = $			
	Services Recurring Monthly			
	Average Monthly Cost to Client			
18	**Weekly Units x 4.3 = Monthly Units x Maximum Rate per Hour (this is the rate per Hour at 100% on the Fee Rate Schedule, or $29.65) x Cost Share Fee Rate (use decimal) = Average Monthly Cost to Client**			
19	**Biweekly Units x 2.15 = Monthly Units x Maximum Rate per Hour (this is the rate per Hour at 100% on the Fee Rate Schedule, or $29.65) x Cost Share Fee Rate (use decimal) = Average Monthly Cost to Client**			
	Home Care recipients will be monthly at the above rate per hour for service received.			
	The monthly bill can never exceed the Maximum Fee (see Line 15)			

Distributed on 4/15/2025

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 the following services funded by the New York City Department for the Aging ("NYC Aging"): [*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*].

- ☐ You are not expected to need NYC Aging-funded services within the next 90 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(s) terminated, you have 30 days from the date of this letter to request a hearing to appeal the determination. If you request a hearing, a Settlement Conference will be hosted by NYC Aging, where you will have an opportunity 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; or
  c. 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

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 EISEP client who is

[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."

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

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 – do NOT add the NYC Aging logo to this letter

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"): [*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 reason(s) 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 days from the date of this letter to request a hearing to appeal 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.

Yours,

[Signature of Case Manager]

cc: [Name], CMA Supervisor

cc: [Name], CMA Director

Attachment G: Template for Denial of Home Delivered Meals for Ineligibility

*[Determination of Ineligibility Template for Case Management Agencies denying JUST **home-delivered meals**]*

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

*CMA: **delete the header and dd your Logo/Letterhead** – do NOT add the NYC Aging logo to this letter*

Date:

Dear [Client's Name],

We have determined that you are not eligible for Home Delivered Meals funded by the New York City Department for the Aging ("NYC Aging").

This determination is based on the following reasons: [*CMA to insert reason(s) for denial of HDM*].

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 with this determination, you have 30 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 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 days of submission to the Case Management Agency.

Yours,

[Signature of Case Manager]

cc: CMA Supervisor

cc: CMA Director

CMA: **Delete this and include the Grievance Form**

Attachment H: 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 are not expected to need services within the next ninety (90) 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 I: 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 J: 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 in-person visit, phone call, or virtual visit.

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 K: Friendly Visiting Volunteer Agreement Template

NYC Aging Friendly Visiting Program Volunteer Agreement

Volunteer Name:_____

A. I have met with the Friendly Visiting Program Staff 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 clarify with 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 client tracking system.

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 understand and agree to the following:

- 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.
- 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 Name (print): _____

Volunteer Signature: _____

Program Staff Name (print): _____

Program Staff Signature: _____