Area Agency on Aging
Service Standards

Provided by the:

Department for Aging and Rehabilitative Services (DARS)

Office for Aging Services (OAS)

8004 Franklin Farms Drive

Henrico, VA 23229-5019

DARS

VIRGINIA DEPARTMENT FOR AGING
AND REHABILITATIVE SERVICES

Table of Contents

Standard	Page
Adult Day Care	3
Care Coordination	8
Checking	16
Chore	20
Communication, Referral and Information and Assistance	26
Congregate Nutrition	32
Disease Prevention and Health Promotion	51
Elder Abuse Prevention	55
Emergency	57
Employment	62
Health Education & Screening	66
Home Delivered Nutrition	72
Homemaker	88
Identification Discount	94
Legal Assistance	97
Long-Term Care Coordinating Activities	104
Medication Management	106
Money Management	110
Options Counseling	116
Personal Care	126
Preparation and Administration of the Area Plan	133
Public Information and Education	136
Registered Dietitian Nutritionist Services	139
Residential Repair and Renovation	145
Senior Outreach to Services	149
Service Coordination Level One	154
Service Coordination Level Two	161
Gap Filling Services	168
Socialization and Recreation / Multipurpose Senior Center	172
Transportation	177
Volunteer	184

ADULT DAY CARE
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Adult Day Care is the provision of personal care and supportive services for dependent adults in a supervised, protective, congregate setting during some portion of a twenty-four hour day. Services offered in conjunction of adult day care typically include social and recreational activities, training, counseling, meals for adult day care and services such as rehabilitation, medications assistance and home health aide services for adult day health.[1] The service may be provided for a fee by family caregivers for respite.

Eligible Population

Adult Day Care programs are targeted to persons 60 years of age or older who are frail, have disabilities, or who are at risk of institutional placement. Priority shall be given to persons in the greatest economic or social need and/or living in rural or isolated areas, with particular attention to low-income minority individuals.[2]

Service Delivery Elements

The area agency or service provider must perform all of the following components of adult day care services:

Licensure:
Service providers of adult day care services must be licensed by the Virginia Department of Social Services and comply with the Virginia Department of Social Services' Standards and Regulations for Licensed Adult Day Care Centers.[3]

Service-Specific Assessment:
A service-specific assessment using the full Uniform Assessment Instrument (UAI) must be performed on each potential client that identifies:

- whether the person meets the criteria specified in Eligible Population;
- what the person's service-specific needs are;
- what level of priority for service delivery the person meets.

Further, admission and assessment responsibilities must be in accordance with licensure standards.[4]

Care Plan:
A written individualized care plan shall be developed, reviewed and revised with licensure standards and with involvement from the Participant or Authorized Representative or Family

[1] National Aging Program Information System Reporting Requirements – State Program Report Definitions
[2] Older Americans Act of 1965 as amended, Section 306(a)(4)(A)(i)
[3] Code of Virginia, Section 63.2-1733
[4] Standards and Regulations for Licensed Adult Day Care Centers, Department of Social Services, Commonwealth of Virginia, 22 VAC 40-60-560 through 564.

Member to the greatest extent possible.[5] When "participant" is used throughout the standards, it can also mean authorized representative or family member, as deemed appropriate by the agency and/or the participant. The plan should consider the need for coordination of care for each participant, and if care is needed, and, if the participant is a client of another agency, the care plan shall reflect the services provided by the other agency. The service provider will afford the participant the opportunity to participate in the implementation and evaluation of the plan.

Service Agreement:
A service agreement shall be completed between the participant and the service provider and distributed in accordance with licensure standards.[6] The agreement must also state that the participant has the opportunity to voluntarily contribute toward the cost of services paid for by Older American Act funds.[7]

An Area Agency is permitted to implement cost sharing for recipients of this service.[8]

The area agency or service provider must perform all activities in accordance with licensure standards, including but not limited to:

- Service Activities[9]
- Meal Provision[10]
- Service Records[11]
- Service Reassessments[12]

Administrative Elements

The area agency or service provider must perform all of the following components of adult day care services, including but not limited to:

- Participants Rights[13]
- Emergency Procedures[14]
- Discharge Plan[15]
- Fee for Service

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

[5] Ibid., 22 VAC 40-60-570
[6] Ibid., 22 VAC 40-60-580
[7] Older Americans Act of 1965 as amended, Section 315(b)
[8] Ibid., Section 315(a)
[9] 22 VAC 40-60-691 through 705, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[10] Ibid., 22 VAC 40-60-770 through 860
[11] Ibid., 22 VAC 40-60-150 through 190
[12] Ibid., 22 VAC 40-60-564
[13] Ibid., 22 VAC 40-60-692
[14] Ibid., 22 VAC 40-60-960 through 1020
[15] Ibid., 22 VAC 40-60-660 through 690

income.[16] There must be a written policy on handling Client Program Income (CPI) and other gratuities or donations.

- Cost Sharing/Fee for Service: An Area Agency is permitted to implement cost sharing/fee for service for this service using Title III funding.[17]

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided the method of solicitation is non-coercive.[18]

Staff Qualifications: Provider agencies must meet or exceed all personnel requirements as set forth by licensure standards.[19]

Job Description: For each paid and volunteer position an Area Agency Aging or service provider 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.

Quality Assurance

Staff Training:
Provider agencies shall meet or exceed all training and quality assurance requirements as set forth by licensure standards.[20]

Supervision:
Service providers shall regularly supervise their adult day care staff to ensure safe, effective, and appropriate care to each participant. The frequency and method of supervision is determined by agency policy. Supervision shall be documented regularly.[21]

Program Evaluation:
Area agency on aging must have a written evaluation plan for systematic, periodic, objective evaluation of the effectiveness of adult day care services. The plan shall be implemented and a written report of findings produced. The report is to be used as a basis for planning and implementing changes in program goals, procedures, and aid resource utilization. Service contractors must be monitored annually.

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[16] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[17] Older Americans Act of 1965, as amended, Section 315(a)
[18] Older Americans Act of 1965, as amended, Section 315(b)
[19] Ibid., 22 VAC 40-60-200 through 390
[20] Ibid., 22 VAC 40-60-280
[21] Ibid., 22 VAC 40-60-320 (3, 4)

Client Records:
Service providers are to maintain specific program and participant records that include:

- Full Uniform Assessment Instrument[22]
- Care plan[23]
- Service agreement[24]
- Service documentation [25]
- Service reassessment[26]
- Discharge plan[27]
- Appeals process[28]
- Emergency procedures[29]
- Program evaluation
- Consent to Exchange Information

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

- Hours (Spent in Day Care)
- 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 client level data transmitted to VDA by the last day of the following month.

[22] Ibid., 22 VAC 40-60-564
[23] Ibid., 22 VAC 40-60-570
[24] Ibid., 22 VAC 40-60-580
[25] Ibid., 22 VAC 40-60-590
[26] Ibid., 22 VAC 40-60-564
[27] Ibid., 22 VAC 40-60-680, 690
[28] Ibid., 22 VAC 40-60-680
[29] Ibid., 22 VAC 40-60-690 through 1020

Adult Day Care
FAQ's

1. **What determines eligibility for this program?**
   A service specific assessment will be done utilizing the Full Uniform Assessment Instrument. Other admission and assessment procedures will be done in accordance with the Department of Social Services Standards and Regulations for Licensed Adult Day Care Centers.

2. **Can a person receive personal care or home health and still attend day care?**
   Receiving one service does not preclude a client from receiving other services if needed. This, of course, depends on the availability of the service.

3. **Is Medicaid or Medicare accepted for day care programs?**
   This would depend on the client's eligibility for these programs and, if a certified provider is available offering this service.

4. **Can this service be used for my parent while I work?**
   Service may be provided for purchase of respite for family caregivers.

5. **Where can I find a copy of the Department of Social Services Standards and Regulations?**
   A copy is available on the VDA Web Site.

CARE COORDINATION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Care Coordination 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] Care Coordination is a distinct and comprehensive service. It entails investigating a person's needs and resources, linking the person to a full range of appropriate services, using all available funding sources and monitoring the care provided over an extended period of time.

Eligible Population

Care 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.[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 and shall be dependent in two (2) or more activities of daily living and significant unmet needs which result in substantive limitations in major life activities.

Unlike Medicaid elderly care coordination or Title III care coordination the state-funded Care Coordination for Elderly Virginians Program is not an entitlement program. Care coordination shall be available to the extent that state appropriations allow.

The care coordination team may decide to deny care coordination services if the team determines the client can be better served/more efficiently served in an institutional setting.

Service Delivery Elements

Care Coordination providers must perform all of the following:

Outreach:

Outreach is the proactive seeking of older persons who may be in need of care 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 coordination of care.

Intake/Screening:

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

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

likelihood of needing care coordination or another service 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.

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. (Cost sharing is prohibited in Title III Care Coordination.)

Care Planning:
The care plan is the link from the assessment to the delivery of services. Working with the person and the caregivers, the Care Coordinator develops a plan to address the problems and strengths identified in the assessment; the establishment of desired client-specific goals; the development of a complete list of services to achieve these goals, the responsibilities of the Care Coordinator, client, and informal and formal supports; and the 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 acceptance or denial into care coordination shall be mailed within five (5) working days of completion of the plan of care.

Arranging for Service Delivery:
Service delivery is the process through which the Care 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 care coordination agency.

Monitoring:
Monitoring is the maintenance of regular contact with the person, 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 change. Contact must be made monthly with the client for purposes of monitoring the implementation of the care plan.

Reassessment:
Reassessment is the formal review of the client's status to determine whether the person's 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 have changed, the care plan is adjusted. This review is done at least every six months 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). Reassessments must be completed at least every six months. 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 client. The change should be noted on the care plan and in the care coordination progress notes. The Care Coordinator should make two copies of the revised care plan, mailing one to the client and retaining the other in the client's file.

- 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:
Care Coordination services can be terminated at the discretion of the service provider. Written notification of termination of care coordination services shall be mailed to the client 10 business days in advance of the date the action is to become effective.

Administrative Elements

A qualified Care 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 Care Coordinator's job application form or supporting documentation, or observable in the job or promotion interview.

Staff Qualifications:

- Knowledge: Care Coordinators should have a knowledge of aging and/or the impact of disabilities and illness on aging; conducting client assessments (including psychosocial, health and functional factors) and their uses in care planning; interviewing techniques; consumers' rights; 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 file documentation, and service planning process and the major components of a service plan.

- Skills: Care Coordinators should have skills in negotiating with consumers and service providers; observing, filling and reporting behaviors; identifying and documenting a consumer's needs for resources, services and other assistance; identifying services within the established services system to meet the consumer's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of elderly and/or disabled persons, and assessing individuals using the Uniform Assessment Instrument (UAI).

- Ability: Care 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 interview.

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

Individuals meeting all the above qualifications shall be considered a qualified Care Coordinator; however, it is preferred that the Care 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 aged or disabled.

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 AIM 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 care coordination services, including travel time for Care Coordination for Elderly Virginians Program clients Assessment time is included in hours, if this process leads to care 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 client level data transmitted to VDA by the last day of the following month.

Organizational Structure:
Care Coordination Services are separate and discreet services of an area agency on aging. Care Coordinators must be organizationally separate from management of services provided by the agency and which the care 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 prohibited in Title III Care Coordination.[3]

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

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided that the method of solicitation in non-coercive.[4]

Quality Assurance:

Criminal Background Checks:

- VDA strongly recommends that the agency and its contractors protect their vulnerable older 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, service arrangement, and monitoring.

- Each staff person must participate in a ten (10) hour in-service training per year. Content should be based on the Care Coordinator's need for professional growth and upgrading of skills.

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

Caseload Size:
The ratio of clients to Care 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 Care Coordinator.

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

Program Evaluation:
The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service. Service providers shall be monitored annually.

Complaint and Appeals:
Care Coordination agencies shall have in place a written Complaint Procedures and Appeals Procedures.

Client Bill of Rights:
Care Coordination agencies shall make a bill of rights available to all clients. This is a statement of the rights of the person receiving care coordination services and includes basic tenets that should be followed in providing the service. Clients should receive copies of the bill of rights on commencement of care coordination and, sign and date a copy to be kept in the client's file.

Client Records:
Records must be maintained for all recipients of services. Care Coordination for Elderly Virginians Program (CCEVP) participants must use forms recommended in the CCEVP Policies and Procedures Manual. Such records must contain the following:

- Intake instrument(s)
- Full Uniform Assessment Instrument
- Determine Your Nutritional Health Nutritional Checklist
- Federal Poverty documentation and Fee for Service calculations must be part of the client record. Federal Poverty/VDA Sliding Fee Scale form may be used. (Cost Sharing is prohibited in Title III Care Coordination.)
- Original Care Plan
- Monthly Progress Notes
- Case Coordination Fee Form
- Purchase of Gap-Filling Services Form

- Acceptance/Denial Notice
- Care Coordination Outcome Report
- Client Bill of Rights
- Consent to Exchange Information Form

Care Coordination
FAQs

1. **What care coordination programs operate in Virginia?**
   Area Agencies on Aging offer both Title III Care Coordination and the Care Coordination for Elderly Virginians Program sponsored by the Commonwealth of Virginia. Some agencies offer both programs. Consult the web page to see where these programs are located.

2. **What is the Care Coordination for Elderly Virginians Program?**
   The Care Coordination for Elderly Virginians Program began as a pilot program in 1991 to effectively link elderly Virginians to appropriate long-term care services. Currently, 18 area agencies on aging participate in this program, enabling many elderly Virginians to maintain their independence instead of being institutionalized.

3. **What is the job of the care coordinator?**
   The care coordinator seeks older persons who may need services in order to continue independent living. He/she evaluates a person's need for services by using a full Uniform Assessment Instrument. If the client is dependent in two or more activities of daily living and has need of multiple services to maintain self-sufficiency in the community, the care coordinator will arrange and monitor services for the client.

4. **How are hours determined for care coordination as reported in AIM and the AMR?**
   Hours are determined per client and include all hours relating to care coordination including travel time for clients. (Assessment time is included if this process leads to care coordination.)

5. **Where can one find the correct forms for the files of the Care Coordination for Elderly Virginians Program clients?**
   These forms can be located in the Care Coordination for Elderly Virginians Policies and Procedures Manual located on the VDA website.

CHECKING
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Checking is the service of contacting older persons at their residence to make sure that they are well and safe. This activity may also serve to provide psychological reassurance to an older person who is alone and in need of personal contact from another individual.

Eligible Population

Checking services are targeted to persons 60 years of age or older who are frail, have disabilities, or who are at risk of institutional placement. Priority shall be given to older persons who are in the greatest social and economic need and/or are residing in rural or geographically isolated areas, with particular attention to low-income minority individuals.[1]

Service Delivery Elements

Service Specific Assessment**:**

A service specific assessment using Virginia Service-Quick Form must be performed on each potential client to determine:

- Whether the person meets the criteria specified in eligible population;
- What the person's service specific needs are;
- What level of priority for service delivery the person meets
- 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.

Agencies providing Checking Services must perform the following:
Telephone or visit an older person in order to provide comfort or help. May include "Lifeline" or other automated checking/reassurance services.

Administrative Elements

Staff Qualifications**:**

- Knowledge: staff shall have an awareness of the biological, psychological, and social aspects of aging; community resources and public benefits eligibility requirements.
- Skills: staff should have skills in establishing and sustaining interpersonal relationships and problem solving.
- Ability: staff should have ability to communicate with persons with different socio-economic backgrounds and to work independently.

[1] Older Americans Act of 1965 as amended, Section 306(a)(5)(A)(i)

Job Description:
For each paid and volunteer position funded by Title III of the Older Americans Act, 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
- Current description of the minimum entry-level standard of performance for each job.

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

- Contacts (Telephone calls or visits to clients)
- 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 client level data transmitted by the last day of the following month.

Consumer Contributions/Program Income:
There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.

- Cost Sharing/Fee for Service: An Area Agency is permitted to implement cost sharing/fee for service for recipients of this service.[2]

And/Or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service provided the method of solicitation is non-coercive.[3]

Quality Assurance

Criminal Background Checks:

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

[2] Ibid., Section 315(a)
[3] Ibid., Section 315(b)

Staff Training:

- (**Initial**) In-depth orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- (**Ongoing**) At least annual in-service training, the content of which to be based on the need for professional growth and upgrading of knowledge, skills, and abilities.

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

Program Evaluation:
The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service. Service providers shall be monitored annually.

Client Records:

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- Federal Poverty Documentation and Fee for Service calculation must be part of the client record. Federal Poverty/VDA Sliding Fee Scale form may be used.
- Service Documentation

Checking
FAQ's

1. **Does the checking service standard require that a client be visited in his home?**
   No, a client may be telephoned or participate in an automated checking/reassurance service.

CHORE
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES (DARS) SERVICE STANDARD

Definition
Chore services provide assistance to persons having difficulty with one or more of the following instrumental activities of daily living: heavy house work, yard work or sidewalk maintenance.[1]

Eligible Population
Chore services are targeted to persons 60 years of age or older who are frail, have disabilities, or who live in isolated areas, with particular attention to low-income minority individuals and individuals with limited English proficiency.[2]

Service Delivery Elements
The Area Agency on Aging must perform all of the following components of chore services:

Service Specific Assessment:
A service specific assessment using the Part A of the Uniform Assessment Instrument shall be performed on each potential client to determine:

- The person meets the criteria specified in eligible population
- The person's needs for supports/services
- The level of priority for service delivery the person meets
- The person's Federal Poverty Level. The Federal Poverty/VDA form may be used for documentation.
- Any fee for service charge determined by the applicable sliding fee scale

Service Plan:
A written individualized service plan shall be developed which identifies the supports/services to be provided to the client in response to established need. The plan is to be developed prior to service commencement by the Area Agency on Aging with involvement from the client or authorized representative or family member to the greatest extent possible. When "client" is used throughout this service standard, it can also mean authorized representative or family member, as deemed appropriate by the Area Agency on Aging and/or the client. The client will be ensured the opportunity by the Area Agency on Aging to participate in the implementation and evaluation of the service plan. The plan may be modified to reflect any change in the client's needs. Each plan shall include:

- Identified service needs
- Services to be delivered by the service provider and/or by other sources
- Goal(s) and objective(s) of support(s)/service(s)
- Service units to be provided

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

Service Agreement:
A service agreement will be completed between the Area Agency on Aging and the service provider with input from the client. If the Area Agency on Aging is the service provider, it will produce the service agreement. The client will receive a copy of the agreement. The agreement will include:

- Services to be provided
- Scheduled hours/days of service
- Information regarding voluntary contributions/payment for service
- Emergency contacts
- Severe weather policy

Service Activities:
Service activities provided by the service provider agency may include:

- Window – washing
- Floor cleaning (scrubbing and polishing)
- Yard Maintenance
- Painting – limited
- Chopping and stacking wood
- Carrying coal, wood and water
- Removal of ice and snow
- Minor repair work performed in the home on furniture and appliances
- Minor repair work performed on the home (e.g. light carpentry work, hinge work, door knob repair, replace broken glass, etc.)
- Heavy cleaning

Service Record:
The client will sign a service record when the service is provided. Service records will be maintained at the Area Agency on Aging.

Service Reassessment:
A review of the client's need for services, the amount of services provided and the appropriateness of the care plan will be performed by the Area Agency on Aging when the client's condition/situation changes, but at least annually.

- Federal Poverty Level will 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 Termination Policy:
The Area Agency on Aging must have a service termination policy that includes:

- A service summary
- Appropriate referrals to other community agencies, if needed
- Follow-up services for the client, as appropriate

Chore services can be terminated at the discretion of the service provider, the Area Agency on Aging or the client. The Area Agency on Aging must mail notification of termination of chore services to the client 10 business days in advance of the date the action is to become effective if the service is ended by the service provider or the Area Agency on Aging.

Administrative Elements

Area Agency on Aging Staff Qualifications:

- Knowledge: Area Agency on Aging staff shall have an awareness of the biological, psychological, and social aspects of aging; an awareness of the impact of disability and illness on aging; a general knowledge of minor home repair tasks and major household cleaning tasks; a knowledge of tools and equipment used in minor home repairs and heavy duty cleaning; and an awareness of community resources and consumer rights.
- Skills: Area Agency on Aging staff shall have skills that enable them to establish and sustain personal relationships, work with service providers and solve problems.
- Abilities: Area Agency on Aging staff shall be able to communicate effectively with persons of different socioeconomic backgrounds; to work independently and in groups, and to supervise contractors if necessary.

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

- A current and complete job description of the scope of each employee's or volunteer's duties and responsibilities. This description is updated as often as required.
- A current description of the minimum entry-level standards of performance for each job.

Service Provider Staff Qualifications:

- Knowledge: Service providers should have an awareness of, or sensitivity to the needs of older persons and individuals with disabilities. They will have the knowledge to ascertain the skills and equipment needed to perform the required chores to meet the specialized needs of older persons or individuals with disabilities.
- Skills: Service providers must be able to perform minor home repairs and heavy duty household cleaning as needed by the client. Home repairs may require licensed contractors and the Area Agency on Aging may require a copy of the contractor's license and proof of liability for their files. Volunteers should be supervised by individual(s) with skills in repairing or modifying the homes of older adults.
  -Licensure of private contractors is **required** for any service above $1,200.00
- Abilities: Service providers should be able to perform service activities as demonstrated through references from prior similar work experiences.

Units of Service:
Units of service must be reported in the approved DARS electronic data system for each

client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours spent assessing the need for; and, arranging and delivering chore services)
- Persons served (Unduplicated)

Program Reports:

- Aging Monthly Report (AMR) to DARS by the twelfth (12th) of the following month. This report must be updated and submitted even if no expenditure or units of service occurred.
- AIM or PeerPlace client level data transmitted to DARS by the last day of the following month.
- A completed and properly maintained Part A electronic/digital Uniform Assessment Instrument (UAI) is a mandatory requirement.
- The question "Client in Federal Poverty?" (Answer yes or no) must be asked and recorded.
- A written Policies and Procedures Manual must be maintained for the service.

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. There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.

Cost-Sharing/Fee for Service:
An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.

Voluntary Contributions:
Voluntary contributions shall be allowed and may be solicited 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 Federal Poverty line, at contribution levels based on the actual cost of service.[3]

Quality Assurance

Criminal Background Checks:
The Virginia Department for the Aging strongly recommends that the agency and its contractors protect their vulnerable older citizens by conducting criminal background checks for staff providing any service where they
go to or into a client's home.

