



COMMONWEALTH of VIRGINIA
Department for the Aging

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October 18, 2011

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



12-16

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors, Information & Referral Specialists, Case Managers
Area Agencies on Aging

FROM: Patricia Cummins

DATE: October 18, 2011

SUBJECT: VAIRS ANNUAL CONFERENCE NOVEMBER 15TH IN RICHMOND

The Virginia Alliance of Information and Referral Systems (VAIRS) is holding a one-day training and education conference on **Tuesday, November 15** in Richmond at "The Place at Innsbrook". The conference theme is "Emergency Preparedness".

For conference details and registration, go to www.vairs.org.

Please forward this information to appropriate staff.

We hope to see you there!



12-17

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Nancy Lo, GrandDriver Coordinator

DATE: October 18, 2011

On Tuesday, September 27, 2011 Loudoun County Area Agency on Aging, in collaboration with Virginia GrandDriver, held a CarFit event at the Senior Center at Cascades in Sterling, VA. This program was developed by AARP, American Automobile Association, and American Occupational Therapy Association. Trained volunteers, including an Occupational Therapist, give suggestions for vehicle adjustments to help older adults become safer in their cars. Senior drivers have the highest rate of fatal crashes per mile driven. As people age they experience natural physical changes that can impact their vision, range of motion, hearing, and reaction time. Adjustments of vehicle controls can increase visibility, comfort, and safety. Something as simple as making a mirror adjustment can eliminate blind spots while driving. For more information about this program and to find a CarFit event near you visit www.car-fit.org.



On Friday, September 16, 2011 Loudoun County Area Agency on Aging held its second annual Tools for Healthy Aging Fair at the Senior Center at Cascades in Sterling, VA. This year 32 vendors offered assistive technology and related services that help older adults remain active, healthy and independent. Approximately 170 caregivers and older adults attended this free event. Our vendors included: Granting You Access, a company that offers services for home modification and is a Certified Aging in Place Specialist; Gold's Gym, a local fitness center that gave away a free membership as a door prize.; a certified massage therapist from Massage for Optimum Health who offered a sample massage for deep relaxation; and the non-profit organization Loudoun Volunteer Caregivers offering assistance to older adults and people with disabilities who are in need of assisted transportation to medical appointments or help with daily money management through their AARP Money Management program. If you or someone you know is looking for resources and services to remain healthy and active in the community, please call The Loudoun County Area Agency on Aging for a quick assessment of your needs at 703-777-0257 Email: aaa@loudoun.gov Visit us at: www.loudoun.gov/aaa



12-18

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors and Finance Directors
Area Agencies on Aging

FROM: Marica B. Monroe

DATE: October 18, 2011

SUBJECT: Accrual Based Accounting and Cost Allocations

Hello everyone. We recently had a review by the Department Of Labor and they cited some items that every AAA, whether they receive Title V funds or not, should be reminded of in order to ensure compliance. Please see below and have a good day!

Accrual Based Accounting

Please continue to ensure that the AMR, AMR-OC, and AMR-ARRA reports are all reported based on the accrual basis of accounting. The Title V tabs on the AMR-OC have a separate column for reporting accruals. Please ensure that accruals are included in this column and reported separately. The AMR-OC report has been updated as of 09/30/11 and is included on VDA's website to include tabs for each of the three Title V grants that are currently active, please ensure that the new AMR-OC is used and submitted. Activity should be reported for each of these three grants as the grants originally ending 06/30/2011 were extended and now end 12/31/2011.

Cost Allocations – Please also see Federal regulations 2 CFR Part 230 and 29 CFR 95.23

Allocation of costs should be based on actual activity or current data whichever is relevant.

- Distribution of salaries and wages should be based on after-the-fact determinations of actual time spent working and be supported by personnel activity reports.
- Office-related, employee-related or building-related expenses should be based on actual current date. Costs that are allocated based on the direct allocation method should be prorated using an appropriate base which accurately measures the benefits provided to each program.