Area Agency on Aging Staff Training:

[3] Older Americans Act as Amended 2006. Section 315(b)

- Initial – An in-depth orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting the allowable activities under this service
- Ongoing – A minimum of ten (10) hours per year of in-service training, the content of which is 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. The Case Monitor Section for this service must be completed in the approved DARS electronic data system.

Program Evaluation:
The Area Agency on Aging shall conduct regular and systematic analysis of the persons served and the impact of the service.

- Service providers must be monitored annually. A written copy of the monitoring report will be kept at the Area Agency on Aging.
- Anonymous client surveys must be conducted annually. A file of these surveys with a summary of the survey results will be maintained by the agency.

Client Records:
Area Agencies on Aging must maintain specific program records in the approved DARS electronic data system:

- Part A of the Uniform Assessment Instrument
- Federal Poverty Level
- Service Plan
- Service Reassessment, as needed
- Progress Notes
- Consent to Exchange Information Form
- Caregiver Form, if this service is funded by OAA Title III E

The Area Agency on Aging will also maintain the following additional client records:

- Service documentation, including any fee charged the client
- Signed Client Bill of Rights/Appeals Process
- Denial or Termination of Service Notice

Chore
FAQ's

1. **How does the chore service differ from the homemaker service?**
   Chore service is the performing of heavy-duty household tasks such as window washing or floor cleaning. Homemaker service offers the performance of basic household tasks such as dusting, sweeping, laundry or shopping.

COMMUNICATION, REFERRAL AND INFORMATION AND ASSISTANCE
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definitions

Communication—The process of offering general information to a client, caregiver, professional or other individual. [Ex. A caller asks for the number of the local DSS and the intake coordinator provides the number.]

Referral—The process of informing a client, caregiver, professional or other individual about appropriate choices and linking them with external entities providing opportunities, services, supports and/or resources to meet their needs. A referral does not involve direct services provided by the referring agency (AAA). [Ex. A caller inquires about how to apply for financial assistance. After asking several questions, the intake coordinator determines that the individual may be eligible for Medicaid and refers the caller to the local DSS office.]

Information and Assistance—The process of assessing a client or caregiver and transferring them to a service provided directly by the agency (AAA) or through a subcontractor and paid by the agency, or directly assisting them with obtaining needed services, supports and/or resources and, if necessary, advocating with entities on their behalf. [Ex. A caller inquires about financial assistance. The intake coordinator determines that the individual may be eligible for Medicaid, but is homebound and needs assistance with the application. The caller is assigned a care coordinator who will do a home visit to assess the individual, assist with the Medicaid application process, and determine if there are other services, such as home delivered meals, that could be beneficial.]

Follow-Up—A process of contacting individuals and the organizations to which they were referred 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 a part of the follow-up.

Planning and Evaluation—The process of aggregating and analyzing information collected through the provision of the service; collecting and reporting data on unmet needs for other services; and evaluating the overall effectiveness of the Communication, Referral, and Information and Assistance service.

Eligible Population

Communication and **Referral** services are targeted to persons who are 60 years of age or older, persons with disabilities aged 18 and over, and their families and caregivers.

Individuals are eligible for **Information and Assistance** services if they are 60 years of age or older. Priority shall be given to older individuals who are in the greatest economic and social need, and older individuals at risk for institutional placement, with preference given to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.[1] Families and caregivers of older adults may also receive information and assistance for needed services.

[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

Service Delivery Elements

If an agency provides **Communication**, no further action is required. The agency may opt to document communications in PeerPlace or some other format.

Agencies providing **Referral** services are required to complete the Virginia Service – Quick Form.

Agencies providing **Information and Assistance** services must perform all of the following components:
Assessment: The process of identifying, analyzing, and prioritizing the needs of older persons, utilizing the required minimum assessment tool for the service to which the individual is being transferred, and any other client assessment documents as determined by the AAA. (Refer to the Information Systems Service Guide or applicable service standard.) Federal Poverty/VDA Sliding Fee Scale is required, unless all information needed to determine federal poverty is documented on the UAI (self-declaration only; no income verification is required).

See "Client Records" for the required documentation.

Administrative Elements

Staff Qualifications:

- Knowledge: Communication, Referral and Information and Assistance service staff should have an awareness of the biological, psychological, and social aspects of aging and caregiving; the impact of disabilities and illnesses on individuals; interviewing principles; community resources; and public benefits eligibility requirements.
- Skills: Communication, Referral, and Information and Assistance service staff should have skills in establishing and sustaining interpersonal relationships; problem-solving; advocacy; and use of computer office software.
- Ability: Communication, Referral, and Information and Assistance service staff should have the ability to: communicate with persons of different socio-economic backgrounds; conduct an effective interview; complete an assessment; arrange and negotiate service referrals; and work independently.

Job Descriptions: For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of duties and responsibilities of Communication, Referral, and Information and Assistance service staff; and
- A current description of the minimum entry-level standards of performance for each job.[2]

Agency Data Requirements

Referral and **Information and Assistance** services will collect data to support community needs assessment and community planning activities.

[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

AIM System Agency Data Requirements for Recording Referrals and Information and Assistance

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

- Contacts: count the number of interactions with the client and with agencies, caregivers, professionals and others related to establishing services, and when a Quick Form or Part A of the UAI is completed.
- Persons served (unduplicated): the individual who is receiving a direct service(s).

Optional Units (Not Entered into AIM but may be reported on AMR for AAA use)

- Number of **communication** calls **(i.e., tick marks or call log)**

Program Reports:

- Aging Monthly Report (AMR) is due 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 client level data must be transmitted to VDA by the last day of the following month.

NWD Tools / PeerPlace System Agency Data Requirements for Recording Referrals and Information and Assistance

Note: Each field described below must be asked of an individual for Referral and Information and Assistance services in order to properly coordinate their services and to meet NAPIS and other federal reporting requirements. These fields include all data elements from the Virginia Service – Quick Form, as well as some additional fields now needed to coordinate services across agencies.

*Virginia Service – Quick Form data elements have been noted by an asterisk.

Date: date service need established.

First Name:*

Last Name:*

Street Address: where individual resides*

City: where individual resides*

State: where individual resides*

Zip: where individual resides*

Phone Number: include area code*

Required Fields for ADRC Reporting:

DOB: Individual needing service.*

Contact Type: Received request for service information from

- Consumer/Individual
- Caregiver/Supporter
- Professional
- Other

Service Type: Service Requested.

Disability Type: Record disability category of the individual needing service as either:

- Physical
- MR/DD/ID
- Mental Illness
- Dementia Disorders (includes Alzheimer's Disease)
- Traumatic Brain Injury
- Sensory Disabilities
- Multiple Disabilities
- Unspecified
- No Disability

Federal Poverty: Answered as 'Yes', 'No', or 'Refused to Answer'*

Federal Poverty/VDA Sliding Fee Scale Level A through G*

Assistance Type: Individual needing service was provided:

- Options Counseling
  - Benefits Counseling (as part of options counseling)
  - Long Term Care Futures Planning (as part of options counseling)

Race:*

- American Indian/Alaskan Native
- Asian
- Black / African American
- Native Hawaiian or Other Pacific Islander
- Other
- White
- 2 or More Races
- Refused to Answer

Ethnicity*

- Hispanic
- Non Hispanic
- Refused to Answer

Does the Individual Requesting Service Live Alone: 'Yes' or 'No'*

Gender:*
- Male
- Female

Veteran: 'Yes' or 'No'

FIPS Code:* (often referred to as county code) refers to Federal Information Processing Standards codes of jurisdiction of where the individual resides.

Referral Data Elements for the NWD Tools Application

Referral agency type: category or type of agency, including but not limited to:
- CIL
- CSB
- DRS
- DSS

Units of Service: Units of service must be reported in PeerPlace for each client receiving services.
- Contacts: count the number of interactions with the client and with agencies, caregivers, professionals and others related to establishing services, and when the required fields in the IA record are completed.
- Persons served (unduplicated): the individual who is establishing the need for service(s).

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.[3]

- Cost Sharing/Fee for Service: An Area Agency on Aging is **not** permitted to implement cost sharing/fee for service for recipients of communication, referral or information and assistance services.[4]
- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[5]

Quality Assurance

Staff Training:
- Staff should receive orientation on agency policies and procedures, computer database (PeerPlace or AIM), client rights, client confidentiality, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Staff should receive a minimum of eight (8) hours of in-service training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[4] Older Americans Act of 1965, as amended, Section 315(a)

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

Follow-up: Follow-up is required in 10% of the referrals. Individuals and the organizations to which they were referred should be contacted to determine the quality and effectiveness of the referral and the service provided to the individual referred.

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

Program Evaluation: The agency should conduct regular (at least annual) systematic analysis of the persons served and the impact of the service.

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

- For **referral** purposes only, the Virginia Service - Quick Form is required.
- For **information and assistance**, the required minimum assessment tool for the service to which the individual is being transferred must be completed for clients requiring direct services. (Refer to the Information Systems Service Guide or applicable service standard.)
- Federal Poverty should be determined and documented. The Federal Poverty/VDA Sliding Fee Scale form should be used. (Self-declaration only; no income verification is required.)
- Progress notes or contact logs to document case activity.

CONGREGATE NUTRITION SERVICES (Title III – C1)
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES-VIRGINIA
DIVISION FOR THE AGING
SERVICE STANDARD

Definition[1]

Provision, to an eligible client or other eligible participant at a nutrition site, senior center, or some other congregate setting, a meal which:

- Complies with the most recent edition of the Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture,
- Provides a minimum of 33 1/3 percent of the dietary reference intakes (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if one meal is provided per day,
- Provides a minimum of 66 2/3 percent of the DRI if two meals are provided per day,
- Provides 100 percent of the DRI if three meals are provided per day,
- To the maximum extent practicable, are adjusted to meet any special dietary needs of program participants,
- Complies with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual.

The congregate nutrition site provides opportunities for socialization and recreation that may alleviate isolation and loneliness.

Eligible Population

Congregate Nutrition Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low-income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.[2] In addition to meeting established eligibility, individuals must be mobile, not homebound, and physically, mentally, and medically able to attend a congregate meals program in accordance with written Area Agency on Aging (AAA) guidelines.

The AAA shall establish procedures for offering a meal on the same basis as meals are provided to participating older individuals, to other eligible individuals including the following[3]

- The recipient's spouse, regardless of age or disability
- Individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided
- At the discretion of the AAA, individuals with disabilities, regardless of age, who reside at home with and accompany older eligible individuals to the congregate site

[1] Older Americans Act of 1965, as amended, Section 339 (2) (A)
[2] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)
[3] Older Americans Act of 1965, as amended, Section 339 (2) (H&I)

- At the discretion of the AAA, individuals, regardless of age, providing volunteer services during the meal hours

There is no prohibition against providing services to persons under age 60 with funds from other sources.[4]

Service Delivery Elements

The Area Agency on Aging or service provider must perform all of the following components of the congregate nutrition services:

Program Requirements

Each nutrition services provider must provide at least one hot or other appropriate meal in a congregate setting each day the site is in operation. Additional meals meeting the requirements specified above under "Definitions" may be provided to each participant for days the site is not open.

AAAs must have at least one site operating each of 5 days a week, Monday through Friday, except in a rural area where such frequency is not feasible and a lesser frequency is approved by DARS-VDA.

AAAs that do not have at least one meal site available somewhere within the PSA each day of the week (Monday through Friday, holidays and emergencies excepted) must submit to DARS-VDA for review and approval a plan documenting their rationale and detailing their policies and procedures to address the following issues:

- Documentation of the factors that make it unfeasible to provide meals in at least one congregate meal site each day of the week Monday through Friday.
- On the day(s) that there is no congregate meal site available within the PSA, describe provisions for congregate meal participants to receive meals at other facilities operated by the AAA or service provider such as an adult day health center, assisted living or nursing facility.

The Older Americans Act (OAA) requires that AAAs and nutrition service providers solicit the advice and expertise of (1) a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutrition services, (2) meal participants, and (3) other individuals knowledgeable about the needs of older individuals.[5]

DARS-VDA recommends that AAAs and nutrition service providers hire or contract with a registered dietitian (RD). Please see Guidance on Soliciting the Expertise of the RD.

Program participants and other individuals may be encouraged to actively participate in program planning and volunteer to perform tasks at the meal site to their ability and desire.

[4] Older Americans Act of 1965, as amended
[5] Older Americans Act of 1965, as amended, Section 339 (2) (G)

Nutrition services providers shall design meals that are appealing to program participants and shall enter into contracts that limit the amount of time meals must spend in transit before they are consumed.[6]

Additional Meals

Definition: Meals sent home from the congregate meal site to be eaten at home when the meal site is not open, up to 5 days a week.

If an AAA wishes to provide additional take home meals to congregate nutrition participants, the agency shall develop an Additional Congregate Meal Policy that shall be approved by the agency's governing board.

Requirements for additional meals:

1. The additional meals shall be provided at each visit for the client to carry home herself or himself. The meals shall not be delivered in bulk for the week or month. Clients not attending the site will not receive meals. The additional meals policy must state the maximum number of meals each client should receive, based on the days the congregate meal site is open. The policy should also take into account when the site is closed, such as for holidays, other functions, or repairs.
2. The additional meals policy shall state clients taking meals home must provide a signature indicating the number of meals received. Operationally, the client may indicate next to his or her signature on the sign-in sheet, the number of meals taken home. The signature form shall be included with the site's monthly reporting process for documentation of meals provided for entry into the DARS-VDA approved client database.
3. All additional meals counted as eligible meal units shall meet nutrient content guidance as outlined in the DARS-VDA menu planning guidelines.

AAAs may consider partnering with local agencies such as food banks, food pantries, and other food assistance organizations which may provide or donate food for senior participants' use at home. The food would not be counted as eligible service units, but nonetheless may significantly help senior participants. AAA's may also consider facilitating SNAP or other food assistance enrollment for eligible congregate nutrition participants.

Emergency Meals

Definition: There are two situations when emergency meals may be provided.

Anticipatory – Meals sent home from the congregate meal site at the beginning of the winter and/or summer storm season, in anticipation of inclement weather. Participants are instructed to store the meals until needed in case of congregate meal site closure for inclement weather or other emergencies.

Actual emergency meals – Meals sent in response to an actual weather or emergency event which necessitates closure of the congregate meal site for more than one week.

Requirements:

1. No more than 5 meals may be provided at one time in anticipation of seasonal weather emergencies. If known emergency events and site closures have caused participants to eat their emergency meals, subsequent replacements may be provided in 5 meal allotments.

[6] Older Americans Act of 1965, as amended, Section 339 (2) (B&C)

2. In the event of an actual weather or other emergency, the number of meals provided shall be based on the amount of time the congregate site is closed. Up to 10 meals may be provided at one time, if the congregate meal site will be closed for more than one week.
3. Documentation shall show the number of meals and client names receiving emergency meals. Signatures are preferred, but at a minimum, the client name and number of eligible meals per client shall be reported for entry in the DARS-VDA approved client database.
4. In order to be counted as eligible meals, the emergency meals shall meet nutrient content guidance as outlined in the DARS-VDA menu planning guidelines.

Breakfast Meals

Please see the DARS-VDA Menu Planning Guidelines.

Assessment

- A service-specific assessment using the Virginia Service Quick Form and the Determine Your Nutritional Health screening checklist shall be performed on each potential client or other eligible individual (not a volunteer). Client assessment data shall be documented in the DARS-VDA-approved electronic client database.
- The AAA may develop and use a form (in place of the Virginia Service Quick Form) to be completed by the senior, when appropriate, as long as all information is collected and documented in the DARS-VDA-approved electronic client database.
- Federal Poverty should be determined and documented. The answer to the question "Is the Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database. The Federal Poverty/DARS-VDA form may be used.
- Cost sharing does not apply to this service.
- For an individual of any age, who provides volunteer services during the meal hours (not a site participant) and receives a congregate meal, an assessment is not required. However, a Virginia Service Quick Form shall be requested. At a minimum, the full legal name and service units (collected at least on a monthly basis) must be entered into the DARS-VDA-approved client database. If there is continual service, an update to the volunteer's Virginia Service Quick Form must be requested at least annually. The updated volunteer data must be recorded in the DARS-VDA-approved client electronic database.
- Emergency contact information.

Nutrition Screening

The "Determine Your Nutritional Health" Nutrition Screening checklist developed and distributed by the Nutrition Screening Initiative must be completed during assessment. The AAA or service provider will develop a written plan specifying how the agency will use the screening results.

At a minimum, the screening results may be used in the following ways:

- Referral to appropriate services such as (1) dental professionals for those with tooth or mouth problems, (2) the food stamp program, food bank, or other social programs if they indicate they don't have enough money to buy food, (3) their doctor or a dietitian if they have a chronic condition requiring a special diet, for example.

- Planning nutrition education programs. For example, educating participants how to increase fruit and vegetable intake or to shop for and prepare nutritious meals, depending on what the screening form shows.
- As a criterion in prioritizing client needs for nutrition service especially when program funding is limited.

Care Plan

The Care Plan is optional and may be completed by another department within the Area Agency on Aging. If used, the Care Plan may include nutritional and social needs that can be met through congregate nutrition services. Before the service is delivered, a written individualized care plan may be developed that identifies the service components to be provided to meet the client's assessed need. The plan should be developed with involvement from the client. "Client" may include the individual's authorized representative or family member. The client should be given the opportunity to provide input for the implementation and evaluation of the plan. The plan may be modified to reflect any change in the client's needs. Each plan may include:

- Identified service needs
- Services to be delivered by the service provider or other sources
- Goals and objectives of service to be provided
- Quantity of service units to be provided

Service Confirmation

A service confirmation, which may be in the form of a letter, packet, or handbook shall be provided to the client to explain the service arrangement. The client shall receive a copy that includes:

- Service to be provided
- Scheduled days of service
- Information regarding voluntary contributions
- Description of procedures to be followed if a participant becomes ill or injured
- Service interruption due to severe/inclement weather or other conditions
- Explanation of the Service Termination Policy
- Other policies deemed informative and appropriate by the service provider

If service is denied or the client is placed on a waiting list, written notice shall be provided to the client within 10 business days of the denial decision or placement on the waiting list. The agency's process on filing an appeal shall be provided with the denial.

Service Termination Policy

Service will be terminated at the discretion of the provider. Written notification of service termination shall be mailed 10 business days prior to the date the action is to become effective. The agency's process on filing an appeal shall be provided with the termination notice.

Reassessment

- A review of the participant's need for services, the amount of services provided and the appropriateness of the care plan (if completed) shall be performed when the participant's condition or situation changes, but at least annually.
- The Virginia Service Quick Form, and "Determine Your Nutritional Health" Nutrition

Screening shall be updated at the same time. Client reassessment data shall be documented in the DARS-VDA-approved electronic client database.

- Federal Poverty should be determined and documented. The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database. The Federal Poverty/DARS-VDA form may be used.
- Cost sharing does not apply to this service.
- Update of emergency contact information.

Site Location

Congregate nutrition sites shall be as close as possible to the majority of eligible older individuals' residences. Where feasible, sites shall be located that encourage joint arrangements with schools and other facilities serving meals to children in order to promote intergenerational meal programs.[7]

The AAA or provider shall develop written agreements with each agency or organization where a congregate nutrition site is located. The agreement shall include responsibilities and obligations of each party including, but not limited to:

- Sanitation of restrooms and common areas; cleaning, care and maintenance of facility and grounds; pest control; snow removal; obtaining Health Department Permits; fire inspection; insurance coverage of items owned by the congregate program; liability insurance; compliance with all applicable federal, state and local laws
- Staffing interrelationships and roles, including responsibility and authority
- Cost or payments to be incurred by either party
- Days and hours the congregate site~~s~~ will operate in the facility
- Provision for termination of the agreement by either party

Physical Facilities, Accessibility and Equipment

Each nutrition site shall meet minimum requirements related to the physical facility and equipment, including, but not limited to:

- Meet Americans with Disabilities Act requirements, and if necessary, have a written plan to accommodate seniors with disabilities
- Access to a kitchen or approved work area, for the set-up and dispensing of meals. This includes all equipment necessary to maintain proper food temperatures. If used for the nutrition program, there shall be operating thermometers in the refrigerator and freezer. Approval of the area by the local health department may be requested, but is not required, for sites where food is served but not prepared.
- Separate sinks for hand washing and food service
- Equipment, including tables and chairs for meals and other programs, which are sturdy and appropriate for older persons. The site shall have adequate space to accommodate persons with canes, walkers, wheelchairs, and other assistive devices.
- Door exit signs
- Occupancy limit signs, if required by locality

[7] Older Americans Act of 1965, as amended, Section 339 (2) (E)

- Telephone accessible to staff
- Fire extinguisher(s) in good working order
- Readily accessible first aid kit

Nutrition Education, Nutrition Counseling, and other Nutrition Services

AAAs and nutrition service providers will provide nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of meal participants.[8] The nutrition services and programs offered by AAAs will be described in the Area Plan and comply with the following definitions:

Nutrition Education (1 session per participant) -- A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise.[9]

Information for nutrition education will be obtained from a reputable source or provided by a registered dietitian or other qualified individual. The participant shall be provided with information on a continuing basis, but at least quarterly. Scheduled programs shall be documented as having taken place including dates, tracking of participant attendance for the DARS-VDA-approved client database, and the source and/or presenter of the information.

Food Safety: At least once a year, Nutrition Education on food safety, such as food handling, reheating, and storage, shall be provided and may include a review of how meals are safely handled at the meal site as well as information for home food safety practices.

Nutrition Counseling (1 session per participant) -- Provision of individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-to-one by a registered dietitian, and addresses the options and methods for improving nutrition status.[10]

Disease Prevention and Health Promotion: When the Administration for Community Living (ACL) mandates that Title III-D funds shall only be used for highest tier evidence-based programs, AAAs shall be expected to comply. See DP/HP Service Standard for current requirements and definitions.

Lower tier activities may be offered in the congregate nutrition site through the use of community volunteers and in-kind contributions of local health organizations, as long as no Title III-D funding is used to support them, when highest tier evidence-based activities are mandated by the ACL. Lower tiered activities might be, for example, nutrition education provided in-kind

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[8] Older Americans Act of 1965, as amended, Section 331(3).

[9] Administration on Aging, Title III and Title VII, State Program Report Data Elements at http://www.agid.acl.gov/Resources/DataSources/DataFiles/StateProgramReportForm053110.pdf , page 23, accessed on July 28, 2014.

[10] Administration on Aging, Title III and Title VII, State Program Report Data Elements at http://www.agid.acl.gov/Resources/DataSources/DataFiles/StateProgramReportForm053110.pdf , page 23, accessed on July 28, 2014.

by Cooperative Extension program assistants, or health screenings provided by volunteer nurses, physicians, and other credentialed and trained health professionals. DP/HP information may be provided to the participant on a continuing basis, but at least monthly. Scheduled programs shall be documented as having taken place including dates, tracking of participant attendance, and the source and/or presenter of the information.

Physical Activity and Exercise

Voluntary participant-appropriate physical activities may be offered on a continuing basis, with the goal of at least weekly. Daily participant-appropriate physical activity will be provided as feasible and may include yoga, exercise, and tai chi classes taught by volunteer instructors. Participants will be advised to discuss participation in the physical activity program with their physician or health care professional. If Title III-D funding is used to support such activities as yoga, exercise, tai chi, etc. these must be structured highest criteria programs, when highest tier evidence-based activities are mandated by ACL that have undergone research study and have been published in peer-reviewed literature.

Community Services and Public Benefits

Congregate Nutrition Services shall provide a link to other available community services such as health screening, counseling, consumer education, senior employment, preventive health services, food stamps and other public benefits, etc.

Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program

The AAA or service provider must assist clients in taking advantage of benefits available under the SNAP EBT (Electronic Benefit Transfer) Card and may do so by assisting clients to apply for and use benefits. The AAA or service provider may, but is not required to, accept food stamps from eligible clients as their meal contribution. The AAA or service provider may encourage the seniors to use the food stamps to purchase nutritious food to consume at home. AAAs or service providers that wish to accept food stamps must apply for authorization through their local USDA-FNS field office and assure that all federal, state, and local agency provisions relating to their use and handling are met.

Emergency Situations

The AAA or service provider shall have written procedures to follow in the event of weather-related emergencies or other situations that may interrupt service or the transportation of participants or supplies to the nutrition site.

A written plan that describes procedures to be followed if a participant becomes ill or injured, shall be explained to staff, volunteers, and participants and shall be visibly posted (or otherwise readily available) at each congregate site. “911” posted near a telephone, along with the center’s address, is recommended. Site staff shall keep emergency contact information on hand for each participant. Emergency contact information shall be kept up-to-date.

Fire Safety

Fire drills shall be conducted at least quarterly, in accordance with local fire marshal recommendations; documentation is required. During the fire drill, fire exit routes shall be designated and reviewed. Staff shall be knowledgeable about the location and operation of all

fire extinguishers at the site.

Removal of Food Items
The AAA or service provider shall establish and post a policy about food items that participants may, or may not, take home. The sign and printing shall be large enough to be seen and read and shall be reviewed as frequently as necessary with participants. The AAA or service provider may elect to disallow removal of any food items or may allow removal of nonperishable foods such as bread, crackers, pieces of fresh fruit, etc.

Drinking Water
To encourage participants to maintain hydration, drinking water shall be available and located near participants. When feasible, water shall be available at each table.

Menu Planning
Meals shall meet the requirements specified above under "Definitions." In order to facilitate menu planning, DARS-VDA has developed Meal Planning Guidelines that nutrition program providers must use to ensure that meals meet the nutrient requirements. See DARS-VDA Menu Planning Guidelines.

Sweets Guidelines
See DARS-VDA Guidelines For Sweets Served At The Congregate Nutrition Site.

Donated Foods
The AAA or service provider may establish policies and procedures regarding use or distribution of foods donated by local vendors and retailers. All donated food prepared or served in the program shall meet quality standards. The AAA or service provider may determine which foods are acceptable, healthful, and/or nutritious for distribution or use during the operation of the meal site.

Meals Brought in by Participants
The AAA or service provider may establish policies and procedures to allow or disallow meals brought in by participants. The policies and procedures may address such situations as participants who attend site activities and either do not eat the meal or bring their own meal, pot luck meals, and sharing of ethnic cuisines. In any case, only the meals provided by the program funds and that meet meal definitions and standards shall be counted as eligible service units.

Meal Preparation
Congregate meals may be provided on site, by a central kitchen, or contracted through other organizations. Congregate meal sites, central kitchens, and subcontractors are required to follow all applicable regulations and standards of the Virginia Department of Health, Food Regulations and the DARS-VDA Menu Planning Guidelines. Whether the food service operation is provided by the AAA or contracted out, the final responsibility for overall food service operation shall rest with the AAA.

Procurement
When contracting for meal preparation, delivery of meals, and site operations, all procurement

transactions shall be conducted in a manner to provide open and free competition. Specifications for bids, and the terms and conditions of the resulting contracts, shall comply with service standards and guidelines as established by DARS General Services Division.

Food Service Operation

Compliance with applicable provisions of State or local codes and regulations regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual is required.[11] This includes, but is not limited to health, fire and safety codes and regulations; building codes; purchasing regulations; licensure requirements; and any other requirements applicable to each meal preparation site and food service vendor used for the nutrition program.

If applicable, the current food permit and/or inspection report, issued by the Health Department shall be posted or be on file. When the local Health Department is able to comply, inspection of the meal site by the local Environmental Health Specialist is recommended, but not required. The Nutrition Director shall maintain copies of all current inspection reports according to AAA record retention policy, but not less than one year.

Food must be prepared, plated and transported with the least possible manual contact, with suitable utensils and on surfaces that, prior to use, have been cleaned, rinsed and sanitized to prevent cross contamination. Effective procedures for cleaning (removing visible dirt and stains) and sanitizing (reducing the number of micro-organisms by using hot water at 171 degrees (77 degrees C) or above, or a chemical sanitizing solution) dishes, equipment, food contact surfaces, work areas, serving and dining areas shall be written, posted or readily available, and followed consistently.

Material Safety Data Sheets (MSDS) must be readily available on any chemicals. Employees must be informed about potentially dangerous chemicals used in the workplace and how to safely use them. Toxic materials, such as cleaners and sanitizers, shall be maintained in the original container, or transferred to a clearly labeled appropriate container.

Health and Hygiene of Food Servers

The AAA or service provider shall have policies and procedures regarding health and hygiene for all individuals who prepare and/or serve food that includes:

- Infectious illness such as diarrhea, vomiting, fever, sore throat, etc.
- Open sores on hands or arms
- Gloves worn over nail polish and artificial fingernails for individuals serving food
- Central kitchens will abide by Virginia Department of Health Food Regulations

Food Safety & Potentially Hazardous Food Items

"Potentially hazardous food" is any food or food ingredient, natural or synthetic, which requires temperature control because it is in a form capable of supporting:

- The rapid and progressive growth of infectious or toxigenic microorganisms;
- The growth and toxin production of Clostridium botulinum; or

[11] Older Americans Act of 1965, as amended, Section 339 (2) (F)

- In raw shell eggs, the growth of Salmonella enteritidis.[12]

Potentially hazardous food includes:

- An animal food (a food of animal origin) that is raw or heat-treated;
- A food of plant origin that is heat-treated or consists of raw seed sprouts;
- Cut melons; and
- Garlic-in-oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth as specified above in this definition.[13]

In addition, any food that consists in whole or in part of:

- Milk or milk products;
- Shell eggs;
- Beef, poultry, pork, lamb, fish, and shellfish;
- Tofu;
- Soy protein foods; and
- Cooked rice, beans, potatoes (baked or boiled), or other heat-treated plant foods.[14]

In order to retain maximum nutritional value and food quality, foods shall be served as soon as possible after preparation. The AAA or service provider(s) shall make every effort not to exceed two hours of holding time between the completion of cooking and the serving of the meal and shall minimize, to the extent possible, the length of delivery routes for transporting meals to congregate sites.

Potentially hazardous hot food items shall be maintained at or above 135 degrees Fahrenheit (F) and potentially hazardous cold food shall be maintained at or below 41 degrees F.[15] Fruits and vegetables that are cooked for hot holding shall be cooked to a temperature of 135°F.[16] Frozen foods shall be maintained frozen.[17] If food temperatures are found to be in the temperature danger zone (41 – 135 degrees F) for two or more hours, the food must be discarded (Two Hour Rule).

Potentially hazardous food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds.[18] Food must be reheated within two (2) hours or thrown away, and can only be reheated once.[19] Hot food holding facilities are prohibited for the rapid reheating of potentially hazardous foods.

Temperature checks on potentially hazardous food shall be taken, and documented, on a daily basis with a correctly calibrated food thermometer at the time all food leaves the production area

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[12] 12 VAC 5-421-10, Food Regulations, Department of Health, Virginia Administrative Code
[13] 12 VAC 5-421-10, Food Regulations, Department of Health, Virginia Administrative Code
[14] Serving Safe Food, Second Edition: Employee Guide, The Educational Foundation of the National Restaurant Association 1996
[15] 12 VAC 5-421-820, Food Regulations, Department of Health, Virginia Administrative Code
[16] 12 VAC 5-421-720, Food Regulations, Department of Health, Virginia Administrative Code
[17] 12 VAC 5-421-770, Food Regulations, Department of Health, Virginia Administrative Code
[18] 12 VAC 5-421-760, Food Regulations, Department of Health, Virginia Administrative Code
[19] Serving Safe Food, Second Edition: Employee Guide, The Educational Foundation of the National Restaurant Association 1996

(including the food service vendor's kitchen) and again at the time the meal is served.

Thermometers and their cases must be kept clean. During temperature measuring, thermometers should be sanitized between each food; an alcohol swab may be used. After use, thermometers should be washed, rinsed, sanitized and allowed to air dry.

Metal stem-type food temperature measuring devices, accurate to + or – 2 degrees F shall be used to assure the attainment and maintenance of proper internal cooking, holding, or refrigeration temperatures of all potentially hazardous foods. Prior to use in a food product, thermometers shall be cleaned and sanitized according to industry standards. Food temperature measuring devices may not have sensors or stems constructed of glass, except that thermometers with glass sensors or stems that are encased in a shatterproof coating, such as candy thermometers, may be used.[20]

To maintain accuracy, thermometers must be calibrated regularly using the ice method or boiling point method. Thermometers must be calibrated after dropping and after extreme temperature changes. Even if the food thermometer cannot be calibrated, it must still be checked for accuracy using the ice method or boiling point method. Any inaccuracies must be taken into consideration when using the food thermometer or the food thermometer must be replaced. At a minimum, check and/or calibrate thermometers at least monthly and maintain records of check and/or calibration.

For milk stored in a refrigerator maintained at 41 degrees or below, the temperature of the refrigerated unit may be taken and documented, instead of the milk temperature. The accuracy of the refrigerator thermometer should be verified on an ongoing basis by taking a product temperature.

Each AAA or service provider shall have a written policy specifying the temperatures meals must meet in order to be delivered to program participants. The AAA or service provider shall also have written procedures for handling potentially hazardous food items that do not meet or maintain correct temperatures. This information will be provided to all site managers.

Food Quality

All foods, whether purchased by or donated to the program, must meet the following criteria:

- Food shall be obtained from sources that comply with law[21]
- Meet or exceed all applicable federal, state and local laws, ordinances, and regulations
- Safe and unadulterated[22]
- Food in a hermetically sealed container shall be obtained from a food processing plant that is regulated by the food regulatory agency that has jurisdiction over the plant[23]
- If served, hot dogs, luncheon meat, and soft cheeses (feta, Brie, Camembert, Blue veined, Mexican style) must meet temperature requirements
- Pasteurized shell, liquid, frozen, or dry eggs or egg products shall be substituted for raw

[20] 12 VAC 5-421-1090, Food Regulations, Department of Health, Virginia Administrative Code
[21] 12 VAC 5-421-270, Food Regulations, Department of Health, Virginia Administrative Code
[22] 12 VAC 5-421-260, Food Regulations, Department of Health, Virginia Administrative Code
[23] 12 VAC 5-421-280, Food Regulations, Department of Health, Virginia Administrative Code

shell eggs in the preparation of foods such as Caesar salad, hollandaise or béarnaise sauce, mayonnaise, and egg-fortified beverages and for recipes in which more than one egg is broken and eggs are combined[24]

The following foods must not be used:[25]

- Prepackaged un-pasteurized juice (including un-pasteurized apple cider)
- Raw animal foods, such as raw fish raw-marinated fish, raw molluscan shellfish, and steak tartare
- Partially cooked animal food such as lightly cooked fish, rare meat, soft-cooked eggs that are made from raw shell eggs, and meringue
- Raw seed sprouts (including alfalfa, clover and radish)
- Home-canned foods
- Any foods prohibited under the Virginia Department of Health Food Regulations or updated versions of The Food Code

Handling Food Product Recalls

AAAs, nutrition service providers, and subcontractors shall develop and implement policies and procedures that include information on responding to Food Recall Notices. Procedures to consider include:

- Developing and completing a food recall action checklist.
- Identifying the recalled food product.
- Counting the recalled product in inventory.
- Identifying where and how to segregate the recalled food.
- Placing warning labels on the segregated food product.
- Notifying staff not to use the segregated food product.
- Counting the amount of recalled food product already used.
- Accounting for the entire recalled food product by consolidating counts for product used and product in inventory.
- Obtaining information needed for public communications; whether the product was served, to whom it was served, and the date served.

Handling Foodborne Illness Outbreaks

AAAs, nutrition service providers, and contractors shall make reasonable efforts to avoid problems with food product contamination and with food borne illnesses through their food purchasing specifications and buying practices; product receiving and storage procedures; and food handling and delivery practices.

In the event of a complaint that a client became sick from a food and/or beverage they consumed at the meal site, the AAA, service provider, and contractor shall have policies and procedures in place to handle the suspected outbreak.

Complete information such as the following on the suspected outbreak should be gathered:

- Name, address, and telephone number of the person reporting;
- Who became ill and what were their symptoms;

[24] 12 VAC 5-421-950, Food Regulations, Department of Health, Virginia Administrative Code
[25] 12 VAC 5-421-950, Food Regulations, Department of Health, Virginia Administrative Code

- Was the illness diagnosed by a physician (get the physician's name and contact information);
- What specific foods and/or drinks were consumed (save samples if any of the food remains);
- What was the day and time the food was eaten;
- Who was the person who served or provided the food, if any;
- Other relevant information concerning the time, date, or circumstances of the suspected outbreak.

Outbreaks of suspected foodborne illness shall be reported to the local health department immediately for investigation and AAAs, service providers, and subcontractors shall cooperate fully in the investigation.

Administrative Elements

Staff Qualifications

Individuals responsible for the direction of Nutrition Services shall possess the following minimum qualifications:

- Knowledge: Biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; community resources; public benefits eligibility requirements; food and nutrition; safe food handling; and disease prevention and health promotion
- Skills: Management and supervisory principles; transportation scheduling, if appropriate; program planning; establishing and sustaining interpersonal relationships; problem solving.
- Abilities: Communicate with persons with varying socioeconomic backgrounds; work independently.

Job Descriptions[26]

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of nutrition services staff duties and responsibilities; 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 DARS-VDA-approved client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Eligible Meals (required for the DARS-VDA-approved client database) – The number of eligible congregate meals served; see Definitions and Nutrition Services Incentive Program
- Persons Served (unduplicated) - The number of eligible persons who received an eligible congregate meal; see "Eligible Population"

[26] 22 VAC 30-60-240, Grants To Area Agencies On Aging, Department for Aging and Rehabilitative Services Regulations, Virginia Administrative Code

Program Reports

- Aging Monthly Report (AMR) to DARS-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.
- The DARS-VDA-approved client database client level data transmitted to DARS-VDA by the last day of the following month.

Consumer Contributions/Program Income

There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.[27]

Cost Sharing/Fee for Service: An Area Agency on Aging is not permitted to implement cost sharing/fee for service for recipients of this service.[28]

Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service, provided that the method of solicitation is non-coercive. Voluntary 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.[29]

For voluntary contributions, the AAA shall consult with the relevant service providers and older individuals in the planning and service area to determine the best method for accepting voluntary contributions. The AAA and service providers shall not means test for any service for which contributions are accepted, or deny services to any individual who does not contribute to the cost of the service. The AAA shall ensure that each service provider will:

- Provide each recipient with an opportunity to voluntarily contribute towards the cost of the service;
- Clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;
- Assure that the method of solicitation is non-coercive;
- Protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;
- Establish appropriate procedures to safeguard and account for all contributions; and
- Use all collected contributions to expand the service for which the contributions were given and to supplement (not supplant) federal funds received.[30]

A sign large enough to be seen and read shall be posted about the opportunity to contribute to the cost of the meal and shall include a suggested amount and the cost of the meal for ineligible visitors and guests.

Nutrition Services Incentive Program

[27] 22 VAC 30-60-400, Grants To Area Agencies On Aging, Department for Aging and Rehabilitative Services Regulations, Virginia Administrative Code
[28] Older Americans Act of 1965, as amended, Section 315(a)
[29] Older Americans Act of 1965, as amended, Section 315(b)
[30] Older Americans Act of 1965, as amended, Section 315(b)

Congregate Nutrition Service providers receiving Older Americans Act funds may participate in the Nutrition Services Incentive Program (previously USDA commodity food/cash distribution program).

To be counted as an eligible meal, and therefore, receive NSIP reimbursement, the following requirements must be met:

- The person receiving a meal must meet eligibility requirements under Title III-C1 of the Older Americans Act
- The participant or other eligible individual (not a volunteer) must be assessed using the Virginia Service Quick Form and the "Determine Your Nutritional Health" Nutrition Screening Checklist, and Federal Poverty/DARS-VDA Sliding Fee Scale (unless all information needed to determine federal poverty is documented on the Virginia Service Quick Form). Assessment data shall be documented in the DARS-VDA-approved client electronic database.
- The question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database.
- Cost sharing does not apply to this service
- For an individual who provides volunteer services during the meal hours (not a site participant) and receives a congregate meal: a Virginia Service Quick Form shall be requested. At a minimum, the full legal name and service units (collected at least on a monthly basis) must be entered into the DARS-VDA-approved electronic client database.
- The participant may make a donation, but cannot be charged for the meal, means tested for participation, or asked for a cost-share
- The AAA or service provider shall have a record keeping system that tracks frequency of participation and generate unduplicated count information (match the participant's name with their meal)
- The meal must meet DRI nutrient requirements and Dietary Guidelines defined above
- Snacks, partial meals and second helpings cannot be counted as a "meal" for reporting purposes
- Congregate meals programs are authorized to serve two- and even three-meal a day programs and each meal can be reported for reimbursement purposes.
- Cash disbursements received under the Nutrition Services Incentive Program (NSIP) shall only be used to purchase United States agricultural commodities and other foods for their nutrition projects.[31]

Agencies are not eligible to receive Older Americans Act funding for meals nor eligible to receive funding under NSIP if the agency:

- Is an adult day care agency that charges for meals in an adult day care facility as part of the total package of services
- Is an adult day care agency that provides meals funded by the USDA Child and Adult Care Food Program and reports the same meal to both programs
- Is an adult day care agency that provides meals funded through a Medicaid Waiver program

The meal is eligible if an adult day care provides meals only with Older Americans Act

[31] Older Americans Act of 1965, as amended, Section 311(d)(2)

and matching funds.[32]

Congregate meals provided to resident(s) living at an Assisted Living facility (previously called Adult Care Residence) and receiving Auxiliary Grant are not eligible for NSIP funding. The Assisted Living must reimburse the AAA for the cost of the congregate meal if Older Americans Act funds are used. The AAA should develop a written agreement with each facility indicating the cost of each meal and specifics about how payment will be made. Each AAA should have a written policy regarding attendance of Assisted Living residents at congregate nutrition sites.

Congregate meals provided under the National Family Caregiver Support Program (Title III-E, Supplemental Services) can be counted as NSIP meals if they are provided to the older care recipient, a caregiver over the age of 60, or a caregiver under the age of 60 who is the spouse of the care recipient. If the meal is provided to a caregiver under age 60 who is not a spouse, Title III-E, Supplemental Services funds may be used but the meals are not NSIP eligible meals.

Quality Assurance

Meal providers are encouraged to provide congregate meal services with the advice and expertise of (1) a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services, (2) meal participants, and (3) other individuals knowledgeable with regard to the needs of older individuals.[33]

Staff Training

- At hiring, staff involved with providing and assessing for nutrition services shall receive orientation on agency and nutrition services policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Workers shall receive a minimum of 10 (ten) documented hours of in-service or other training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities. This may include participant donations, safe food handling, taking and recording food temperatures, and what to do if meal temperatures are not in compliance.
- All individuals, including volunteers that prepare and/or serve food will receive training in personal hygiene, hand washing, health policies, and safe food handling.

Individuals responsible for the direction of Nutrition Services and/or AAA designees involved with nutrition services and/or meals subcontractor must receive and maintain certification in safe food handling. Central kitchens will abide by Virginia Department of Health Food Regulations.

Supervision

Consultation and supervision shall be available to all staff providing the service. All staff working in the preparation of food must be under the supervision of a person qualified to ensure the application of hygienic techniques and practices in safe food handling, preparation, and service.

[32] Administration on Aging, Nutritional Services Technical Assistance Brief Number 2, March 2001
[33] Older Americans Act of 1965, as amended, Section 339

Program Evaluation

The agency must develop a written program evaluation plan to conduct regular systematic analysis of the persons served and the impact of the service. Evaluation may include client surveys for program planning and menu input. Surveys should be compiled and summarized in a format reporting how the data gathered will be used to improve services.

Local caterers and companies that provide subcontracted meal preparation and organizations that provide congregate site management, as well as those to which the entire program is subcontracted, shall be monitored at least annually. There shall be a written policy that includes: content of monitoring (such as use of DARS-VDA Monitoring Instrument), frequency, and reporting back to the AAA especially on any corrective action(s) recommended and carried out.