In-kind contributions should also be determined or valued based on actual or current data.



12-19

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

AND: Nutrition Directors, Care Coordinators, and Health Promotion and Disease
Prevention Coordinators

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

DATE: October 18, 2011

SUBJECT: Educational Event in Roanoke

Following is a flyer announcing an educational event in Roanoke on Wednesday. My apologies for the tight deadline.

Free Educational Event

The Hidden Epidemic: Alcohol, Medications, and the Older Adult

Sponsored by the Geriatric Training and Education Fund of the Virginia Center on Aging

Purpose: This training is designed to increase professionals' understanding of the dynamics of alcohol and drug abuse in later life and effective interventions to improve services and coordination among providers.

Target Audience: Professionals and volunteers working with older adults, including social workers, therapists, substance abuse counselors and physicians. Caregivers, family members and advocates are also welcome.

To register, go to our online sign-up at www.fsrv.org or contact Cathy Thompson at 563-5316 x3011 or by email at cthompson@fsrv.org. Registration deadline is Monday, October 17.



Date:
Wednesday, October 19

Time:
9:00am-12:00pm

Venue:
High Street Baptist Church
Fellowship Hall
2302 Florida Ave., NW
Roanoke, VA 24017
Parking available at the church

Program Presenters:

Dr. Verna Sellers, MD, MPH, CMD, AGSF will present *Strategies to Address the Unique and Complex Needs of Older Adults with Alcohol and Substance Use Issues*.

Dr. Sellers, serves as medical director of geriatric services for Centra Health and Pace in Lynchburg, Va., and will identify key issues surrounding alcohol and drug abuse among older adults. What is the most effective tool to identify substance abuse among this population, and what are the most practical and cost-effective treatments? How do we encourage compliance with treatment, and what is the success rate for older patients who undergo treatment? Learn to identify this hidden epidemic, intervene and treat older patients who too often go untreated and suffer in silence from alcohol and drug abuse.

Ms. Regina Whitsett will present *Why It Is Important to Create a Roanoke Regional Alcohol and Aging Awareness Group (AAAG)*.

Ms. Whitsett is as an Education Coordinator with the Virginia Department of Alcoholic Beverage Control. Ms. Whitsett supervises Community Coalition grantees throughout the Commonwealth who receive federal funding to reduce underage drinking. Ms. Whitsett is also the chair of the Alcohol and Aging Awareness Group (AAAG) (a national and state award winning group with over 80 members) created by VA ABC in March 2007. As chair of the AAAG, Ms. Whitsett works in collaboration with over 60 state and private organizations to address alcohol misuse and alcohol and medication interactions in older adults.





12-20

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Finance Directors
Area Agencies on Aging

FROM: Marica B. Monroe

DATE: October 18, 2011

SUBJECT: Final Contract Year 2011 Financial Report And Service Report (13th Month Report)

Please read carefully and follow instructions.

The Contract Year 2011 Financial Report And Service Report (13th Month Report) should be completed and electronically submitted to the Virginia Department for the Aging (VDA) by the close of business, **November 11, 2011**. This report is used by Area Agencies on Aging (AAAs) to report finalized annual performance, expenditures and receipts for the fiscal period October 1, 2010 through September 30, 2011. The following schedules must be submitted.

- **Final Contract Year 2011 Financial and Service Report:** This year the Aging Monthly Report (AMR) will be used to report compiled annual programmatic and financial information for the period October 1, 2010 to September 30, 2011. When completing your report, select **Final (13th Mo)** from the month drop down menu on the payment worksheet. Please name your file, "Final PSA xx," when emailing your submission to reports@vda.virginia.gov. Insert your PSA number in the characters denoted by xx.

Please make certain your Agency's AIM or PeerPlace data supports the AMR service data.