Policies and Procedures

The AAA and service provider must maintain, at the minimum, the following policies and procedures:

- Offering congregate meals to other eligible individuals
- Use of Nutrition Screening results
- Service Termination Policy
- Collection, disposition and accounting for program income, including safeguarding and accounting for donations
- Weather related emergencies and other situations that affect service delivery
- Ill or injured participants
- Removal of food items
- Food server health and hygiene
- Required meal temperatures
- Handling potentially hazardous food items that do not meet temperature standards
- Cleaning and sanitizing
- Program evaluation plans, including monitoring of subcontractors
- Medical Foods (if applicable)
- Attendance of Assisted Living residents at congregate nutrition sites

Posted Information

Posted information shall be large enough for participants to read, up to date, and organized. The following information shall be accessible to participants and staff:

- Menu
- Activity and program calendar
- Opportunity for a voluntary donation, suggested amount of meal donation, meal cost for ineligible visitors and guests
- Procedure to follow if a participant becomes ill or injured and/or “911” and address of the meal site
- Removal of food items policy
- Food permit, if applicable
- Cleaning and sanitizing procedures (posted or readily available)

Service Records

Service documentation that will be maintained according to AAA record retention policy (but not less than one year) includes, but is not limited to:

- Site registration/transportation sign-in sheets that identify participants and volunteers, staff, and guests who receive a meal
- Documentation of physical activity, disease prevention/health promotion, and nutrition education activities, such as activity calendars
- Records of temperature checks
- Current Health Department permit and inspection report, if issued
- Fire Drills
- All menus from all vendors with nutrient analysis or meal pattern worksheet

Client Records

AAA and/or service providers must maintain client records in the approved DARS-VDA electronic database that include:

- Virginia Service Quick Form
- Answers to the "Determine Your Nutritional Health" Nutrition Screening Checklist
- Federal Poverty documentation must be part of the client record. The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database. The Federal Poverty/DARS-VDA Sliding Fee Scale form may be used.
- Care Plan (optional, but if completed must be recorded in the DARS-VDA-approved electronic client database.)
- Service reassessment
- Consent to Exchange Information, if information is shared with other agencies
- Emergency Contact Information

The AAA or service provider must maintain the following additional records:

- Service confirmation
- Appeal process

DISEASE PREVENTION & HEALTH PROMOTION
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
VIRGINIA DIVISION FOR THE AGING
SERVICE STANDARD

Definitions

I. Evidence-Based

A. All programs using Title III-D funds must meet the definition of evidence-based programming. The program must include all of the following to be considered evidence-based:

- Demonstrated through evaluation to be effective for improving the health and wellbeing or reducing disease, disability and/or injury among older adults; *and*
- Proven effective with older adult population, using Experimental or Quasi-Experimental Design; *and*
- Research results published in a peer-review journal; *and*
- Fully translated in one or more community site(s)*; *and*
- Includes developed dissemination products that are available to the public.

**For purposes of the Title III-D definitions, being "fully translated in one or more community sites" means that the evidence-based program in question has been carried out at the community level (with fidelity to the published research) at least once before. Sites should only consider programs that have been shown to be effective within a real world community setting.*

B. There are two ways to determine if a program meets the definition of evidence-based; either is acceptable.

- Document whether the program meets each of the 5 bullets in the definition. If it does, it can be supported with Title III-D funds; *or*
- The program is considered to be evidence-based by any operating division of the U.S. Department of Health and Human Services (HHS).
    - HHS has eleven operating divisions
    - An HHS division has included the program on a registry of evidence-based programs, or has reviewed it and deemed it evidence-based.

For example, this would include programs listed on the Administration of Community Living (ACL), Aging and Disability Evidence-Based Programs and Practices; Centers for Disease Control and Prevention (CDC), Compendium of Effective Interventions; Substance Abuse and Mental Health Services Administration (SAMHSA), National Registry of Evidence-Based Programs and Practices; and the National Institute of Health (NIH), Cancer Control Evidence-based Portal, etc.

There are numerous evidence-based programs that are administered throughout HHS. For a list of the HHS Family Agencies, visit http://www.hhs.gov/about/foa/index.html.

Additional information on Disease Prevention and Health Promotion Services, Older Americans Act (OAA) Title III-D, including Frequently Asked Questions, can be found at http://www.aoa.acl.gov/AoA_Programs/HPW/Title_IIID/index.aspx

II. Evidence-based program versus evidence-based service/practice:

While the terms "evidence-based program" and "evidence-based service/practice" are often used interchangeably, they are not the same. Evidence-based services/practices can be part of an evidence-based program, but the reverse is not always true. Title III-D funds are required to be used on evidence-based programs.

A. Evidence-based services/practices refer to strategies or activities utilized by evidence-based programs as part of their larger intervention. For example, evidence-based self-management programs (such as diabetes prevention programs or pain management programs) may incorporate similar evidence-based practices such as blood pressure screenings or glucose checks, even though the outcome goals of these programs may be very different.

B. Evidence-based programs refer to organized and typically multi-component interventions with clearly identified linkages between core components of the program and expected outcomes for an identified target population. For example, an evidence-based falls prevention program could involve educational enrichment classes, as well as one or more evidence-based services (for example, strength and balance building exercises and/or a home environmental assessment component). Such programs must also have methods available to guide their dissemination in the community, such as materials and trainings.

Eligible Population

Disease Prevention and Health Promotion Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low- income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.

Service Delivery Elements

Program Requirements

Disease prevention and health promotion services and information shall be provided at multipurpose senior centers and congregate meal sites, or at other appropriate community sites convenient and accessible to older individuals.

Assessment

- If the client does not already have an assessment in the Virginia Division for the Aging (VDA)-approved electronic client database, a Virginia Service – Quick Form or CRIA encounter is required for each person who participates in a program activity.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA-approved electronic client database.
- Any fee for service charge to the client shall be determined by a VDA approved sliding fee scale. The Federal Poverty/VDA form may be used.

Administrative Elements

Staff Qualifications

Staff conducting evidence-based programs shall meet the training and certification requirements set forth by the specific program.

Job Descriptions

For each paid position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of staff disease prevention and health promotion service duties and responsibilities; 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 VDA-approved client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Sessions – Service activities provided to a specific individual. Activities can be provided one-to-one or in a group setting. A unit is one (1) session. A session is one event that lasts a part of an hour up to one full day.
  For example, a six-week Chronic Disease Self-Management Program (CDSMP) workshop would equal 6 sessions or 6 units. If a workshop consists of 6 topics presented in a day, this would equal 1 session or 1 unit.
- Persons served (unduplicated) - The number of persons who participate in a session.

Group Units – For this service, there are no group units; therefore, group units cannot be entered into the VDA-approved electronic client database.

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.
- Client level data from the VDA-approved electronic database shall be entered by the last day of the following month.

Consumer Contributions/Program Income
There must be a written policy on handling of Client Program Income (CPI) and other voluntary contributions and fees.

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing /fee for service for recipients of this service.

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

Quality Assurance

Staff Training

- At hiring, staff shall receive orientation on agency and departmental policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Staff conducting evidence-based programs shall meet the training and certification requirements set forth by the specific program.

Supervision
Consultation and supervision shall be available to all staff providing the service.

Program Evaluation
The AAA shall conduct regular and systematic analysis of the persons served and the impact of the service, in accordance with the evidence-based program requirements. There shall be a written plan and a written report of findings. Evaluation may include client satisfaction surveys.

Client Records
The AAA or service provider must maintain specific client records in the approved VDA electronic database that include:

- Consent to Exchange Information, if information is shared with other agencies.
- Virginia Service - Quick Form or CRIA encounter. At a minimum, this information must be updated annually.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA-approved electronic client database.

The AAA or service provider must maintain the following additional records:

- Documentation that the service took place.
- Cost Sharing (Fee for Service) calculations, if applicable. The Federal Poverty/VDA Sliding Fee Scale form may be used.

ELDER ABUSE PREVENTION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Elder Abuse Prevention services are programs to assist older individuals, their families and caregivers, to prevent and remedy neglect or exploitation. See 42 United States Code (USC) §3002 (22) & (23).

Eligible Population

Individuals are eligible for Elder Abuse Prevention Services if they are 60 years of age or older. Preference shall be given to older individuals who are indigent; unable to care for themselves and who have no one available and willing to provide needed care. Services may also be provided to the family or caregiver of an older individual to assist the family caregiver to provide appropriate care. See 42 United States Code (USC) §3002 (35).

Service Delivery Elements

- Elder abuse prevention services should concentrate on public education. See 42 United States Code (USC) §3058i.
- Elder abuse prevention services will coordinate with the Long-Term Care Ombudsman Program.
- Abuse, neglect or exploitation of older persons must be reported to the local Department of Social Services. See Virginia Code §63.1-53.3. In addition, suspected sexual abuse of older persons must be reported to local law enforcement officials. See Virginia Code §63.1-53.3.C.
- If there is reason to believe a crime has been committed, the suspected crime must be reported to the local law enforcement agency.
- Services for the elder abuse program include determining if additional services are needed and arranging for those services. Follow-up may also include advocacy for the older individual with the Department of Social Services staff.

Assessment:

A service specific assessment should be performed on each individual client, utilizing the Virginia Service – Quick Form:

Federal Poverty/VDA Sliding Fee Scale is required, unless all information needed to determine federal poverty is documented on Virginia Service – Quick Form.

Administrative Elements

Staff Qualifications:

Staff should know the biological, psychological and social aspects of aging; Virginia's Adult Protective Services Law; elder abuse prevention and intervention; the services provided by community resources; and problem solving complaint resolution techniques. See 42 United States Code (USC) §3058i. (b)(8)(C).

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

- Persons Served – Unduplicated number of individuals for whom services were provided.
- Contacts – count each contact with the client and collateral contacts with agencies related to establishing services.

Optional Units of Service (Not Entered into AIM):

- Referrals* – Number of elder abuse and elder victim reports/referrals made to Department of Social Services and law enforcement agencies.
- Presentations* – Number of education/training group activities conducted.
- Participants* – Number of people attending education/training group presentations.

*These activities cannot be entered into the AIM system; but may be reported on the AMR Optional Unit Report.

Program reports:

- AIM client level data transmitted by the last day of the following month
- 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.

Quality Assurance

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

Staff Training:
Training must be coordinated with the Department of Social Services staff and will include information about elder abuse, Virginia's Adult Protective Services law, and procedures for making referrals and coordinating with other agencies. Continuing education will update personnel on changes and improve professional skills about elder abuse prevention.

EMERGENCY
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Providing financial aid and other resources, including referrals to other public and private agencies, to persons 60 and older who have an emergency need for help. The program provides for immediate and short-term assistance in getting resources in an emergency that endangers the health or well-being of older persons.

Eligible Population

Persons 60 years of age and older with emergency needs that cannot be met through other services. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements

Agencies providing Emergency service must perform all of the following components:

Resource file: The development and maintenance of accurate, up-to-date, and well-organized information on opportunities, services, and resources available in the community, including detailed data on service providers.

Information: The process of informing an older person of available opportunities, services, and resources.

Assessment: The process of identifying, analyzing, and prioritizing the needs of older persons, utilizing the Virginia Service – Quick Form, other client assessment documents, and Federal Poverty/VDA Sliding Fee Scale (unless all information needed to determine federal poverty is documented on Virginia Service – Quick Form).

Referral: The process of initiating an arrangement between the older person or caregiver and the service provider, which should include:

- 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 resource.
- if necessary, advocating with agencies on behalf of older persons.

[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

Administrative Elements

Staff Qualifications:

- Knowledge: Emergency service staff should have an awareness of the biological, psychological, and social aspects of aging; the impact of disabilities and illnesses on aging; interviewing principles; community resources; and public benefits eligibility requirements.
- Skills: Emergency service staff should have skills in establishing and sustaining interpersonal relationships; problem-solving; and advocacy.
- Ability: Emergency service staff should have the ability to communicate with persons of different socio-economic backgrounds; conduct an effective interview; complete an assessment; arrange and negotiate service referrals; and work independently.

Job Descriptions:

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of duties and responsibilities of Emergency service staff; and
- A current description of the minimum entry-level standards of each job.[2]

Units of Service:

Units of service must be reported in AIM for each client receiving services. Services units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Contact; count those contacts with the client and collateral contacts with agencies/caregivers related to establishing services.
- Persons served (unduplicated): the client/caregiver who is to receive a service(s).

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 client level data transmitted to VDA by the last day of the following month.

Consumer Contributions/Program Income

The Area Agency on Aging shall formally adopt written policies and procedures, adopted by the governing board, regarding the collection, disposition, and accounting for program income.[3]

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[4]

And/or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[5]

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[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[4] Older Americans Act of 1965, as amended, Section 315(a)

Quality Assurance

Staff Training:

- Emergency service staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Emergency service staff should receive a minimum of 10 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.

Program Evaluation:

The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Client Records:

Service providers must maintain specific program records that include:

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- 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.

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

Emergency Services
Frequently Asked Questions

1. Q - What types of emergencies can the Area Agency on Aging provide assistance?

   A - The most common requests are for: heating oil, electric bills, medications, hygiene supplies, medical equipment, in-home care, food, clothing, transportation, home repairs.

2. Q - Can the Area Agency on Aging provide reimbursement to someone who has already paid for an emergency situation?

   A - No. Emergency services must be provided at the time of the emergency.

3. Q - Where can I get assistance with purchasing a haring aide or eyeglasses?

   A - Contact the local Lions Club. The Area Agency on Aging may be aware of a resource in your area.

4. Q - I was just discharged from the hospital and need medical equipment to help me at home. What resources can help with this?

   A - Contact your local Area Agency on Aging for listing of local loan closets. Work with your hospital discharge planner or local social worker. Medicaid or Medicare will cover some durable medical equipment if ordered by a physician.

5. Q - Where can I get help with purchasing medications?

   A - The Area Agency on Aging can assist with applying for the *Pharmacy Connection Program*, which will provide free medications to eligible individuals. A physician must authorize the service. Also there are a number of private prescription plans to consider. Also you can apply for Medicaid through the local department of social services, which pays for medications.

6. Q - My utilities are being cut off. Where can I get assistance paying the bill?

   A - Area Agencies on Aging can provide one-time emergency energy assistance, depending on available funds. The local department of social services administers a fuel assistance program.

7. Q - Where can I get assistance in repairing my home?

A - Contact you local Area Agency on Aging to see if they provide residential renovation and repair services. Also local *Community Action Programs* may be a resource for home repairs. Some localities have *Christmas in April*, the leading volunteer organization that rehabilitates the homes of low-income homeowners.

8. Q - I have received some important documents about my benefits that I cannot understand. There are forms to complete and return. Where can I get assistance with the forms?

   A - Contact your local Area Agency on Aging and request assistance with completing the forms.

9. Q - I need help with my insurance and doctor bills. Where can get assistance?

   A - Contact your local Area Agency on Aging and request assistance from the Virginia Insurance Counseling Assistance Program (VICAP).

fdc 2/15/02

EMPLOYMENT – Title III
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition
Employment service as a Title III service is assisting person's age 60 or older to obtain part-time or full-time employment.

Eligible Population
Persons 60 years of age and older. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements
Service-Specific Assessment:
A service-specific assessment using at a minimum, the Virginia Service – Quick Form must be completed on each potential client that determines:

- 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.

Preparation for Placement: Assistance to individuals seeking employment should include at least:

- Assessing what the person's service-specific needs are; has a need for employment or for training to gain new job skills or upgrade current skills
- Providing information on available employment opportunities.
- Counseling the older person in preparation for job interviews with prospective employers.
- Coordinating with activities conducted under the Title V Senior Community Service Employment Program and the Workforce Investment Act.

Administrative Elements
Staffing

Employment Staff Qualifications:

- Knowledge and awareness of biological, psychological, and social aspects of aging; the impact of disabilities and illnesses on aging; employment and training resources and opportunities available for older workers. Familiarity with employment opportunities.
- Skill in assessing the employment needs of older persons; establishing and sustaining interpersonal relationships; interviewing techniques; problem-solving; and team-building
- Ability to communicate with persons with different socio-economic backgrounds and work independently and to motivate people.

[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

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

- individual hours
- persons served
- placement in employment or training program

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 client level data transmitted to VDA by the last day of the following month.

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.[2] There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[3]

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.[4]

Allowable Costs:
Program costs may not be paid with funds from Title V of the Older Americans Act.

Quality Assurance
Staff Training:

- (Initial) in-depth orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- (Ongoing) at least annual in-service training, the content of which to be based on the need for professional growth and upgrading of knowledge, skills, and abilities.
- Must attend training provided by Virginia Department for the Aging that is specifically for Employment service.

[2] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[3] Older Americans Act of 1965, as amended, Section 315(a)
[4] Older Americans Act of 1965, as amended, Section 315(b)

Case Review

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

Program Evaluation

- The agency should conduct regular systematic analysis of the persons served and the impact of the service.
- Subcontractors shall be monitored annually.

Client Records

- Virginia Services – Quick Form. (Must be updated annually). Client characteristics (age, race, residence, social need, economic need).
- Federal Poverty documentation and Cost Sharing (Fee for Service), if applicable, calculations must be part of the client record. The Federal Poverty/VDA Sliding Fee Scale form may be used.

FAQ'S
Title III Employment

1. How does this program differ from Title V Employment?

Title III Employment is the means in which the AAA's can assist a person in obtaining employment, i.e. how to write a resume, assess need for new job skills, counsel in preparation for job interviews.

2. What type of reports are required? How often?

The Aging Monthly Report (AMR) is due by the 12th of each 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 client level data transmitted to VDA by the last day of the following month.

HEALTH EDUCATION & SCREENING
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definitions

Health Education: The provision of information or materials, or both, specifically designed to address a particular health related issue. The activity may be preventive in nature and may promote self-care and independence. Health and nutrition education services include information concerning prevention, diagnosis, treatment, and rehabilitation of age-related diseases and chronic disabling conditions.[1]

Health Screening: The provision of an assessment or screening to determine an individual's current health status, including counseling, follow-up and referral as needed. Health screening services are designed to detect or prevent illnesses, or both, that occur most frequently in older individuals.[2]

Eligible Population

Health Education and Screening Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low-income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.[3]

Service Delivery Elements

Health Education

The Area Agency on Aging or service provider must provide informative and educational opportunities for older persons to acquire knowledge about wellness, health related issues and self-care. These opportunities may include: group presentations and discussions, wellness clubs, classes, newsletters, and health fairs.

Health Screening

The Area Agency on Aging or service provider must perform all of the following components of health screening:

- Provide individual or group health screening.
- Provide the individual with the opportunity to learn about individual health status.
- Perform standard examinations, procedures, or tests to gather information about the individual's health or medical status.
- Assist the individual to follow up on screening results, if indicated.
- Refer the individual to a physician or treatment facility if medical attention is needed.

[1] Older Americans Act of 1965, as amended, Section 321
[2] Ibid.
[3] Older Americans Act of 1965, as amended, Section 306 (a)(4)(A)(i)

Assessment

- A service-specific assessment shall be performed on each potential client that determines whether the individual is eligible for the service, the amount of the individual's service-specific need, and the individual's level of priority for service delivery.
- If individual hours will be entered into the VDA-approved electronic client database, the Virginia Service – Quick Form (if Part "A" Uniform Assessment Instrument is not completed) is required.
- Use of the Virginia Service – Quick Form is recommended, but not required, if there are only group hours or contacts that will not be entered into the VDA-approved electronic client database.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA approved electronic client database.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale. The Federal Poverty/VDA form may be used.

Administrative Elements

Staff Qualifications

Whenever possible, the Area Agency on Aging or service provider shall utilize health experts and other qualified community resources to provide information, conduct screenings and advise on appropriate follow-up. When AAA or service provider staff are used, they shall possess the following minimum qualifications:

- Knowledge: Biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; community resources; public benefits eligibility requirements; disease prevention and health promotion; medical conditions; learning styles of older adults.
- Skills: Establishing and sustaining interpersonal relationships; problem solving; designing educational materials; public speaking; health screening.
- Abilities: Communicate with persons with varying socioeconomic backgrounds; work independently.

Job Descriptions[4]

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of health education and screening services staff duties and responsibilities; 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 VDA-approved client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

[4] 22 VAC 5-20-250, Grants to Area Agencies on Aging, Department for the Aging Regulations, Virginia Administrative Code.

- Hours (individual) – The number of hours spent one-on-one providing health education and/or health screening services to the individual senior.
- Persons served (unduplicated) – The number of persons who are provided with the service and who receive individual hours.

Individual Hours - Service activities provided to a specific individual; individual hours are required for AIM.

Optional Group Units (Not entered into the VDA-approved client database)

- Group Participants – The number of people attending the presentation, meeting, or program (activity provided to more than one person or in a group setting).
- Number of Group Presentations – Number of programs on health education/health screening topics.

Group Units – These activities cannot be entered into the VDA-approved client database. They are reported on the Optional Units page of the AMR.

Program Reports

- Aging Monthly Reports (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.
- Client level data from the VDA-approved electronic client database shall be transmitted to VDA by the last day of the following month.

Consumer Contributions/Program Income

There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations. [5]

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[6]

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. Voluntary 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. [7]

Quality Assurance

Staff Training

- At hiring, staff shall receive orientation on agency and departmental policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.

[5] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[6] Older Americans Act of 1965, as amended, Section 315(a)

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

- Workers shall receive a minimum of 10 hours of in-service or other training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision

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

Program Evaluation

The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Client Records

The AAA or service provider must maintain specific client records in the approved VDA electronic database that include:

- Consent to Exchange Information, if information is shared with other agencies.
- Virginia Service - Quick Form (if Part "A" Uniform Assessment Instrument – page 1-3 minimum is not completed). At minimum, this form must be updated annually.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded.

Service providers must maintain the following additional records:

- Service documentation, such as activity calendars or service records documenting health education and screening programs took place.
- Cost Sharing (Fee for Service) calculations, if applicable.

Virginia Department for the Aging
Health Education and Screening

Question: What happened? There used to be separate service standards for Health Education and Health Screening.

Answer: We combined the Health Education and Health Screening Service Standards into one. These are also now combined on the Aging Monthly Report (AMR).

Question: We offer health education and screening to groups. How do we report this in AMR and AIM?

Answer: Only individual hours may be reported in AIM and the AMR. Individual health risk assessments or individual nutrition counseling are examples of service activities provided one-on-one to an individual senior.

Even though group hours and contacts are not reported to VDA, agencies may continue to provide service activities to more than one person or in a group setting. Your agency will decide whether to continue to track group hours internally.

Question: We provide health education and screening services at community health fairs. It is very time intensive to have seniors fill out the Virginia Service – Quick Form, and some seniors resent the questions.