- **Final (13th Mo) – Schedules A, B, & C:** Schedules A, B, & C have been written in Excel and are available on the VDA website at <http://vda.virginia.gov/reportsandinstructions.asp>. The three

schedules are tabbed as separate worksheets in the workbook. The workbook should be downloaded to your computer before completion. Please name the file, "ABC PSA xx," when emailing your submission to: reports@vda.virginia.gov. Schedules A, B, & C are to be included in your audited financial statements as supplementary information and your audit firm is **required** to include these schedules in their audit opinion. Please ensure all funds received from VDA are included and that recorded amounts reconcile to the September 2011 remittance advice to be provided by VDA. American Recovery and Reinvestment Act funds must be reported separately and are highlighted in **yellow** as a separate line item on the necessary schedules. **Please ensure that the agency submission and the schedules included by your auditor in the audit report are in the current format.**

- **Schedule A, Status of Funds:** This schedule provides an accounting of grant funds on hand at the beginning of the period, and receipt and expenditures of grant funds during the period. Although general fund awards for the fiscal year ending on June 30, 2011 needed to be obligated by June 30, 2011, the recipient had until September 30, 2011 to liquidate the obligations. If a cash balance exists on September 30, 2011 from any general fund award for the Program Year (PY) ending on June 30, 2011, please refund the balance to VDA with a copy of Schedule A as your remittance advice.
- **Schedule B, Costs by Program Activity:** This schedule accounts for the expenditure of funds by activity rather than grant. Please ensure that Schedules A & B tie where appropriate. Again, Schedule B has been modified to correspond to the Aging Monthly Report. It now includes separate sections to report Title III activity (Except III-E) and a section to report III-E activity. If there are no audit adjustments, the data reported on your final AMR should be the same as reported on Schedule B.
- **Schedule C, Status of Inventories:** Tangible personal property purchased with funds from a Federal or State grant should be included. Generally, equipment or large quantities

of food would be the main items reported. Equipment with a fair market value of less than \$5,000 per unit should not be reported.

Contractor Certification Form: This form should be prepared on AAA letterhead and signed by the AAA Executive Director. The form is available on the [VDA website](#).

Please mail the Contractor Certification to:

Marica B. Monroe, Financial Manager
Virginia Department for the Aging
1610 Forest Avenue, Suite 100
Richmond, VA 23229

Your submission should include **all** contracts issued by VDA to support contract year 2011 operations. All funds received during the period, October 1, 2010 to September 30, 2011, should be accounted for and included. **As a reminder, your agency's audit report is due to VDA by December 15th**. One 30-day extension may be requested in writing, but the extension request must be received before December 15th.

CERTIFICATION

I, (Insert Name)_____ certify that I am the
Executive Director_____ of_(Area Agency on
Aging)_____.

I have reviewed the Final (13 Month) Aging Monthly Report (AMR) and Status of Funds, Costs by Program Activity, and Status of Inventories (Schedules A, B, & C) for contract year 2011. By submitting these reports, as required by the Virginia Department for the Aging (VDA) Regulations, Section, 22 VAC 5-20-480 and Section 22 VAC 5-20-500, I certify, that to the best of my knowledge and belief, this information is a true, correct, and complete statement prepared from the books and records of the agency in accordance with applicable instructions, except as noted.

Further I certify that all costs and revenues reported are allowable as specified by the contracts issued with the VDA. Any audit adjustments that occur subsequent to the filing of these documents, shall be promptly reported to the VDA.

Executive Director

Date



12-21

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman, Director of Administrative Services

DATE: October 18, 2011

SUBJECT: Director and Board Notes – AAA Self-Assessment

Attached are two Self-Assessments of Board and Agency operations. Most of the items are based on state or federal legislation, regulation, federal policy, or the Title III Area Plan Contract. One or two of the items are best practices that have been identified that that will be incorporated in future contracts.