Answer: The Virginia Service – Quick Form is required only if individual hours will be entered into the AIM system and if Part "A" Uniform Assessment Instrument is not completed. Use of the Virginia Service – Quick Form is recommended, but not required, if there are only group hours or contacts that will not be entered into AIM.

You must present the Virginia Service – Quick Form to the senior if you wish to enter the individual hours into AIM and AMR. The senior may elect to not provide all of the information.

Each AAA will need to make a decision about whether to enter individual information for seniors attending a health fair if only 5 – 10 minutes will be reported.

Question: How do we report "persons served?"

Answer: "Persons served" are the number of seniors (unduplicated) who are provided with the service and who receive individual hours. Individual hours are the number of hours spent one-on-one providing the service to the individual senior.

Persons who receive the service in a group setting (more than one person), such as attending a group presentation, are not reported to VDA through AIM or AMR. Your agency will decide whether to continue to track group hours internally.

HOME DELIVERED NUTRITION
(Title III – C2 & Fee for Service)
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES-VIRGINIA DIVISION FOR THE AGING
SERVICE STANDARD

Definition[1]

Provision, to an eligible client or other eligible participant at the client's place of residence, a meal which:

- Complies with the most recent edition of the Dietary Guidelines for Americans, published by the Secretary of Health and Human Services and the Secretary of Agriculture,
- Provides a minimum of 33 1/3 percent of the dietary reference intakes (DRI) as established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if one meal is provided per day,
- Provides a minimum of 66 2/3 percent of the DRI if two meals are provided per day,
- Provides 100 percent of the DRI if three meals are provided per day,
- To the maximum extent practicable, are adjusted to meet any special dietary needs of program participants,
- Complies with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual.

The meal must be delivered and received at the home of the eligible individual who is homebound.

Homebound: Someone unable to leave home to attend regular social activities such as a senior center or congregate nutrition site. The recipient may be able to go to medical appointments, but needs escort assistance to do so safely. A client without access to adequate nutrition and for whom transportation to a congregate site is unfeasible may be considered homebound.

Eligible Population

Home Delivered Nutrition Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low-income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.[2]

Eligibility criteria include:

- The individual must be homebound as defined above.
- The individual must be unable to prepare meals and have no one available to prepare meals.
- The individual must be able to remain safely at home, with home delivered nutrition as a support service.

Other individuals eligible to receive home delivered nutrition services, include:

- The recipient's spouse, regardless of age or disability
- At the discretion of the AAA, an individual with disabilities, regardless of age, who resides at

[1] Older Americans Act of 1965, as amended, Section 339 (2) (A)
[2] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

home with the recipient over age 60 who receives a home delivered meal.

The AAA shall establish procedures for offering a meal on the same basis as meals are provided to participating older individuals, to other eligible individuals listed above. There is no prohibition against providing services to persons under age 60 with funds from other sources.[3]

Service Delivery Elements

The Area Agency on Aging or service provider must perform all of the following components of Home Delivered Nutrition Services:

Program Requirements

Each nutrition services provider must establish and operate nutrition projects for older individuals which, on 5 or more days a week (except when a lesser frequency is approved by the State agency or when a client's individually assessed and documented need is less), provide per meal recipient at least one home delivered meal per day, which may consist of hot, cold, frozen, dried, canned, fresh, or supplemental food and any additional meals which the provider elects to provide.[4]

An inherent part of the home delivered meal program is the social contact and well-being check that naturally take place when the meal is delivered. It is a concern that this vital aspect of the program is lost when bulk meals are only delivered once or twice a month, especially in rural areas where clients are isolated, vulnerable, and may not have other contacts. It is likewise a concern when meals are delivered by commercial companies such as FedEx and UPS whose mission is package delivery and not necessarily the social, safety, nutritional, or functional needs of the HDM participant. Commercial package delivery of HDM shall be reserved for the small 1-2 percent of the population of a jurisdiction that is geographically isolated and remote from usual HDM routes, if applicable.

AAAs that deliver meals less than weekly to 25% or more of their total home delivered meal clients shall, along with their service provider(s), if applicable, develop and submit a plan for State agency (DARS-VDA) review and approval. The plan will consist of a narrative addressing the following points:

- The AAA shall describe the criteria they will use to identify the most vulnerable individuals receiving meals less than weekly. It is recommended that the AAA develop and describe their criteria with emphasis on using data that is collected using the UAI and other screening and assessment tools already in place. The AAA may consider using data found on pages 3 and 4 of the UAI (living arrangements and functional status) as some of their criteria. Suggested criteria include geographical isolation, lack of family contact and support, high nutrition risk, multiple medical conditions, ADL needs, lack of ability to communicate (such as no phone), structural problems in the home, etc.

- The AAA shall describe how they will provide, monitor, and document appropriate social contact and safety checks with the above-identified, most vulnerable individuals. Contact might be by/through telephone or technology, partnerships with local volunteer organizations, fire/police/TRIAD, enrollment in the agency's already established checking

[3] Older Americans Act of 1965, as amended
[4] Older Americans Act of 1965, as amended, Section 336

program, etc. The frequency of contact must also be addressed in the plan narrative. The AAAs will fully describe the contact method and frequency, and provide all sample forms. If the AAA is using an outside organization to perform the social contacts and safety checks, the formal agreement with the organization shall be attached. The agreement shall include a full description of the contact method and frequency and include all sample forms.

- The narrative shall describe how the documentation will be maintained to demonstrate that the social contacts and safety and security checks are taking place and any issues identified are receiving appropriate follow-up. Documentation shall be available during monitoring.

- The AAA shall describe how they will conduct individual client follow-up evaluation every 6 months to ensure that the meals are still meeting the need and being used properly by the client. The AAA will monitor to make sure meals are not accumulating or being given away, sold, or discarded and that the client still has the facilities and physical ability necessary to store and heat the meals. If the client is not already being re-assessed bi-annually for another service, this evaluation may be, for example, a checklist completed by the driver, a survey asked of the client, or another method developed by the agency, described fully in the narrative, and sample forms attached to the narrative. Documentation of the 6-month evaluation/assessment shall demonstrate that the assessment is being conducted and any issues identified are receiving appropriate follow-up, and shall be maintained and available during monitoring.

- The narrative shall describe the AAA's plan for nutrition education for the HDM participants.

- The narrative shall describe the AAA's plan for solicitation of the HDM participants for voluntary contributions.

- The narrative shall provide a description of the delivery method, including whether volunteers or staff are delivering the meals. If commercial package delivery companies (FedEx, UPS) will be used to deliver meals, the narrative must include a full description of the delivery procedures including whether the client is required to sign for meals, what happens if the client is not there to receive meals, how meal non-delivery is reported to the AAA, what the AAA's responsibility is when meals are not received, what the shelf-life of the meals is if they are not delivered in the expected time frame, how assistance is provided if required by a disabled client, and any other component related to delivery of meals, food safety, and integrity of the program.

- The AAA must attach the food vendor contract/agreement if the food vendor is shipping the meals directly to the client.

- The AAA must attach the nutrient analyses documenting that the meals provided meet 1/3 of the nutrient needs of older individuals and, for example, they are not heavy on sodium or light on fiber, protein, and vegetables, as many shelf stable meals may be. Be reminded that breakfast may not be used as a standalone meal.

- Attach the Advisory Committee- and Governing Board-approved policy showing that infrequent delivery of HDM is an agency policy. If it is not a practice that the Advisory Council or Governing Board signs policies, then attach minutes showing that the specific policy/practice of infrequent delivery of HDM (not the Area Plan) was approved by the Advisory Committee and/or Governing Board.

- Any other information the AAA deems relevant.

Plans shall be submitted for review and approval prior to the AAA beginning to deliver HDM less frequently than weekly and updated when significant changes are made to the plan. Thereafter, plans will be reviewed annually in conjunction with the Area Plan review.

A template is available.

The Older Americans Act (OAA) requires that meal providers solicit the advice and expertise of (1) a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutrition services, (2) meal participants, and (3) other individuals knowledgeable about the needs of older individuals.[5]

DARS-VDA recommends that AAA and nutrition service providers hire or contract with a registered dietitian (RD). Please see Guidance on Soliciting the Expertise of the RD.

Nutrition services providers shall design meals that are appealing to program participants and shall enter into contracts that limit the amount of time meals must spend in transit before they are consumed.[6]

Assessment

- A service-specific assessment using the Uniform Assessment Instrument shall be performed on each potential client that determines whether the individual is eligible for the service, the amount of the individual's service-specific need, and the individual's level of priority for service delivery. A home visit to assess eligibility for home delivered nutrition services is strongly recommended.
- Part "A" Uniform Assessment Instrument and "Determine Your Nutritional Health" Nutritional Screening are required. Client assessment data shall be documented in the DARS-VDA-approved electronic database.
- Federal Poverty should be determined and documented. The answer to the question "Is Client in Federal Poverty?' (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database. The Federal Poverty/DARS-VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.
- Emergency contact information.

Nutrition Screening

The "Determine Your Nutritional Health" Nutrition Screening checklist developed and distributed by

[5] Older Americans Act of 1965, as amended, Section 339
[6] Ibid

the Nutrition Screening Initiative must be completed during assessment. The AAA or service provider will develop a written plan specifying how the agency will use the screening results.

At a minimum, the screening results may be used in the following ways:

- Referral to appropriate services such as (1) dental professionals for those with tooth or mouth problems, (2) the food stamp program, food bank, or other social programs if they indicate they don't have enough money to buy food, (3) their doctor or a dietitian if they have a chronic condition requiring a special diet, for example.
- Planning nutrition education programs. For example, educating participants how to increase their fruit and vegetable intake or to shop for and prepare nutritious meals, depending on what screening forms show.
- As a criterion in prioritizing client needs for nutrition service especially when program funding is limited.

Care Plan

The Care Plan is optional and may be completed by another department within the AAA. If used, the Care Plan may include nutritional and social needs that can be met through home delivered nutrition services. Before the service is delivered, a written individualized care plan may be developed that identifies the service components to be provided to meet the client's assessed need. The plan should be developed with involvement from the client. "Client" may include the individual's authorized representative or family member. The client should be given the opportunity to provide input for the implementation and evaluation of the plan. The plan may be modified to reflect any change in the client's needs. Each plan may include:

- Identified service needs
- Services to be delivered by the service provider or other sources
- Goals and objectives of service to be provided
- Quantity of service units to be provided

Service Confirmation

A service confirmation, which may be in the form of a letter, packet, or handbook, shall be provided to the client to explain the service arrangement. The client shall receive a copy that includes:

- Service to be provided
- Scheduled days of service
- Information regarding voluntary contributions
- Description of procedures to be followed if a participant is ill or injured or not at home when the meal is delivered
- Service interruption due to severe/inclement weather or other conditions
- Explanation of the Service Termination Policy
- Other policies deemed informative and appropriate by the service provider

If service is denied or the client is placed on a waiting list, written notice shall be provided to the client within 10 business days of the denial decision or placement on the waiting list. The agency's process on filing an appeal shall be provided with the denial.

Service Termination Policy

Service will be terminated at the discretion of the provider. Written notification of service termination

shall be mailed 10 business days prior to the date the action is to become effective. The agency's process on filing an appeal shall be provided with the termination notice.

Reassessment

- A review of the client's need for services, the amount of services provided and the appropriateness of the care plan (if completed) shall be performed when the client's condition or situation changes, but at least annually.
- Part "A" Uniform Assessment Instrument and "Determine Your Nutritional Health" Nutrition Screening Checklist shall be updated at the same time. Client reassessment data shall be documented in the DARS-VDA-approved client electronic database.
- Federal Poverty should be determined and documented. The question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database. The Federal Poverty/DARS-VDA form may be used.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.
- Update of emergency contact information.

Nutrition Education, Nutrition Counseling, and other Nutrition Services

AAAs and nutrition service providers will provide nutrition education, nutrition counseling, and other nutrition services, as appropriate, based on the needs of meal participants.[7] The nutrition services and programs offered by AAAs will be described in the Area Plan and comply with the following definitions:

Nutrition Education, Disease Prevention and Health Promotion

Nutrition Education Definition: A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants and caregivers in a group or individual setting overseen by a dietitian or individual of comparable expertise.[8]

Accurate information about Nutrition Education, Disease Prevention and Health Promotion shall be provided to the homebound participant on a continuing basis, but at least twice a year. Nutrition and health information will be obtained from a reputable source, registered dietitian, or other qualified individual. The information may be provided in such forms as a newsletter, flyer, brochure, article, or pamphlet and must be documented as having been distributed. A listing or calendar with the date and a copy of the item distributed is acceptable documentation.

Food Safety: At least once a year, Nutrition Education on food safety, such as information on proper handling, reheating, and storage of the home delivered meal or general food safety information for seniors, shall be provided.

Disease Prevention and Health Promotion: See Disease Prevention and Health Promotion Service Standard for definitions

[7] Older Americans Act of 1965, as amended, Section 331(3).

[8] Administration on Aging, Title III and Title VII, State Program Report Data Elements accessed at http://www.agid.acl.gov/Resources/DataSources/DataFiles/StateProgramReportForm053110.pdf page 23, accessed on July 8, 2014 .

Immunization: AAAs and service providers must provide to homebound older individuals available medical information approved by health care professionals, such as informational brochures and information on how to get vaccines, including vaccines for influenza, pneumonia, and shingles, in the individuals' communities.[9]

Nutrition Counseling (1 session per participant) -- Provision of individualized guidance to individuals, who are at nutritional risk, because of their health or nutritional history, dietary intake, chronic illnesses, or medications use, or to caregivers. Counseling is provided one-to-one by a registered dietitian, and addresses the options and methods for improving nutrition status.[10]

Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program

The AAA or service provider must assist clients in taking advantage of benefits available under the SNAP Electronic Benefit Transfer (EBT) Card and may do so by assisting clients to apply for and use benefits. The AAA or service provider may, but is not required to, accept food stamps from eligible clients as their meal contribution. The AAA or service provider may encourage the seniors or their caregivers to use the food stamps to purchase additional nutritious food for the participant to consume in the home. AAAs or service providers that wish to accept food stamps must apply for authorization through their local USDA-FNS field office and assure that all federal, state, and local agency provisions relating to their use and handling are met.

Emergency Situations

The AAA or provider shall have written procedures to follow in the event of weather-related emergencies or situations that may interrupt service or delivery of meals to the homebound participant. A written plan that describes procedures to be followed if a client is ill or injured when a meal is delivered shall be explained to staff, volunteers, the homebound participant, and their authorized representative or emergency contact person.

Menu Planning

Meals shall meet the requirements specified above under "Definitions." In order to facilitate menu planning, DARS-VDA has developed Meal Planning Guidelines that nutrition program providers must use to ensure that meals meet the nutrient requirements. See DARS-VDA Menu Planning Guidelines.

Donated Foods

The AAA or service provider may establish policies and procedures regarding use or distribution of foods donated by local vendors and retailers. All donated food prepared or served in the program shall meet quality standards. The AAA or service provider may determine which foods are acceptable, healthful, and/or nutritious for distribution to home delivered meals recipients.

Meal Preparation

Home delivered nutrition services may be provided through a central kitchen or contracted through

[9] Older Americans Act of 1965, as amended, Section 339 (2)(K)

[10] Administration on Aging, Title III and Title VII, State Program Report Data Elements at http://www.agid.acl.gov/Resources/DataSources/DataFiles/StateProgramReportForm053110.pdf page 23, accessed on July 8, 2014 .

other organizations. Central kitchens and subcontractors are required to follow all applicable regulations and standards of the Virginia Department of Health, Food Regulations and the DARS-VDA Menu Planning Guidelines. Whether the food service operation and delivery of meals are performed by the AAA or contracted out, the final responsibility for the overall service operation shall rest with the AAA.

Procurement

When contracting for meal preparation and delivery of meals, all procurement transactions shall be conducted in a manner to provide open and free competition. Specifications for bids, and the terms and conditions of the resulting contracts, shall comply with service standards and guidelines as established by DARS General Services Division.

Food Service Operation

Compliance with applicable provisions of State or local laws regarding the safe and sanitary handling of food, equipment, and supplies used in the storage, preparation, service, and delivery of meals to an older individual is required.[11] This includes, but is not limited to health, fire and safety codes and regulations; building codes; purchasing regulations; licensure requirements; and any other requirements applicable to each meal preparation site and food service vendor used for the nutrition program.
If applicable, the current food permit and/or inspection report, issued by the Health Department shall be posted or be on file. The Nutrition Director shall maintain copies of all current inspection reports according to AAA record retention policy, but not less than one year.

Food must be prepared, plated and transported with the least possible manual contact, with suitable utensils and on surfaces that, prior to use, have been cleaned, rinsed and sanitized to prevent cross contamination. Effective procedures for cleaning (removing visible dirt and stains) and sanitizing (reducing the number of micro-organisms by using hot water at 171 degrees (77 degrees C) or above, or a chemical sanitizing solution) dishes, equipment, food contact surfaces, work areas, serving and dining areas shall be written, posted or readily available, and followed consistently.

Material Safety Data Sheets (MSDS) must be readily available on any chemicals. Employees must be informed about potentially dangerous chemicals used in the workplace and how to safely use them. Toxic materials, such as cleaners and sanitizers, shall be maintained in the original container, or transferred to a clearly labeled appropriate container.

Health and Hygiene of Food Servers

The AAA or service provider shall have policies and procedures regarding health and hygiene for all individuals who prepare and/or serve food that includes:

- Infectious illness such as diarrhea, vomiting, fever, sore throat, etc.
- Open sores on hands or arms
- Gloves worn over nail polish and artificial fingernails for individuals serving food
- Central kitchens will abide by Virginia Department of Health Food Regulations

Food Safety & Potentially Hazardous Food Items

"Potentially hazardous food" is any food or food ingredient, natural or synthetic, which requires temperature control because it is in a form capable of supporting:

[11] Older Americans Act of 1965, as amended, Section 339

- The rapid and progressive growth of infectious or toxigenic microorganisms;
- The growth and toxin production of Clostridium botulinum; or
- In raw shell eggs, the growth of Salmonella enteritidis.[12]

Potentially hazardous food includes:

- An animal food (a food of animal origin) that is raw or heat-treated;
- A food of plant origin that is heat-treated or consists of raw seed sprouts;
- Cut melons; and
- Garlic-in-oil mixtures that are not acidified or otherwise modified at a food processing plant in a way that results in mixtures that do not support growth as specified above in this definition.[13]

In addition, any food that consists in whole or in part of:

- Milk or milk products;
- Shell eggs;
- Beef, poultry, pork, lamb, fish, and shellfish;
- Tofu;
- Soy protein foods; and
- Cooked rice, beans, potatoes (baked or boiled), or other heat-treated plant foods.[14]

In order to retain maximum nutritional value and food quality, foods shall be served as soon as possible after preparation. The AAA or service provider(s) shall make every effort not to exceed two hours of holding time between the completion of cooking and the serving of the meal and shall minimize, to the extent possible, the length of delivery routes for transporting meals.

Potentially hazardous hot food items shall be maintained at or above 135 degrees Fahrenheit (F) and potentially hazardous cold food shall be maintained at or below 41 degrees F.[15] Fruits and vegetables that are cooked for hot holding shall be cooked to a temperature of 135°F.[16] Frozen foods shall be maintained frozen.[17] If food temperatures are found to be in the temperature danger zone (41 – 140 degrees Fahrenheit) for two or more hours, the food must be discarded (Two Hour Rule).

Potentially hazardous food that is cooked, cooled, and reheated for hot holding shall be reheated so that all parts of the food reach a temperature of at least 165 degrees F for 15 seconds.[18] Food must be reheated within two (2) hours or thrown away, and can only be reheated once.[19] Hot food holding facilities are prohibited for the rapid reheating of potentially hazardous foods.

Temperature checks on potentially hazardous food shall be taken on a daily basis with a correctly

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[12] 12 VAC 5-421-10, Food Regulations, Department of Health, Virginia Administrative Code
[13] Ibid
[14] Serving Safe Food, Second Edition: Employee Guide, The Educational Foundation of the National Restaurant Association 1996
[15] 12 VAC 5-421-820, Food Regulations, Department of Health, Virginia Administrative Code
[16] 12 VAC 5-421-720, Food Regulations, Department of Health, Virginia Administrative Code
[17] 12 VAC 5-421-770, Food Regulations, Department of Health, Virginia Administrative Code
[18] 12 VAC 5-421-760, Food Regulations, Department of Health, Virginia Administrative Code
[19] Serving Safe Food, Second Edition: Employee Guide, The Educational Foundation of the National Restaurant Association 1996

calibrated food thermometer at the time all food leaves the production area (including the food service vendor's kitchen), at the first meal delivery stop and at the last meal delivery stop.

Thermometers and their cases must be kept clean. During temperature measuring, thermometers should be sanitized between each food; an alcohol swab may be used. After use, thermometers should be washed, rinsed, sanitized and allowed to air dry.

Metal stem-type food temperature measuring devices**,** accurate to + or – 2 degrees F shall be used to assure the attainment and maintenance of proper internal cooking, holding, or refrigeration temperatures of all potentially hazardous foods. Food temperature measuring devices may not have sensors or stems constructed of glass, except that thermometers with glass sensors or stems that are encased in a shatterproof coating, such as candy thermometers, may be used.[20]

To maintain accuracy, thermometers must be calibrated regularly using the ice method or boiling point method. Thermometers must be calibrated after dropping and after extreme temperature changes. Even if the food thermometer cannot be calibrated, it must still be checked for accuracy using the ice method or boiling point method. Any inaccuracies must be taken into consideration when using the food thermometer or the food thermometer must be replaced. At a minimum, check and/or calibrate thermometers at least monthly and maintain records of check and/or calibration.

For milk stored in a refrigerator maintained at 41 degrees or below, the temperature of the refrigerated unit may be taken and documented, instead of the milk temperature. The accuracy of the refrigerator thermometer should be verified on an ongoing basis by taking a product temperature.

Each AAA or service provider shall have a written policy specifying the temperatures meals must meet in order to be delivered to recipients. The AAA or service provider shall also have written procedures for handling potentially hazardous food items that do not meet or maintain correct temperatures. This information will be provided to all individuals who deliver meals.

Meal recipients should be advised to consume the meal immediately at delivery, refrigerate, or later reheat hot meals to a minimum temperature of 165 degrees for 15 seconds. Food containers may be labeled with this information.