The document titled "Area Agency on Aging Board of Directors" is to be completed by the AAA Governing Board Chairman. By design it is not burdensome and contains only 40 questions. The document titled "Area Agency on Aging Executive Director/CEO" is to be completed by the Executive Director.

Please complete the assessment and return to me by December 1st. Signed assessments can be scanned, faxed or mailed.

I will be working with the five governmental AAAs to develop an appropriate 'Board of Directors' questionnaire for their operations.

If you have any questions about this survey, please contact me.

Virginia Department for the Aging
Area Agency on Aging Board of Directors
Self-Assessment

Has the Board approved the agency's *Whistleblower Policy* required by the IRS 990? Is there an opportunity to appeal to the Board?
Is staff aware of the agency's *Whistleblower Policy*?

Finances

Has the Board approved through policy who can sign checks? Some Boards establish a threshold where two signatures are required.
Has the Board approved all lines of credit available to the agency?
If the agency has a line of credit, has the Board approved through policy when and what purpose the line of credit can be used?
Does the Board or an appropriate committee solicit bids from CPA firms for the annual audit at least every 5 years?
Has the agency changed auditing firms at least once every 5 years even if they were the lowest bid?
In addition to the annual audit, does the CPA prepare a management letter containing recommendations for improvements in the financial operations of the AAA?
Does the AAA file its annual audit with VDA by December 15th of each year?
Is the Board made aware of the agency's fundraising efforts?

Yes	Needs Work	No or N/A

Contracts

Has the Board assigned authorization and responsibility for entering into binding contracts?

Yes	Needs Work	No or N/A

Travel

Has the Board approved the agency's *Travel Policy* in the last four years with documentation in the Board minutes?
Does the policy include everyone including the Executive Director/CEO?

Yes	Needs Work	No or N/A

Purchasing, Receiving, and Expenditures

Has the Board approved the agency's *Procurement Policy* in the last four years with documentation in the board minutes?
Does the *Procurement Policy* describe dollar thresholds and how competitive procurement will be obtained?
Has the Board approved the agency's *Credit Card Policy*? The policy should include credit cards, limits of credit, and what can be purchased?

Yes	Needs Work	No or N/A

Insurance

Does the AAA have adequate commercial general liability, business auto, commercial, and directors and officers liability insurance coverage?
Does the AAA have a fraud insurance policy that includes the Executive Director/CEO and all staff that handle cash or checks?

Yes	Needs Work	No or N/A

Contingency Management

Does the agency have a *Continuity of Operation Plan* that addresses disasters such as floods, tornadoes, hurricanes, fires, or serious computer malfunctions?

Yes	Needs Work	No or N/A

Virginia Department for the Aging
Area Agency on Aging Executive Director/CEO
Self-Assessment

Area Agency on Aging: _____

Purpose: This tool should help the Management of the AAA assess whether or not adequate internal control processes are in place to ensure that assets are safeguarded, financial and operating information is accurately reported, and compliance with external laws and regulations is maintained. A "Yes" answer indicates that a desired control is in place. A "Needs Work" answer indicates that a control weakness may be present, and corrective action may be necessary. A "No or N/A" answer indicates that the question may not be applicable to your particular work environment; however, careful consideration of the question's intent should be made.

Personnel

Is there an up-to-date organizational chart that clearly defines lines of authority and responsibility?

Do staff have accurate and up to date job descriptions that includes all major expectations?

Is adequate training provided to employees to accomplish their jobs?

If employee turnover is unusually high, do you know the root causes?

Are there performance evaluations, at least annually, where employees and supervisors discuss expectations, goals, and performance?

Are employees required to sign a confidentiality agreement prohibiting inappropriate disclosure of information relating to individual/client privacy?

Yes	Needs Work	No or N/A

Finances

Control responsibilities have been clearly communicate to and are understood by employees?

Management over-ride of established controls is not tolerated or the over-ride to established policy is approved and documented appropriately?