Area Agency on Aging or service providers unable to take first and last meal temperatures on all routes shall work with all subcontractors to implement the following:

- Meal temperatures will be documented when food leaves the central kitchen. Food must be over 135 degrees or under 41 degrees. Temperature and time records will be available during monitoring.
- All ready-to-eat meals (not frozen or shelf stable) must be delivered within 2 hours of leaving the central kitchen.
- The meal recipient will be advised to consume the meal immediately at delivery, refrigerate, or later reheat hot meals to a minimum temperature of 165 degrees for 15 seconds.
- Documentation must be maintained with the time the meal left the central kitchen and the time at the last delivery stop. Records will be available during monitoring. As an alternative to recording the time at the last delivery stop, food containers will be labeled appropriately. For

[20] 12 VAC 5-421-1090, Food Regulations, Department of Health, Virginia Administrative Code

example, "Eat this hot meal immediately or refrigerate and later reheat to a minimum temperature of 165 degrees for 15 seconds."
- Whenever possible, random temperatures will be taken and documented for the first and last delivery stop.

Service providers shall have in place policies that ensure that home delivered meals are not left unattended if the client is not at home.

Food Quality

All foods, whether purchased by or donated to the program, must meet the following criteria:
- Food shall be obtained from sources that comply with law[21]
- Meet or exceed all applicable federal, state and local laws, ordinances, and regulations
- Safe and unadulterated[22]
- Food in a hermetically sealed container shall be obtained from a food processing plant that is regulated by the food regulatory agency that has jurisdiction over the plant[23]
- If served, hot dogs, luncheon meat, and soft cheeses (feta, Brie, Camembert, Blue veined, Mexican style) must meet temperature requirements
- Pasteurized shell, liquid, frozen, or dry eggs or egg products shall be substituted for raw shell eggs in the preparation of foods such as Caesar salad, hollandaise or béarnaise sauce, mayonnaise, and egg-fortified beverages and for recipes in which more than one egg is broken and eggs are combined[24]

The following foods must not be used:[25]
- Prepackaged un-pasteurized juice (including un-pasteurized apple cider)
- Raw animal foods, such as raw fish raw-marinated fish, raw molluscan shellfish, and steak tartare
- Partially cooked animal food such as lightly cooked fish, rare meat, soft-cooked eggs that are made from raw shell eggs, and meringue
- Raw seed sprouts (including alfalfa, clover and radish)
- Home-canned foods
- Any foods prohibited under the Virginia Department of Health Food Regulations or updated versions of The Food Code.

Handling Food Product Recalls

AAAs, nutrition service providers, and subcontractors shall develop and implement policies and procedures that include information on responding to Food Recall Notices. Procedures to consider include:
- Developing and completing a food recall action checklist.
- Identifying the recalled food product.
- Counting the recalled product in inventory.

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[21] 12 VAC 5-421-270, Food Regulations, Department of Health, Virginia Administrative Code
[22] 12 VAC 5-421-260, Food Regulations, Department of Health, Virginia Administrative Code
[23] 12 VAC 5-421-280, Food Regulations, Department of Health, Virginia Administrative Code
[24] 12 VAC 5-421-950, Food Regulations, Department of Health, Virginia Administrative Code
[25] 22 VAC 30-60-240, Grants to Area Agencies on Aging, Department for Aging and Rehabilitative Services Regulations, Virginia Administrative Code.

- Identifying where and how to segregate the recalled food.
- Placing warning labels on the segregated food product.
- Notifying staff not to use the segregated food product.
- Counting the amount of recalled food product already used.
- Accounting for the entire recalled food product by consolidating counts for product used and product in inventory.
- Obtaining information needed for public communications; whether the product was served, to whom it was served, and the date served.

Handling Foodborne Illness Outbreaks

AAAs, nutrition service providers, and contractors shall make reasonable efforts to avoid problems with food product contamination and with food borne illnesses through their food purchasing specifications and buying practices; product receiving and storage procedures; and food handling and delivery practices.

In the event of a complaint that a client became sick from a food and/or beverage they consumed from their home delivered meal, the AAA, service provider, and contractor shall have policies and procedures in place to handle the suspected outbreak.

Complete information such as the following on the suspected outbreak should be gathered:

- Name, address, and telephone number of the person reporting;
- Who became ill and what were their symptoms;
- Was the illness diagnosed by a physician (get the physician's name and contact information);
- What specific foods and/or drinks were consumed (save samples if any of the food remains);
- What was the day and time the food was eaten;
- Who was the person who served or provided the food, if any;
- Other relevant information concerning the time, date, or circumstances of the suspected outbreak.

Outbreaks of suspected foodborne illness shall be reported to the local health department immediately for investigation and AAAs, service providers, and subcontractors shall cooperate fully in the investigation.

Administrative Elements

Staff Qualifications

Individuals responsible for the direction of Nutrition Services shall possess the following minimum qualifications:

- Knowledge: Biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; community resources; public benefits eligibility requirements; food and nutrition; safe food handling; and disease prevention and health promotion
- Skills: Management and supervisory principles; transportation and meal delivery route scheduling, if appropriate; program planning; establishing and sustaining interpersonal relationships; problem solving.
- Abilities: Communicate with persons with varying socioeconomic backgrounds; work independently.

Job Descriptions[26]

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of nutrition services staff duties and responsibilities; 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 DARS-VDA-approved client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Meals (required for the DARS-VDA-approved client database) – The number of NSIP eligible home delivered meals served; see Definitions and Nutrition Services Incentive Program
- Non NSIP Meals (required for the DARS-VDA-approved client database) – The number of fee for service home delivered meals served that are not eligible for NSIP reimbursement
- Persons Served (unduplicated) – The number of persons who received home delivered nutrition services; see "Eligible Population"

Program Reports

- Aging Monthly Report (AMR) to DARS-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.
- DARS-VDA-approved client database client level data transmitted to DARS-VDA by the last day of the following month.

Consumer Contributions/Program Income There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.[27]

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service only for recipients of the general fund (state funds) program.[28] Cost sharing/fee for service does not pertain to meals that receive Nutrition Services Incentive Program (NSIP), Title III, or any Federal monies. Any fee for service charge to the client under the Fee for Service program shall be determined by the applicable sliding fee scale.

Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited for this service, provided that the method of solicitation is non-coercive.[29]

For voluntary contributions, the AAA shall consult with the relevant service providers and older individuals in the planning and service area to determine the best method for accepting voluntary

[26] 22 VAC 30-60-400, Grants To Area Agencies On Aging, Department for Aging and Rehabilitative Services Regulations, Virginia Administrative Code

[27] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[28] Older Americans Act of 1965, as amended, Section 315(a)

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

contributions. The AAA and service providers shall not means test for any service for which contributions are accepted, or deny services to any individual who does not contribute to the cost of the service. The AAA shall ensure that each service provider will:

- Provide each recipient with an opportunity to voluntarily contribute towards the cost of the service;
- Clearly inform each recipient that there is no obligation to contribute and that the contribution is purely voluntary;
- Assure that the method of solicitation is non-coercive;
- Protect the privacy and confidentiality of each recipient with respect to the recipient's contribution or lack of contribution;
- Establish appropriate procedures to safeguard and account for all contributions; and
- Use all collected contributions to expand the service for which the contributions were given.[30]

Nutrition Services Incentive Program (NSIP)

Home-Delivered Nutrition Services providers receiving Older Americans Act funds may participate in the Nutrition Services Incentive Program (previously USDA Commodity Food/Cash Distribution Program).

To be counted as an eligible meal, and therefore, receive NSIP reimbursement, the following requirements must be met:

- The person receiving a meal must meet eligibility requirements under Older Americans Act
- The client or other eligible individual must be assessed using Part "A" Uniform Assessment Instrument, "Determine Your Nutritional Health" Nutrition Screening Checklist, and Federal Poverty/DARS-VDA Sliding Fee Scale (unless all information needed to determine federal poverty is documented on UAI).
- The client may make a donation, but cannot be charged for the meal, means tested for participation, or asked for a cost-share
- The AAA or service provider shall have a record keeping system that tracks frequency of participation and generate unduplicated count information (match the client's name with their meal)
- The meal must meet DRI nutrient requirements and Dietary Guidelines defined above
- Snacks and partial meals cannot be counted as a "meal" for reporting purposes
- Home Delivered Meals programs are authorized to offer two- and even three-meal-a-day programs and each meal can be reported for reimbursement purposes
- Cash disbursements received under the Nutrition Services Incentive Program shall only be used to purchase United States agricultural commodities and other foods for their nutrition projects.[31]

Home delivered meals provided under the National Family Caregiver Support Program (Title III-E, Supplemental Services) can be counted as NSIP meals if they are provided to the older care recipient, a caregiver over the age of 60, or a caregiver under the age of 60 who is the spouse of the care recipient. If the meal is provided to a caregiver under age 60 who is not a spouse, Title III-E, Supplemental Services funds may be used but the meals are not NSIP eligible meals.

Quality Assurance

[30] Older Americans Act of 1965, as amended, Section 315(b)
[31] Older Americans Act of 1965, as amended, Section 311(d)(2)

Home delivered nutrition services shall be provided with the advice and expertise of (1) a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services, (2) meal participants, and (3) other individuals knowledgeable with regard to the needs of older individuals.[32]

Criminal Background Checks
Language is still being developed.

Staff Training

- At hiring, staff involved with providing and assessing for nutrition services shall receive orientation on agency and nutrition services policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Workers shall receive a minimum of 10 (ten) documented hours of in-service or other training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities. This may include participant donations, safe food handling, taking and recording food temperatures, and what to do if meal temperatures are not in compliance.
- All individuals, including volunteers, that prepare and/or serve food will receive training in personal hygiene, hand washing, health policies, and safe food handling
- All individuals, including volunteers, who deliver meals and document temperatures, will receive training in taking and recording food temperatures and what to do if meal temperatures are not in compliance. Written materials are acceptable for volunteers.

Individuals responsible for the direction of Nutrition Services and/or AAA designee involved with nutrition services and/or meals subcontractor must receive and maintain certification in safe food handling. Central kitchens will abide by the Virginia Department of Health Food Regulations.

Supervision
Consultation and supervision shall be available to all staff providing the service. All staff working in the preparation of food must be under the supervision of a person qualified to ensure the application of hygienic techniques and practices in safe food handling, preparation, and service.

Program Evaluation
The agency must develop a written program evaluation plan to conduct regular systematic analysis of the persons served and the impact of the service. Evaluation may include client surveys for program planning and menu input. Surveys should be compiled and summarized in a format reporting how the data gathered will be used to improve services.

Local caterers and companies that provide subcontracted meal preparation, as well as organizations to which the entire program is subcontracted, shall be monitored at least annually. There shall be a written policy that includes: content of monitoring (such as use of DARS-VDA Monitoring Instrument), frequency, and reporting back to the subcontractor especially on any corrective action(s) recommended and carried out.

[32] Older Americans Act of 1965, as amended, Section 339

Policies and Procedures

The AAA and service provider must maintain, at the minimum, the following policies and procedures:

- Offering home delivered meals to spouses and other eligible individuals
- Use of Nutrition Screening results
- Service Termination Policy
- Collection, disposition and accounting for program income, including safeguarding and accounting for donations
- Weather related emergencies and other situations that affect service delivery
- Ill or injured client
- Employee health and hygiene
- Required meal temperatures
- Handling potentially hazardous food items that do not meet temperature standards
- Procedures for volunteers who deliver meals
- Cleaning and sanitizing
- Program evaluation plans, including monitoring of subcontractors
- Liquid Nutrition Supplements (if applicable)

Service Records

Service documentation that will be maintained according to AAA record retention policy (but not less than one year), includes, but is not limited to:

- Documentation that identifies meal recipients and number of meals received
- Records of temperature checks
- Documentation of nutrition education
- Current Health Department permit or inspection report, if issued
- All menus from all vendors with nutrient analysis or meal pattern worksheet

Client Records

AAA and/or service providers must maintain specific client records in the approved DARS-VDA electronic database that include:

- Part "A" Uniform Assessment Instrument
- "Determine Your Nutritional Health" Nutrition Screening Checklist
- Federal Poverty documentation. The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the DARS-VDA-approved electronic client database.
- Care Plan (optional, but if completed must be documented in the DARS-VDA-approved client electronic database.)
- Service reassessment
- Consent to Exchange Information, if information is shared with other agencies

The AAA or service provider must maintain the following additional records:

- Service confirmation
- Cost Sharing (Fee for Service), if applicable, calculations must be part of the client record. The Federal Poverty/DARS-VDA Sliding Fee Scale form may be used.
- Appeal process

HOMEMAKER
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES (DARS) SERVICE STANDARD

Definition
Homemaker services provide assistance to persons with the inability to perform one or more of the following activities of daily living: preparing meals, shopping for personal items, managing money, using the telephone or doing light housework.[1]

Eligible Population
Homemaker services are targeted to persons 60 years of age or older who are frail, have disabilities, or who are at risk of institutional placement. Priority shall be given to persons who are in the greatest economic or social need and/or residing in rural or geographically isolated areas, with particular attention to low-income minority individuals and individuals with limited English proficiency.[2]

Service Delivery Elements
The Area Agency on Aging (AAA) must perform all of the following components of homemaker services:

Service-Specific Assessment:
A service-specific assessment using Part A of the Uniform Assessment Instrument shall be performed by the Area Agency on Aging on each potential client to determine whether the individual is eligible for the service, the amount of the individual's service-specific need, and the individual's level of priority for service delivery.

- 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.

Care Plan:
A written individualized care plan must be developed by the Area Agency on Aging that identifies the service components to be provided to meet the client's assessed need. The plan must be developed prior to service commencement with involvement from the client or an authorized representative or family member. When "client" is used throughout the standards, it can also mean authorized representative or family member, as deemed appropriate by the agency and/or the client. The client shall be afforded the opportunity to participate in the implementation and evaluation of the plan. The plan may be modified to reflect any change in the client's needs. Each plan must include:

- identified service needs
- services to be delivered by the service provider or other sources
- goals and objectives of service to be provided
- the quantity of service units to be provided

[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)

Service Agreement:
A service agreement shall be completed between the client and the service provider. If the Area Agency on Aging is the service provider, the AAA will complete the service agreement. A copy of the Service Agreement will be maintained at the Area Agency on Aging. The agreement will explain the service arrangement to the client. The client shall receive a copy of the agreement. The agreement shall include:

- services to be provided
- scheduled hours and days of service
- information regarding voluntary contributions
- emergency contacts
- severe weather policy

Service Activities:
Service activities provided by the provider agency may include:

- Basic housekeeping and home management skills necessary to ensure safe, sanitary conditions in the client's home, such as dusting, vacuuming, sweeping and mopping. Housekeeping is performed only for the client;
- Instructing client in home management, including maintaining an orderly environment, proper food storage, preparation of shopping lists, meal planning and preparation;
- Shopping assistance with or without client;
- Personal laundry and mending of clothing;
- Client transportation may be provided only when other transportation services are unavailable and for scheduled appointments. Need must be clearly documented. Routine transportation is not permitted.

Client assistance may include:

- Assistance with eating, including set up, opening containers, and cutting food. Feeding is not permitted.
- Assistance with bathing of areas that the client cannot reach. Bed baths or transferring are not permitted.
- Assistance with dressing of ambulatory clients, such as the fastening of clothing on the client. Lifting or putting on braces or other supports is not permitted.
- Assistance with personal grooming, such as combing hair, brushing dentures and shaving with an electric razor. Cutting nails or shaving with a blade is not permitted;
- Supportive assistance with ambulation, such as providing stabilization to the client while walking. Lifting and transferring are not permitted.

Service Record:
A service record or log, signed by the client, shall record the date and duration of each time the service is provided. The service record or log shall be maintained at the Area Agency on Aging. Service units must be recorded in the approved DARS electronic data reporting system.

Service Reassessment:
A review of the client's need for services, the amount of services provided and the appropriateness of the care plan shall be performed by the Area Agency on Aging when the client's condition or situation changes, but at least annually.

- Federal Poverty Level 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 Termination Policy:
Homemaker services can be terminated at the discretion of the Area Agency on Aging, the service provider or the client. The client shall receive a copy of the termination policy when service begins. The policy shall have provisions for: appropriate advance notice to client, preferably of ten business days; a service summary, and referrals to other community service programs, as appropriate.

Administrative Elements

Area Agency on Aging Staff Qualifications:

- Knowledge: Area Agency on Aging staff should have an awareness of the biological, psychological, and social aspects of aging; an awareness of the impact of disability and illness on aging, and a knowledge of community resources and consumer rights.
- Skills: Area Agency on Aging staff should have skills in establishing and sustaining interpersonal relationships and in problem solving.
- Ability: Area Agency on Aging staff should have the ability to communicate with persons of different socioeconomic backgrounds and to work independently and in groups. Staff should have the ability to determine specific household tasks necessary to improve the environment and living conditions of the client.

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

- A current and complete job description which shall cover the scope of a the staff member's duties and responsibilities, and
- A current description of the minimum entry-level standards of performance for each job.

Service Provider Staff Qualifications:

- Knowledge: Service provider staff should have an awareness of the biological, psychological, and social aspects of aging; an awareness of the impact of disability and illness on aging, and an awareness of community resources and consumer rights.
- Skills: Service provider staff should have skills in establishing and sustaining interpersonal relationships and in assessing what skills and equipment are essential to performing needed household tasks.
- Ability: Service provider staff should have the ability to perform household tasks needed by the client.

Units of Service:
Units of service must be reported in the approved DARS data system for each client receiving the service. Service units can be reported by a client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours spent assessing the need for, arranging and delivering homemaker services for the client.)
- Persons served (unduplicated)

Program Reports**:**

- Aging Monthly Report (AMR) to DARS by the twelfth (12th) of the following month. If the Area Agency on Aging supports the homemaker 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 DARS by the last day of the following month.
- A completed and properly maintained electronic/digital Part A of the Uniform Assessment Instrument (UAI) is a mandatory requirement.
- The question "Client in Federal Poverty?" (Answer Yes or No) must be asked and recorded.
- A written Policies and Procedures Manual must be maintained for the service.

Consumer Contributions/Program Income:
The Area Agency on Aging shall formally adopt written policies and procedures, approved by the agency's governing board, regarding the collection, disposition, and accounting for program income.[3] There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.

Cost Sharing:
An Area Agency on Aging is permitted to implement cost sharing for recipients of this service.[4]

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.[5]

Quality Assurance

Criminal Background Checks:
DARS strongly recommends that the agency and its contractors protect their vulnerable older clients by conducting criminal background checks for staff providing any service when said staff goes to or into a client's home.

[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[4] Older Americans Act of 1965 as amended 2006, Section 315(a)
[5] Older Americans Act of 1965 as amended 2006, Section 315(b)

Staff training:
Each homemaker service provider agency providing the above mentioned service activities shall comply with the following:

- At hiring, homemakers should receive orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting the allowable activities under this service;
- All homemakers shall have a minimum of 16 hours basic training within the first year of employment; training topics should include, but are not limited to ethics and confidentiality in patient care, home safety precautions, working with diverse populations, and home management.
- Workers should receive a minimum of 8 hours per year of in-service training 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.
- The Case Monitor Section for this service must be completed in the approved DARS electronic data system

Program Evaluation:
The Area Agency on Aging should conduct regular and systematic analysis of the persons served and the impact of the service.

- Service providers must be monitored annually. A written copy of the monitoring report must be maintained by the agency.
- Anonymous client surveys shall be conducted annually. A file of annual anonymous client surveys with a summary of the surveys shall be maintained by the agency.

Client Records:
Area Agencies on Aging must maintain specific program records in the approved DARS electronic data system that includes:

- Part A of the Uniform Assessment Instrument
- Federal Poverty Level
- Care Plan
- Service Reassessment, as needed
- Progress Notes
- Consent to Exchange Information Form
- A Caregiver Form, if this service is funded by OAA Title III E.

Area Agencies on Aging are to maintain the following additional client records:

- Service plan/documentation, including any fee charged the client
- Signed Client Bill of Rights/ Appeals Process
- Denial or Termination of Service Notice

Homemaker
FAQ's

1. **Are certain activities prohibited to homemaker service providers?**
   Yes, providers should consult the Virginia Department for the Aging Service Standards to make sure they are knowledgeable about prohibited activities.

2. **Is training required for homemaker service staff?**
   Yes, at hiring, homemakers should receive orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting the allowable activities under this service. All homemakers shall have a minimum of 8 hours per year of inservice training after completing the first year of employment. Training programs that provide certification must comply with the guidelines of the Homecare University.

3. **The VDA Homemaker Service Standard states that homemaker training that provides Certification must comply with training guidelines as established by the National HomeCaring Council. Where can I find information about this organization?**
   In 1986, the National Association for Home Care merged with the National Homecaring Council, which became part of the NAHC's related Foundation for Hospice and Home Care. For further information on this organization, please consult its website at www.nahc.org.

IDENTIFICATION DISCOUNT
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition
Provision to persons 60 years of age and older of a card which verifies their age and which can be used as identification to cash checks and to obtain discounts for goods and services.

Eligible Population
Persons 60 years of age and older. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements
Agencies providing an Identification/Discount service must perform all of the following component:

Assessment: The process of identifying, analyzing, and prioritizing the needs of older persons, utilizing the Virginia Service – Quick Form and other client assessment documents. Federal Poverty/VDA Sliding Fee Scale is required, unless all information needed to determine federal poverty is documented on Virginia Service – Quick Form.

Card: The process of issuing an identification/discount card to persons 60 years of age and older.

Administrative Elements
Staff Qualifications:
Staff qualifications for the Identification/Discount service shall be established by Area Agency on Aging policy.

Job Descriptions:
For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on aging shall maintain:
- A current and complete job description which shall cover the scope of a I.D. Discount staff duties and responsibilities; and
- A current description of the minimum entry-level standards of performance for each job.[2]

Units of Service:
Units of service must be reported in AIM for each client receiving services. Services units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.
- The number of cards issued to an individual.

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[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)
[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

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 client level data transmitted to VDA by the last day of the following month.

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.[3]

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[4]

And/or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[5]

Quality Assurance

Staff Training:

- Identification/Discount Program staff should receive orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Identification/Discount Program staff should receive a minimum of 10 hours in-service training, the content of which to be 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.

Program Evaluation:

The agency shall conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Client Records:

Service providers must maintain specific program records that include:

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- 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.

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[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[4] Older Americans Act of 1965, as amended, Section 315(a)

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

Identification/Discount Program
Frequently Asked Questions

1. Q - Who is eligible to participate in Area Agency on Aging identification/discount programs?

   A - Individuals must be age 60 and older.

2. Q - Is there a cost for the identification/discount card?

   A - No, although voluntary contributions are appreciated.

3. Q - What should I present to receive the identification/discount card?

   A - You should provide verification of your age and identity, such as a birth certificate, a driver's license or Social Security card.

LEGAL ASSISTANCE
VIRGINIA DEPARTMENT FOR THE AGING

SERVICE STANDARD[1]

(Effective 1/1/09)

I. SERVICE PROVIDED

Legal Assistance funded by Title III-B of the Older Americans Act (OAA)

II. DEFINITIONS

"**Legal Assistance**" as defined in the Older Americans Act --

(A) means legal advice and representation provided by an attorney to older individuals (60 years of age and older) *with economic or social needs; and*

(B) includes--

(i) to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and

(ii) counseling or representation by a nonlawyer where permitted by law.

Public Law 109-365, §102(33) enacted 10/17/06[2]

In Virginia, "Legal Assistance" also may include –

Outreach to those in greatest social or economic need targeted under the Older Americans Act, education, group presentations and training designed to protect the legal rights of older adults using materials developed under the direct supervision of an attorney.

Terms used in the OAA definition of Legal Assistance have the following meanings:

- "Attorney" means: A lawyer licensed and authorized by the Virginia State Bar to practice law in the Commonwealth of Virginia.
- "Nonlawyer" means: A person who is not a licensed attorney, but who is specifically permitted by federal or state law to provide limited counseling or representation (for example representation in Social Security administrative hearings and certain other public benefit hearings).
- "Economic Need": The OAA does not define this term, but it does define

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1 If you have questions about anything contained in this Standard, please contact the Legal Services Developer at the Virginia Department for the Aging

2 All sections of the Older Americans Act as Amended in 2006 {Public Law (P.L.) 109-365} referenced in this Standard can be found on both the Administration on Aging and The Center for Social Gerontology web sites: http://www.aoa.dhhs.gov/OAA2006/Main_Site/oaa/oaa_full.asp and http://www.tcsg.org/law/2006OAACompleteComp.pdf

"Greatest Economic Need" as *" … the need resulting from an income level at or below the poverty line."* (P.L. 109-365, §102(23),(43))

* "Social Need": The OAA does not define "social need," but it does define "Greatest Social Need" as *"… the need caused by non-economic factors, which include –*
  (A) physical and mental disabilities;
  (B) language barriers; and
  (C) cultural, social, or geographical isolation, including isolation caused by racial or ethnic status, that –
  (i) restricts the ability of an individual to perform normal daily tasks; or
  (ii) threatens the capacity of the individual to live independently.
  P.L. 109-365, §102(24)

"**Unduplicated Client":** The US Administration on Aging requires states to report the numbers of "unduplicated" persons served with OAA funds. For legal assistance, this means the number of different individuals who received legal assistance from the legal provider during a federal fiscal year. For the "unduplicated count," a client is counted only once for the year regardless of how many times the client returned that year for assistance on either the same or different legal issues. Thus the number of "cases" handled by a legal provider is often greater than the number of "unduplicated clients."

III. ELIGIBLE POPULATION

As defined in the OAA, Legal Assistance is for *persons aged 60+ "in social or economic need*." The Act further specifies that services be particularly targeted to older individuals: with greatest economic need; with greatest social need; at risk for institutional placement; with limited English proficiency; low-income minority older individuals; and, those residing in rural areas. (See for example, P.L. 109-365, §306(a)(4)). In Virginia, residents of long-term care facilities are also a very important group to be targeted for legal assistance.

However, while the Act requires that these groups be particularly targeted for service, mechanisms to achieve targeting may not include the use of a means test. Allowable and effective mechanisms to achieve targeting without means testing include strategic outreach to specific target groups of older persons and/or persons who work with them, and focusing on particular types of legal issues that reflect the most critical and basic needs of the target populations, for example public benefits, housing, and long term care.

IV. SERVICE DELIVERY ELEMENTS

A. TYPES OF LEGAL ASSISTANCE PROVIDERS

Legal assistance must be provided by an attorney or by a paralegal/law student

under the direct supervision of a licensed attorney. The Act calls for Area Agencies on Aging (AAAs) to select as their legal assistance provider the entity that is best able to provide the targeted legal services described in the Act. Examples of things to consider in selecting the "best entity," include such things as the capacity of the provider to:

- Protect the autonomy, dignity and independence of vulnerable older persons;
- Focus outreach and service on those in the greatest social and economic need – often those least able to advocate on their own behalf;
- Foster cost-effective, high quality legal services, having maximum impact on those in greatest social and economic need and their most critical legal needs;
- Assist vulnerable older persons in preventing legal problems through education and outreach; and
- Be accessible throughout the Planning and Service Area (PSA), particularly to the target populations specified in the OAA.

See the OAA, P.L. 109-365, §307(a)(11) for required contract provisions or contact the State Legal Services Developer at VDA for technical assistance (see Footnote 1).

AAAs can accomplish this through one, or a combination, of the following methods:

1. CONTRACT WITH A LEGAL AID FUNDED BY LEGAL SERVICES CORPORATION (LSC).
   This means that the AAA contracts with an existing licensed local legal aid program that is funded by the LSC and operates in accordance with Federal law.

2. CONTRACT WITH A LEGAL AID NOT FUNDED BY LSC.
   This means that the AAA contracts with an existing licensed local aid program that is not funded by the LSC. In this case, the OAA requires the Legal Aid not funded by LSC to coordinate services with any existing LSC-funded program in the area (usually a different local legal aid program) in order to maximize the use of limited OAA Title III-B funds.

3. STAFF ATTORNEY HOUSED IN AAA:
   This means an attorney employed by the AAA who provides legal assistance directly to older clients in social or economic need. In this case, the OAA requires coordination of services with an existing LSC-funded program (usually a local legal aid program) in order to maximize the use of limited OAA Title III-B funds. It is important that, under this model, the attorney not serve as in-house counsel to the AAA. Further, under the OAA, the AAA would need a waiver from VDA in order for the AAA staff attorney to provide direct service to clients.

4. CONTRACT WITH A PRIVATE ATTORNEY.
   This means that the AAA contracts with a private attorney to provide legal assistance to older clients in social or economic need. In this case, the

OAA requires coordination of services with an existing LSC-funded program (usually a local legal aid program) in order to maximize the use of limited OAA Title III funds.

5. CONTRACT WITH A LAW SCHOOL CLINICAL PROGRAM.
   If an AAA is considering a law school, please contact the Legal Services Developer at VDA (see Footnote 1)

In all cases where practical, an attempt should be made to involve the private bar in legal assistance activities, including groups within the private bar willing to furnish legal assistance to older adults on a pro bono or reduced fee basis.

B. PRIORITY SERVICES:

The Older Americans Act uses the term "priority services" in two ways.

First, it designates legal assistance services as one of three priority services (access, in-home, and legal) that in the absence of a waiver from VDA, must be funded by every AAA. At a minimum, each AAA must fund each of the priority services at a base level established by VDA. The current base level for Virginia is 1% of Title III-B allocated funds. However, AAAs are permitted and encouraged to increase the base level as appropriate.

(P.L. 109—365 §306(a)(2), §307(a)(2)(C))

Second, the Act addresses the types of legal issues that are to receive priority in delivering services. It requires that in funding legal assistance services, area agencies *"… give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination."*

(P.L. 109—365 §307(a)(11) (E))

C. OUTREACH TO TARGET GROUPS, EDUCATION, TRAINING & PRESENTATIONS:

Recognizing that OAA III-B resources are inadequate to meet the legal needs of all older persons, legal assistance services must be particularly targeted to older persons in greatest economic and social need. The OAA specifies a number of target groups, with emphasis on low-income older persons, low-income minority older persons, older persons with limited English proficiency, and those residing in rural areas. Often, the target populations don't recognize their problems as being legal in nature and don't know where or how to access affordable legal services. Further, they are often the least able to advocate on their own behalf, while they are the most difficult to reach and serve. Targeted outreach and strategic education/presentations on critical legal issues affecting the most vulnerable older persons are essential to effective targeting. This type of outreach and education is best achieved through joint planning by the AAA and legal provider and coordinating efforts to conduct outreach and education. Qualified individuals will conduct outreach, education and training, and legal training materials will be developed under the direct supervision of an attorney.

D. PROHIBITED SERVICES:

Legal Assistance will not be provided for:

- Any criminal matter;
- Any civil action involving post criminal conviction relief;
- Any action concerning euthanasia or abortion;
- Any strike, boycott, picketing or demonstration; or
- Any illegal activity.

See 42 United States Code §2996e; 42 United States Code §2996f and 42 United States Code (USC) §14404.

Further, the OAA Regulations (Title 45 Code of Federal Regulations (CFR), §1321.71(g)-(k)) include prohibitions specific to III-B legal assistance providers and the use of III-B legal assistance funds. These include:

- Providing legal assistance in fee-generating cases, with certain exceptions (45 CFR §1321.71(g));
- Engaging in specified prohibited political activities (45 CFR §1321.71(h));
- Engaging in lobbying activities as described in the Regulation (45 CFR §1321.71(i));
- Participating in any public demonstrations, boycotts, etc. as described in the Regulation (45 CFR §1321.71(j));
- Paying dues exceeding $100 to any organization (other than a bar association) that engages in the above prohibited activities (45 CFR §1321.71(k)).

V. ASSESSMENT:

The Virginia Service Quick Form (July 2008)[3] is used for legal assistance services. Federal poverty should be determined and documented on this form.

A. ADMINISTRATIVE/REPORTING ELEMENTS

1. UNITS OF SERVICE DEFINED:
   As used *here, "unit of service" is for reporting purposes only, not for billing purposes*. Under the Administration on Aging NAPIS reporting system, a unit of service for legal assistance is one hour. What this means is that each hour of providing legal assistance (including such things as case preparation, legal research, drafting documents, preparing materials for outreach/community education, conducting the outreach/education, etc.) is equal to the corresponding number of "units."

2. PROGRAM REPORTS:

[3] The Virginia Service Quick Form was revised in July 2008 to make clear that name, address and telephone numbers are not permitted for Legal Assistance and Elder Abuse Services. In order to protect client confidentiality and the attorney-client relationship, a unique number (or numbers and letters) should be used to track services and outcomes.

Information to be reported is captured at three different points: (a) at client intake; (b) at case closing; and (c) when special outreach/community legal education activities are conducted.

(a) At Client Intake: At the time of client intake, a client- specific assessment should be performed to capture information relevant to targeting and needed for reporting. This includes:
- Client demographics/characteristics such as age, gender, ethnicity, race; and
- The type of legal issue on which the client is seeking assistance.

(b) At Case Closing: Information to be captured at the time of case closing includes:
- The type of legal issue on which service was provided to the client;
- The outcome of the service for the client; and
- The total number of hours ("units") spent by the provider on the client's case.

(c) When Special Outreach/Community Legal Education Activities are Conducted: Information to be captured will include:
- Dates and locations of outreach and educational activities;
- Type of outreach conducted or topic of educational presentation;
- Specific groups targeted by the outreach or types of persons attending the educational activity;
- Estimated number of people reached through the outreach or educational activity;
- Estimated number of hours spent in preparation, travel, and conduct of the outreach or educational activity.

3. INFORMATION REPORTED TO VDA & DUE DATES

The information that must be reported by AAAs to the Virginia Department for the Aging (VDA) includes:
- Number of "Unduplicated" Clients/Persons Served. *See the definition of "unduplicated" under roman numeral II above.*
- Number of Hours/"Units of Service" provided. *See definition of "unit of service" under V.A.1. above.*

Due Dates: Aging Monthly Report (AMR) must be submitted monthly to VDA by the 12th day of the following month. Client level data must be transmitted to VDA by the last day of the following month.

Optional Group Units cannot be entered into AIM/NWD tools but may be reported on the AMR Optional Unit Report. These include:
- Group Participants – Number of people attending a presentation, meeting or program provided to more than one person.
- Group Presentations – Number of education/training group presentations on legal assistance topics.

B. QUALITY ASSURANCE & CAPACITY

1. LEGAL ASSISTANCE PROVIDER/STAFF QUALIFICATIONS:
   AAAs are to select as their legal providers, the entity that best meets certain capacity criteria that are important to quality assurance. Examples of important elements of quality assurance include:
   - All attorneys are licensed to practice law in the Commonwealth of Virginia and adhere to the Virginia Rules of Professional Conduct and all professional regulatory requirements to practice law in the Commonwealth;
   - Program staff (including attorneys and paralegals) have experience in serving older adults, and knowledge and understanding of legal issues most critical to those in greatest social and economic need;
   - Programs have mechanisms in place to protect against conflict of interest and to assure client confidentiality.

2. CRIMINAL BACKGROUND CHECKS:
   VDA strongly recommends that the agency and its contractors protect their vulnerable older clients by conducting criminal background checks for staff providing any service where they visit or enter a client's home.

3. STAFF TRAINING:
   At a minimum, legal provider staff must meet continuing legal education requirements to practice law in the Commonwealth. In addition, they should have sufficient training to remain current on the most critical legal issues affecting older persons in greatest economic or social need.

4. PROGRAM EVALUATION (BEST PRACTICE RECOMMENDATION):

   The agency should conduct regular and systematic analysis of the persons served and the impact of the service. Service providers should be monitored annually. Evaluation may include client satisfaction surveys.

5. RECORDS:

   The AAA or service provider must maintain specific program documentation that includes:

   - A unique identifier for each client served (e.g. case number)
   - Virginia Service Quick Form or electronic data equivalent
   - Service provided and case outcome if applicable

Acknowledgment
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LONG-TERM CARE COORDINATING ACTIVITIES
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Provides for the active participation of the Area Agency on Aging staff on local long-term care coordinating committee(s), i.e., in the planning and implementation of a coordinated service delivery system to insure the development and delivery of an adequate supply of home- and community-based services to assist older persons to avoid or delay unnecessary institutionalization, and to assure maximum efficiency and cost-effectiveness in the delivery of those services.

Eligible Population

Not applicable

Service Delivery Elements

Agencies conducting Long-Term Care Coordinating Activities must perform the following components:[1]

Active participation on long-term care coordinating committees and other groups and organizations involved in the development and delivery of long-term care services, such as interagency task groups, planning councils, Medicaid Pre-admission Screening Teams, and other interagency activities aimed at planning and coordinating new or existing services.

Administrative Elements

Staffing:

- As established by AAA policy

Units of Service:

- hours of participation

Program Reports:

- AMR (Aging Monthly Report) due by the 12th of the 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.
- Annual program performance report

Allowable Costs:

Costs associated with activities of this service are allowable

[1] Older Americans Act of 1965, as amended, Section 304(d)(1)(A)

Quality Assurance

Staff Training:

- (**Initial**) in-depth orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- (**On-going**) at least annual in-service training, the content of which to be based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Case Review:

- Not applicable

Program Evaluation:

The area agency on aging should conduct a regular systematic analysis of the persons served and the impact of the service.

Records:

- Minutes of meetings of local long-term care coordinating committee.

MEDICATION MANAGEMENT
DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
VIRGINIA DIVISION FOR THE AGING
SERVICE STANDARD

Definitions

Medication Management Services refer to the following activities:

Medication management: Information and education that helps older citizens understand how to take prescription, over-the-counter (OTC), and herbal medications in a safe and proper manner including following the regimen provided by their physician or pharmacist. Includes information about the use of devices (pill boxes, pill cutters, timers, etc.) that assist persons to take their medications properly.

Medication screening: Referral of older citizens to a physician or pharmacist for information and assistance with their medications. May include invitations to pharmacists to provide this information on an individual basis and/or in group settings.

Medication education: Provision of information to older citizens about prescription, OTC, and herbal medications including common side effects, the dangers of mixing medications, and other issues related to medication management and screening. May include the development of brochures, videos, or other materials or resources that provide information about, or assistance with, the proper management of prescription, OTC, and herbal medications.

Eligible Population

Medication management Services are targeted to persons 60 years of age or older. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low- income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement.

Service Delivery Elements

Program Requirements

The purpose of this program is to encourage older persons to communicate with their physician(s) and pharmacist about medications and to provide services to prevent medication misuse and adverse medication reactions. Services may be provided directly to older persons. Information and/or training about medication management may also be provided to family members, friends, and health care and human services professionals who work with or come into contact with older persons.

Assessment

- If the client does not already have an assessment in the VDA-approved electronic client database, a Virginia Service – Quick Form is required for each person who participates in a medication management program activity where individual hours will be entered into the client database.

- Use of the Virginia Service – Quick Form is recommended, but not required, if there are only group hours or contacts that will not be entered into the VDA-approved electronic client database.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA-approved electronic client database.
- Any fee for service charge to the client shall be determined by the applicable sliding fee scale. The Federal Poverty/VDA form may be used.

Administrative Elements

Staff Qualifications

Whenever possible, the Area Agency on Aging or service provider shall utilize health experts and other community resources to provide services. When AAA or service provider staff is used, they shall possess the following minimum qualifications:

- Knowledge: Biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; community resources; public benefits eligibility requirements; disease prevention and health promotion; medical conditions; learning styles of older adults.
- Skills: Establishing and sustaining interpersonal relationships; problem solving; designing educational materials; public speaking.
- Abilities: Communicating with persons with varying socioeconomic backgrounds; working independently.

Job Descriptions

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of medication management services staff duties and responsibilities; 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 VDA-approved client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (individual) – The number of hours spent one-to-one providing medication management services to the individual senior, family member, or caregiver.
- Persons served (unduplicated) - The number of persons who are provided with the service and who receive individual hours.

Individual Hours - Service activities provided to a specific individual; individual hours are required for the VDA-approved client database.

Optional Group Units (Not entered into the VDA-approved client database)

- Group Participants – The number of people attending the presentation, meeting, or program (activity provided to more than one person or in a group setting).
- Number of Group Presentations – The number of programs on medication management topics.

Group Units – These activities cannot be entered into the VDA-approved client database. They are reported on the Optional Units page of the AMR.

Program Reports

- Aging Monthly Report (AMR) is due 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.
- Client level data from the VDA-approved electronic database shall be transmitted to VDA by the last day of the following month.

Consumer Contributions/Program Income

There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.[1]

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing /fee for service for recipients of this service.[2]

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

Quality Assurance

Staff Training

- At hiring, staff shall receive orientation on agency and departmental policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Workers shall receive a minimum of 10 hours of in-service or other training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

[1] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

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

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

Supervision
Consultation and supervision shall be available to all staff providing the service.

Program Evaluation
The AAA shall conduct regular and systematic analysis of the persons served and the impact of the service, with findings used as a basis for planning and implementing changes in program goals, procedures and resources. There shall be a written plan and a written report of findings. Evaluation may include client satisfaction surveys.

The AAA or service provider must maintain specific client records in the approved VDA electronic database that include:

- Consent to Exchange Information, if information is shared with other agencies.
- Virginia Service - Quick Form, if required. At a minimum, this form must be updated annually.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA-approved electronic client database.

The AAA or service provider must maintain the following additional records:

- Documentation that the service took place.
- Cost Sharing (Fee for Service) calculations, if applicable. The Federal Poverty/VDA Sliding Fee Scale form may be used.

MONEY MANAGEMENT
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Money Management service is assisting eligible older persons in making decisions and completing tasks necessary to manage day-to-day financial matters. The objective of money management services is to enable older persons to maintain financial stability, thereby promoting their well being, independence and self-determination, while protecting their interests and rights.

Eligible Population

Money Management services are targeted to persons 60 years of age or older who are in the greatest economic and social need, with preference given to low-income minority individuals and those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements

The Area Agency on Aging or service provider must perform all of the following components of money management services:

Assessment

The process of identifying, analyzing and prioritizing the needs of older persons utilizing the Virginia Service – Quick Form and other client assessment documents.

- 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.

A service specific assessment shall be performed on each potential client, which determines:

- Whether the person meets the criteria specified in eligible population
- Identifies the person's service-specific needs
- What level of priority for service delivery the person meets

Service Plan

A written individualized service plan shall be developed (with client input) which identifies the service activities to be provided for the client in response to established need. The plan is to be established prior to service commencement by the service provider. The service plan shall include:

- Identified service needs
- Services to be delivered
- Goal(s) and objective(s) of service(s)
- Service unites to be provided

[1] Older Americans Act of 1965 as amended, Section 306(a)(4)(A)(i)

Service Agreement

A service agreement shall be completed between the older person and the service provider. Both must sign the agreement and the older person must receive a copy. The service agreement shall:

- Explain the service activities to be provided
- List scheduled hours/days of service provision
- Provide information regarding voluntary contributions/fees
- Explain emergency procedures

Independence Encouragement

It is important to elicit the older person's participation in Money Management activities to the greatest extent of their capabilities. Making lists of things for the client to do between visits can be helpful. Using difference colors of paper for different types of tasks can also help the client with organizing. If only some bills are a problem, the client should continue to handle those that are not. For example, the client may always pay the rent on time, but cannot manage other bills. The client should continue to pay the rent, therefore, while the service provider handles the other bills. The provider shall record evidence of this activity in the client record.

Service Activities

Service activities provided may include performing or providing assistance with:

- Budget set-up and monitoring
- Establishing a checking and/or savings account
- Arranging direct deposit for all income sources
- Making bank deposits
- Planning, organizing, and managing bill payment
- Writing checks for client's signature for bill payment
- Making cash transactions/change
- Checkbook balancing
- Bank statement reconciliation
- Organizing and managing Medicare benefits reconciliation
- Organizing and managing Medicare supplemental insurance benefits reconciliation
- Organizing and managing long-term care insurance benefits reconciliation
- Organizing and managing other health/medical insurance benefits reconciliation
- Organizing and managing and any other insurance (e.g. homeowners, renters, automobile, etc.) benefits reconciliation

Prohibited Activities Include

- Any activity related to being a "credit services business," i.e., receiving any form of payment for:
    - Improving a consumer's credit report, history or rating
    - Obtaining an extension of credit for a consumer
    - Providing advice or assistance to a consumer with regard to either of the previous two items.
- Managing or giving advice on investments, trusts, etc.
- Income tax preparation, completion and/or filing

- Maintaining possession of an older person's money for man than 48 hours
- Any activity related to appointment as Power of Attorney

Documentation
Service provision shall be recorded following each time service is provided.