Yes	Needs Work	No or N/A

Contracts

Are contracts monitored for service performance according to terms and conditions of the contract?

Yes	Needs Work	No or N/A

Travel

Does the agency's travel policy state that the mileage and per diem reimbursement should not exceed Federal or State limits? The current IRS limit is 55.5 cents per mile and the per diem maximum range is \$41 to \$71 depending on the location.

Are travel reimbursement vouchers independently reviewed for mathematical accuracy?

Is travel authorized in advance by the Executive Director or Board of Directors for overnight trips or day trips where significant expense will be incurred (e.g., over \$500)?

If four or more employees and/or board members are attending the same conference, training, workshop, etc., is there written documentation justifying the need for multiple people attending?

Are lodging and other reimbursement requests supported by valid documentation?

Yes	Needs Work	No or N/A

Virginia Department for the Aging
Area Agency on Aging Executive Director/CEO
Self-Assessment

Payroll

Does the AAA maintain accurate, detailed timesheet signed by the employee and approved by an authorized individual who has first hand knowledge of the work performed?
Do approved timesheets accurately reflect time charged to multiple funding streams and the name of the funding stream?
Are payroll records independently reviewed and compared to supporting timesheets on a periodic basis?
Are employment records securely maintained for each employee that detail wage rates, benefits, taxes withheld each pay period, and any changes in employment status?
Do written policies and procedures exist for accounting for vacations, holidays, sick leave, and other benefits?

Yes	Needs Work	No or N/A

Equipment/Inventory

Is a detailed listing of fixed assets (including equipment) maintained and kept up-to-date?

Are fixed assets (including equipment) tagged or otherwise identified as owned by the grantor?
Are vehicles, furniture, computer equipment, other equipment and machinery items costing \$5,000 or more and with a useful life of one year or more capitalized?
Is a physical inventory count conducted at least once every two years by someone independent of recordkeeping?
Does the sale, transfer, scrapping, dismantling or other disposal of equipment require written approval, especially for grantor owned equipment?
Is a periodic physical count performed by persons other than those who maintain custody of the inventory and/or inventory records?
Is investigation of differences between physical counts and inventory records performed/checked by persons other than those who maintain custody of the inventory and/or

Yes	Needs Work	No or N/A

Insurance

Is insurance coverage reviewed and updated annually?

Yes	Needs Work	No or N/A

Contingency Management

Has the contingency plan been tested at a frequency commensurate with the risk?
Does the contingency plan address alternative procedures?

Yes	Needs Work	No or N/A

Computer Security

Is the physical security of personal computers, terminals, and/or work stations adequate to prevent theft or damage from smoke or spills/moisture?
Are software on computers appropriately licensed to the AAA?
Backup and recovery procedures for personal computers and local area networks, if applicable, are documented and working effectively?
Access security over personal computers and/or local area networks is adequate and passwords are changed periodically?
Is there a procedure for controlling computer viruses in place for the entire agency use including PC's and networks?
A password policy is in place prohibiting unauthorized use of another's account and/or password?

Yes	Needs Work	No or N/A



12-22

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Kathy Miller, Director of Programs

DATE: October 18, 2011

SUBJECT: CCEVP Service Standards

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

As a result of the work group's efforts, four models of support coordination were approved as options that can be funded under the CCEVP. These are Service Coordination Level One, Service Coordination Level Two, S.O.S. and Options Counseling. Draft service standards were sent out for review on August 23, 2011. Comments were received from only a few AAAs. The service standards for Service Coordination Levels One and Two and S.O.S have now been finalized and are attached. They are effective as of today's date.

The Options Counseling Service Standard was developed by a separate work group made up of AAA-CIL teams under the AoA Options Counseling Grant. This standard is currently being implemented by AAAs involved in the work group.

Service Coordination Level One

VIRGINIA DEPARTMENT FOR THE AGING

SERVICE STANDARD

Definition

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

Eligible Population

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

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

Service Delivery Elements

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

Outreach:

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

Intake/Screening

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

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

Assessment:

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

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

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

Service Planning:

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

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

Service Delivery:

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

Monitoring:

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

Reassessment:

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

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

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

Termination:

Service coordination can be terminated at the discretion of the service provider or the individual. Service coordination should be terminated when the individual's service goals are met. Written notification of termination of service coordination shall be mailed to the individual by the agency 10 business days in advance of the date the action is to become effective.

Administrative Elements

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

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

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct assessments (including psychosocial, health and functional factors) and use them in care planning; interviewing techniques; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of record documentation; and the service planning process and the major components of a service plan.
- Skills: Service coordinators should have skills in negotiating with consumers and service providers; observing, documenting and reporting behaviors; identifying and documenting a consumer's needs and preferences for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs and preferences; coordinating the provision of services and supports by diverse public and private providers; analyzing and planning for the service needs of older adults and individuals with disabilities, and assessing individuals using the Uniform Assessment Instrument (UAI).
- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

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

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

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

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

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

Units of Service:

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

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

Program Reports:

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

Organizational Structure:

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

Consumer Contributions/Program Income:

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

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

And/Or

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

cost of services.²

Quality Assurance:

Criminal Background Checks:

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

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, arranging services, and monitoring.
- Each staff person must participate in eight (8) hours of in-service training per year. Content should be based on the service coordinator's need for professional growth and upgrading of skills.

Caseload Size:

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

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

Supervision/Case Review:

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

Program Evaluation:

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

Anonymous client surveys of the service shall be done annually. At least 10% of the clients shall be surveyed. Surveys should be maintained in an agency file with a summary of the survey results.

Complaint and Appeals:

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

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

Client Bill of Rights:

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

Individual Support Records:

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

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

The Area Agency on Aging will maintain:

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

Service Coordination Level Two

VIRGINIA DEPARTMENT FOR THE AGING

SERVICE STANDARD

Definition

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

Eligible Population

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

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

Service Delivery Elements

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

Outreach:

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

Intake/Screening:

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

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

² Older Americans Act of 1965 as amended 2006, Section 306 (a)(4)(A)(i)

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

Assessment:

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

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

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

Service Planning:

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

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

Service Delivery:

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

Monitoring:

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

Reassessment:

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

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

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

Termination:

Service coordination can be terminated at the discretion of the service provider or the individual. Service coordination should be terminated when the individual's service goals are met. Written notification of termination of service coordination shall be mailed to the individual by the agency 10 business days in advance of the date the action is to become effective.

Administrative Elements

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

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

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct assessments (including psychosocial, health and functional factors) and use them in care planning; interviewing techniques; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; the principles of human behavior and interpersonal relationships; effective oral, written, and interpersonal communication principles and techniques; general principles of record documentation; and the service planning process and the major components of a service plan.
- Skills: Service coordinators should have skills in negotiating with consumers and service providers; observing, documenting and reporting behaviors; identifying and documenting a consumer's needs and preferences for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs and preferences; coordinating the provision of services and supports by diverse public and private providers; analyzing and planning for the service needs of older adults and individuals with disabilities, and assessing individuals using the Uniform Assessment Instrument (UAI).
- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter-and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds, and conduct interviews.

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

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

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

- A current and complete job description which shall cover the scope of each position-holder's duties and responsibilities and which shall be updated as often as required, and
- A current description of the minimum entry-level standards of performance for each job.

Units of Service:

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

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

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

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

Organizational Structure:

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

Consumer Contributions/Program Income:

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

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

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation is non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is

at or above 185 percent of the poverty line, at contribution levels based on the actual cost of services.³

Quality Assurance:

Criminal Background Checks:

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

Staff Training:

- All new staff must receive an in-depth orientation on policies and procedures; client's rights; characteristics and resources of the community; and techniques for conducting the assessment, care planning, arranging services, and monitoring.
- Each staff person must participate in eight (8) hours of in-service training per year. Content should be based on the service coordinator's need for professional growth and upgrading of skills.

Caseload Size:

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

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

Supervision/Case Review:

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

Program Evaluation:

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

Anonymous client surveys of the service shall be done annually. At least 10% of the clients shall be surveyed. Surveys should be maintained in an agency file with a summary of the survey results.

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

Complaint and Appeals:

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

Client Bill of Rights:

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

Individual Support Records:

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

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

The Area Agency on Aging will maintain:

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

Senior Outreach to Services (S.O.S.)
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

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

Eligible Population

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

Service Delivery Elements

Program Components:

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

- **Resource File:**
S.O.S. service providers must maintain an accurate, up-to-date, and well-organized information system on the opportunities, services and resources available to seniors in the community, including detailed data on service providers.
- **Electronic Media:**
The use of electronic media to receive and solicit information via the internet is encouraged in the S.O.S. program.

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

Outreach:

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

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

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

Screening/Assessment:

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

- The S.O.S. referral form is to be completed in assessments conducted in the client's home and in community settings.
- Home visit and Area Agency on Aging assessments must utilize pages 1 and 4 of the Uniform Assessment Instrument (UAI) (Page 3 optional).
- Community and congregate setting assessments must utilize Page 1 of the UAI or the Quick Form. In the community setting, page 4 of the UAI is to be completed if warranted by the privacy of the setting.

Cost Sharing:

S.O.S. is not a cost sharing program.

Referral/Assistance:

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

- Advising older persons and their caregivers;
- Providing information to older persons to link them with the opportunities, services, and resources available to meet their needs;
- Assisting the person or caregiver to contact the appropriate community resources; and, if necessary,
- Advocating with agencies on behalf of older persons.

Evaluation:

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

- Contacting individuals to determine the outcome of the referral.

- Determining the quality and effectiveness of the referral and the service provided to the person referred.
- Additional assistance to the individual in locating or using needed services may be part of the follow-up.
- Administering, yearly, an anonymous client satisfaction survey to at least 10% of the clients served in the S.O.S. program.
- Aggregating and analyzing information collected through monthly reports and the yearly client satisfaction survey.

Administrative Elements

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

Staff Qualifications:

- Knowledge: Service coordinators should have a knowledge of: aging and/or the impact of disabilities and illness on aging; how to conduct interviews; consumers' rights; person-centered practices; local human and health service delivery systems, including support services and public benefits eligibility requirements; effective oral, written, and interpersonal communication principles and techniques.
- Skills: Service coordinators should have skills in negotiating with consumers and service providers; identifying and documenting a consumer's needs and preferences; identifying services within the established services system to meet the consumer's needs and preferences; and coordinating the provision of services and supports by diverse public and private providers.
- Ability: Service coordinators should have the ability to demonstrate a positive regard for consumers and their families; be persistent and remain objective; work as a team member, maintaining effective inter- and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, verbally and in writing; develop a rapport and to communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

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

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

Units of Service:

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

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

Program Monthly Reports

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

Criminal Background Checks:

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

Staff Training:

- Staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, techniques for conducting interviews, and procedures for conducting the allowable activities under this service.

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- Service coordinators should receive a minimum of 8 hours of in-service training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision/Case Review:

Consultation, supervision and case review shall be available to all staff providing the service.

Client Records:

Service providers must maintain specific program records that include:

- S.O.S. Referral Form
- UAI – pages 1 and 4 for home visits and area agency on aging assessments; Page 3 is optional. Page 4 of the UAI will be used to determine ADL deficiencies as warranted by the client’s condition and status.
- In community and congregate settings, the Quick Form may be used instead of Page 1 of the UAI. Page 4 is to be completed, if warranted by the privacy of the setting. For example, questions related to incontinence may be omitted.
- Consent to Exchange Information Form – signed by the client.

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