Reassessment
A reassessment of the older person's continued need for service(s), the amount of service(s) provided and the appropriateness of the service plan shall be performed annually, or when the older person's condition/situation changes.

Administrative Elements
Termination
Service will be terminated at the discretion of the provider. Written notifications of service termination shall be mailed 10 business days prior to the date the action is to become effective.

Staff Qualifications
Staff qualifications for the Money Management service shall be established by AAA and/or provider policy and shall include:

- Knowledge of:
  - Biological, psychological and social aspects of aging
  - Impact of disabilities and illnesses on aging
  - Community resources and consumer rights
  - Sound money management practices
- Skill in:
  - Establishing and sustaining interpersonal relationships
  - Planning, organizing and managing financial matters
  - Analyzing and solving problems
  - Advocacy
  - Negotiation
- Ability to:
  - Communicate with persons of diverse socio-economic backgrounds
  - Work independently
  - Allow the older person to participate in money management activities to the greatest extent of their capabilities

Job Descriptions
For each paid and volunteer position funded by Title III of the Older American's Act, an Area Agency on Aging shall maintain:

- A current and complete job description which shall cover the scope of an Money Management services staff duties and responsibilities
- A current description of the minimum entry-level standards of performance for each job.[2]

[2] 22VACS5-20-250 Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

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

- Individual hours
- 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 client level data transmitted to VDA by the last day of the following month.

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.[3] There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.[4]

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[5]

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.

Allowable Costs
Incurred costs shall conform to cost principals and other applicable federal and state regulations and shall be attributable to the specific service activities.

Quality Assurance

Criminal Background Checks:

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

[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[4] Older Americans Act of 1965, as amended, Section 315(b)
[5] Older Americans Act of 1965, as amended, Section 315(a)

Staff Training

- **(Initial)** in-depth orientation on agency policies and procedures, community characteristics and resources and procedures for delivering allowable activities under this service.
- **(On-going)** a minimum of ten (10)hours of in-service or other training per year, the content of which shall be based on the need for professional growth and upgrading of knowledge, skills and abilities.

Supervision

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

Program Evaluation

- The agency should conduct regular systematic analysis of the persons served and the impact of the service.
- Subcontractors shall be monitored annually.

Monitoring:

Annually each MM client's financial records will be reviewed by a person independent of program supervision and program service delivery with review findings documented.

Records

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- Federal Poverty documentation and Cost Sharing (Fee for Service) calculations must be part of the client record. The Federal Poverty/VDA Sliding Fee Scale form may be used.
- Service plan
- Service agreement
- Service delivery documentation; progress reports
- Independence encouragement of documentation
- Consent to Exchange Information form as necessary
- Reassessment documentation
- Termination documentation as necessary
- Program evaluation
- Supervision documentation
- Monitoring documentation

FAQ'S
Money Management

1. Are there any activities that are prohibited?

Yes, there are.

- Any activity related to being a "credit services business".
- Managing or giving advice on investments, trusts, etc.
- Income tax preparation, completion or filing
- Maintaining possession of an older person's money for more than 48 hours
- Any activity related to appointment as guardian or Power of Attorney

2. How does the client know what type of services to expect?

A service agreement shall be completed between the older person and the service provider. Both must sign the agreement and the older person must receive a copy. The service agreement shall:

- Explain the service activities to be provided
- List scheduled hours/days of service provision
- Provide information regarding voluntary contributions/fees
- Explain emergency procedures.

3. What type of reports are required? How often?

The Aging Monthly Report (AMR) is due by the 12th of each 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 client data transmitted to VDA by the last day of the following month.

OPTIONS COUNSELING
VIRGINIA STATEWIDE STANDARDS

Title: Options Counseling Statewide Standards

1.0 Introduction

1.1 Guiding Principles

A. Options Counseling involves respecting the right of individuals to control and make choices about their own lives.

B. Relationship-building and establishing trust are essential to understanding individuals' preferences and needs; counselors must take time to listen and use culturally competent, person-centered approaches.

C. Options Counseling is a process, not an event. It may include multiple contacts over a short-term period, or may be ongoing over a longer period of time.

1.2 Definitions

Individual Action Plan: A documented plan developed by the individual with the support of the Options Counselor as a result of Options Counseling that contains the individual's goals, along with the action steps, resources needed, time lines and responsible parties to achieve the goals.

Individual Support Record: Documentation, by an agency offering Options Counseling, that captures the information required in Section 5.1 (B) through (D) of these Standards. The record may be written or electronic and may incorporate processes and documentation tools already in place or may be a form used exclusively for Options Counseling.

Options: All alternatives that are available in an individual's community from which the individual can choose to reach the individual's goal/s.

Options Counseling: An interactive decision-support process whereby individuals, with support from family members, caregivers, and /or significant others, are supported in their deliberations to make informed long-term support choices in the context of the individual's preferences, strengths, needs, values, and individual circumstances.

Options Counselor: Any individual who provides Options Counseling as described in these Standards. Care coordinators, transition coordinators, peer counselors, case managers and others, who have been trained in the standards, may provide Options Counseling.

Person-Centered Practices: Practices that focus on the preferences and needs of the individual, empower and support the individual in defining the direction for his or her life, and promote self-

determination, community involvement, contributing to society and emotional, physical and spiritual health.

Surrogate Decision-Maker: A person legally authorized to make decisions on behalf of an individual who has been declared legally incapacitated**.**

Unit of Service: The number of contacts (interactions), and the time spent in hours or portions thereof, with and on behalf of each individual. The hours shall be recorded in 15-minute increments

1.3 Eligible Individuals

A. Options Counseling is available to all individuals age 18 and over with a disability and to adults age 60 and over who request long-term supports and/or who are planning for the future regarding long-term supports.

B. Individuals are eligible for Options Counseling regardless of their ability to pay.

2.0 Awareness, Education, Outreach and Marketing

A. Agencies providing Options Counseling shall use statewide universal language to raise awareness, provide education, and/or actively market the availability of Options Counseling to the following, within the agencies' local or regional services areas:

1. Adults 60 and older; and adults 18 and older who have a disability;
2. Individuals residing in hospitals and other institutional settings;
3. Family members, caregivers and supporters;
4. The general public;
5. The medical community, including hospitals;
6. Administrators and staff of long-term support facilities;
7. Long-term support ombudsmen;
8. Providers of long-term community supports and other local agencies having regular contact with older adults and/or individuals with disabilities;
9. Social workers;
10. Health and human services agencies;
11. Local government officials and policy makers; and
12. Advocates and advocacy organizations.

B. Awareness and education activities shall include both outreach and response to inquiries for information.

C. Awareness, education and marketing activities shall be directed both to individuals who pay privately, and to individuals who cannot pay.

D. An agency providing Options Counseling shall identify key partners to assure streamlined eligibility and access to federal, state and local supports and work collaboratively with them to develop an overall Options Counseling implementation strategy.

3.0 Supports Delivery Elements

3.1 Initiating the Options Counseling Process

A. The situational elements that can trigger Options Counseling include, but are not limited to:

1. A life altering personal event or situation;
2. A significant change in the individual's circumstances;
3. Concerns expressed by the individual or the individual's family member or surrogate decision-maker;
4. A life transition;
5. A referral or self-referral to Options Counseling; and/or
6. Availability of new benefits and supports.

B. During an eligible individual's initial contact with the agency, the situational elements that trigger Options Counseling can be identified by use of a standardized questionnaire and response to the following questions:

1. Do you understand the information I have given you? (if "no," refer to Options Counseling; if "yes," ask next question);
2. Do you need additional information? (if "yes," refer to Options Counseling; if "no," ask next question);
3. Do you know what your next steps are? (if "no," refer to Options Counseling; if "yes," do not refer to Options Counseling).

C. Options Counseling is initiated by:

1. The request of an eligible individual or the individual's surrogate decision-maker; or
2. The consent of an eligible individual who is offered Options Counseling or the consent of the individual's surrogate decision-maker.

D. Agencies shall assure that no eligible individual is excluded from Options Counseling.

1. Agencies may set fee schedules that are designed to assure maximum participation of eligible individuals in Options Counseling.
2. Agencies shall assure that Options Counseling is coordinated with any applicable points of entry into support systems.

3. Agencies shall assure that individuals receive and have access to the agency's existing bill of rights and grievance procedures.

3.2 Providing Options Counseling

A. Options Counselors shall actively encourage the eligible individual to involve others, who provide support to the individual, in the Options Counseling process.

B. Options Counselors shall involve the eligible individual and all others the individual wishes to involve in Options Counseling except as follows:

1. When the individual declines to have other individuals present at any point in the counseling, the Options Counselor shall respect the individual's wishes.
2. If the individual has been declared legally incapacitated, the Options Counselor shall require that the individual's surrogate decision-maker be present through all phases of Options Counseling.

C. Options Counselors must make every effort to understand each individual's preferences, needs, values and circumstances by:

1. Developing rapport and trust with the individual;
2. Listening to the individual;
3. Understanding that no two individuals have exactly the same preferences, needs, values or circumstances;
4. Using person-centered practices; and
5. Using a series of questions and scenarios that assist the individuals in evaluating options.

D. The following information must be provided during Options Counseling, dependent upon the individual's unique needs, values and circumstances:

1. Existing long-term support options available in the individual's community tailored to the individual and including information about the individual's current situation;
2. Planning ahead for long-term support;
3. Understanding self-directed and agency-directed supports, and the differences between the two;
4. Medicare and Medicaid benefits and options; and
5. Other supports and benefits available in the individual's community including:
    a. Informal supports;
    b. Social security benefits;
    c. Financial and legal planning resources;
    d. Older adult or disability rights resources;

e. Housing and transportation resources;

f. Opportunities for employment or volunteering;

g. Social and recreational resources;

h. Communication and assistive technology resources; and

i. Caregiver support.

E. The following support, as applicable, shall be provided to the individual while the individual is considering and making decisions:

1. Honoring requests for additional information;
2. Providing Options Counseling in the environment that the individual chooses;
3. Using the method or mode of communication that the individual uses and prefers;
4. Explaining potential risks, consequences and costs of each available option;
5. Exploring alternatives and arranging on-site or virtual tours;
6. Coordinating transportation or giving the individual the information to coordinate transportation;
7. Helping the individual articulate his or her own values, needs and preferences;
8. Listing options, as requested, and their consistency with the individual's stated goals;
9. Clarifying roles of the individual and the Options Counselor; and
10. Providing information and facilitating decision-making at a pace appropriate to the individual.

F. Decisions made as a result of Options Counseling shall be made by the individual or the individual's surrogate decision-maker. The Options Counselor shall respect the individual's right to make decisions that entail a certain amount of risk and shall take action to prevent an individual from engaging in risky behavior consistent with legal requirements.

G. The Options Counselor shall work with the individual to develop an individual action plan for implementing the decisions made as a result of Options Counseling.

3.3. Implementing and Following up Decisions Made as a Result of Options Counseling

A. The Options Counselor shall arrange for delivery of the supports chosen by an individual as a result of Options Counseling, involving others as needed to get the supports fully in place by:

1. Assisting with referrals; and
2. Conducting follow up to assure referrals are in place and adequate for the individual's support.

B. The Options Counselor shall assist the individual to make an effective transition to the supports that the individual has chosen by:

1. Contacting the individual and conducting other follow-up as necessary to verify referrals made;
2. Determining whether the referrals were implemented effectively; and
3. If adjustments are needed, supporting the individual in determining the best alternative course of action.

C. Once the supports are in place:

1. The Options Counselor shall follow up to determine the extent to which the individual's goals have been met.
2. Agencies shall also follow up using a uniform instrument, administered in the method or mode of communication that the individual uses and prefers, to measure individuals' satisfaction with the Options Counseling process and the choices the individual has made.

D. Evaluation for the purpose of quality improvement/quality assurance and program compliance shall be conducted on three levels:

1. System-wide;
2. Agency, in accordance with Section 4.5 A. below; and
3. Individual, using the following domains:
   a. Choice (Whether the individual was in charge of plan that is developed);
   b. Heard (Individual's perspectives, values and preferences were understood and respected);
   c. Supports (Whether the individual received supports needed towards accomplishing their goals);
   d. Informed (Whether the individual was given comprehensive information about options available at the time); and
   e. Autonomy (Whether the individual was empowered to make his or her own decisions)

E. Options Counseling may be terminated when an individual:

1. Is no longer seeking support;
2. No longer has unmet goals;
3. After six months has not responded when contacted;
4. Has exhausted an appeals process and there is a finding that termination is necessary; or
5. Is dissatisfied and the Options Counselor has no further alternatives available to the individual.

F. An individual shall be re-engaged in Options Counseling at any point he or she indicates a desire to pursue additional support options.

4.0 Staffing

4.1 Core competencies

A. Staff who determine the need for Options Counseling must :

1. Have training in the statewide protocol set out in section 3.1 B. of these Standards; and
2. Demonstrate accurate use of the protocol.

B. Agency staff who deliver Options Counseling must have training in the statewide Options Counseling curriculum and be able to:

1. Understand individuals' unique preferences, values, needs and circumstances;
2. Understand and educate individuals about public and private sector resources;
3. Facilitate knowledge of informal supports and self-direction;
4. Encourage future orientation and goal-setting;
5. Follow up after Options Counseling is complete; and
6. Communicate with sufficient skill and clarity, using the individual's preferred mode of communication, so that individuals will be able to make informed choices.

4.2 Staff Roles

A. The following agency staff shall be able to determine an individual's need for Options Counseling:

1. Staff who typically have initial contact with individuals, family members, caregivers and/or health and human service providers who contact the agency;
2. Staff who typically provide transition assistance to individuals; and
3. Staff who provide benefits counseling, assist in determination of eligibility or otherwise facilitate the delivery of supports.

B. An agency providing Options Counseling shall have a minimum of one staff who delivers, and is held out to the public as delivering, Options Counseling.

4.3 Credentials

A. Staff who determine the need for Options Counseling shall have the following minimum qualifications:

1. Good listening, interviewing and communication skills;

2. Knowledge of the issues confronting older adults and individuals with disabilities; and
3. Successful completion of the statewide training module in determining the need for Options Counseling.

B. Staff who deliver Options Counseling shall have the following minimum qualifications:

1. Bachelor's degree, or equivalent experience as determined in writing by the hiring agency;
2. At least one year of experience working directly with older adults and/or individuals with disabilities;
3. Knowledge about long term supports and funding systems;
4. Knowledge about the issues confronting older adults and individuals with disabilities;
5. Good listening, interviewing and communication skills; and
6. Successful completion of the statewide Options Counseling training curriculum.

4.4 Continuing Training

Agencies providing Options Counseling shall require successful completion of an annual statewide Options Counseling best practices training to ensure that staff who deliver Options Counseling have appropriate decision-support skills and knowledge about available resources.

4.5 Monitoring and Supervision

A. Agencies providing Options Counseling shall implement ongoing monitoring to ensure that:

1. Options Counseling is delivered in accordance with these standards; and
2. The outcomes of Options Counseling can be tracked and measured for evaluation.

B. Agencies providing Options Counseling shall implement ongoing supervision for all staff involved in determining the need for and delivering Options Counseling.

C. Options Counseling supervisors must have training in the Options Counseling administration curriculum and must possess the experience or educational training to oversee staff development, program management, program planning, policy/procedural maintenance, and program evaluation.

4.6 Staffing ratios

Agencies providing Options Counseling shall assure that staff who determine the need for and who deliver Options Counseling have sufficient time to devote to their Options Counseling duties.

5.0 Administrative

5.1 Individual support records

A. Individual support records shall be maintained for each individual receiving Options Counseling.

B. Staff who determine the need for Options Counseling shall document the following information in the individual support record:

1. Person making the original contact and relationship to the individual who receives Options Counseling (self, family member, surrogate decision-maker, caregiver, health or human service provider, other);
2. Situation that triggered Options Counseling;
3. The individual's demographic profile;
4. The individual's preferred contact information;
5. The individual's or surrogate decision maker's permission to share information with an Options Counselor; and
6. The date of referral to Options Counseling.

C. Staff who deliver Options Counseling:

1. Shall document the following information in the individual support record:
   a. The date the initial contact was made by the Options Counselor;
   b. Whether the individual is new to Options Counseling or is reengaging in Options Counseling and if reengaging, the reason why;
   c. Others involved in Options Counseling, their relationship to the individual and contact information;
   d. The individual's preferred method or mode of communication and preferred environment for Options Counseling;
   e. The individual's relevant current circumstances, which may include:
      i. Paid and informal supports;
      ii. Employment/ financial resources and benefits;
      iii. Financial/legal plan for future;
      iv. Housing;
      v. Transportation;
      vi. Social and recreational activities; and
      vii. Assistive technology;

f. The options discussed with the individual including alternative supports and, if the individual requests it, the risks and benefits of each;

g. The individual's action plan reflecting the individual's preferences, needs, values, personal goals/desired outcomes, and definition of success; decision/s made by the individual or the surrogate decision-maker; referrals made by name, date and type of support; and confirmation of implementation of the plan, including enrollment or other evidence of actual receipt of any support to which the individual was referred; and

h. Progress notes referencing each interaction, including the date of contact.

2. Are encouraged to document the individual's future projected immediate, intermediate and long term support needs.

D. Staff who provide follow-up shall document the following information in the individual support record:

1. The date contact is made with the individual;
2. The outcome of the follow up;
3. Whether the individual's goals have been achieved, are unmet or have changed; including what supports the individual received, ;
4. Whether the individual has followed the plan, and, if not, the reason why; or whether the individual needs direct assistance to continue implementing the plan; and
5. The date and reason for termination of Options Counseling.

5.2 Data collection and reporting

A. The agency shall collect the following data on an individual basis and report it on an aggregate level:

1. Demographics of individuals served;
2. Level of individual satisfaction with the Options Counseling process (Choice, Heard, Supports, Informed, and Autonomy) and other evaluation measures such as individual satisfaction with choices and decisions made;
3. Number of individuals, whose goals include living in the community, and who are living in the community six months and 12 months following termination of Options Counseling;
4. Number of individuals:
   a. Provided Options Counseling;
   b. Terminated from Options Counseling; and
   c. Reengaged in Options Counseling; and
5. Number of individuals achieving their goals.

PERSONAL CARE
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES (DARS) SERVICE STANDARD

Definition

Personal Care services provide personal assistance, stand-by-assistance, supervision or cues for persons with the inability to perform one or more of the following activities of daily living: eating, dressing, bathing, toileting, grooming, transferring in and out of bed/chair or walking.[1]

Eligible Population

Personal Care services are targeted to persons 60 years of age or older who are frail, have disabilities, or who are at risk of institutional placement. Priority is given to persons in the greatest economic or social need and/or who reside in rural or isolated areas, with particular attention to low-income minority individuals and limited English proficient individuals.[2]

Service Delivery Elements

The Area Agency on Aging (AAA) or service provider must perform all of the following components of personal care services:

Service-Specific Assessment:

A service-specific assessment utilizing the full Uniform Assessment Instrument (UAI) must be performed by the Area Agency on Aging on each potential client to determine whether the person meets the criteria specified in eligible population and the amount of the individual's service specific need.

- 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.

Care Plan:

A written individualized care plan must be developed by the Area Agency on Aging that identifies the service components to be provided to the client in response to established need. The plan must be developed prior to service commencement by the Area Agency on Aging with involvement from the client or authorized representative or family member. When "client" is used throughout the standards, it can also mean authorized representative or family member, as deemed appropriate by the agency and/or the client. The client shall be afforded the opportunity to participate in the implementation and evaluation of the plan. The plan may be modified to reflect any change in the client's needs. Each plan shall include:

- identified service needs
- services to be delivered by the service provider and/or by other sources
- goal(s) and objective(s) of service(s) to be provided
- service units to be provided

[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)

Service Agreement:
A service agreement shall be completed between the client and the service provider. If the Area Agency on Aging is the service provider, the AAA will complete the service agreement. A copy of the service agreement will be maintained at the Area Agency on Aging. The agreement will explain the service arrangement to the client. The client must receive a copy of the agreement. The agreement should include:

- services to be provided
- scheduled hours/days of service
- information regarding voluntary contributions/payment for service
- emergency procedures (what to do/who to contact)
- severe weather policy

Service Activities:
Service activities provided by the provider agency may include:

- assisting with care of teeth and mouth
- assisting with grooming, to include care of hair, shaving, and ordinary care of nails
- assisting with bathing of individual in bed, in tub, or shower, or sponge bath
- assisting individual with dressing and undressing
- assisting individual to move on/off bed pan, commode or toilet
- assisting individual to turn/change position, transfer, and ambulate
- assisting individual with eating or feeding
- assisting individual with self-administered medications and assuring that individual receives medications at prescribed times; not to include pouring or, in any way, determining dosage of medication
- preparing/serving meals, not to include menu planning for special diets

And services as permitted by the licensing entity, and the Virginia Department of Medical Assistance Services if a Medicaid provider.

Service Record:
Service documentation on each client must be in accordance with the requirements of the agency's certifying entity. A service record or log, signed by the client shall record the date and duration of each time the service is provided. The record or log shall be maintained at the Area Agency on Aging. Service units must be recorded in the appropriate electronic data system.

Service Reassessment:
A review of the client's need for services, the amount of services provided and the appropriateness if the care plan shall be performed by the Area Agency on Aging when the client's condition or situation changes, but at least annually. Service reassessment on each client shall also be in accordance with the requirements of the agency's certifying entity.[3]

- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

[3] Older Americans Act of 1965, as amended, Section 314

- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.

Service Termination Policy:
Personal Care services can be terminated at the discretion of the Area Agency on Aging, the service provider, or the client. The client shall receive a copy of the termination policy when service begins. The policy shall have provisions for: appropriate advance notice to the client, preferably ten business days; a service summary and, referrals to other community service programs. Requirements of the licensing agency should be followed.

Administrative Elements

Licensure:
Personal Care providers, including Area Agencies on Aging and their contractors, must be licensed by the Virginia Department of Health.

Area Agency on Aging Staff Qualifications:

- Knowledge: Area Agency on Aging staff should have an awareness of the biological, psychological, and social aspects of aging; an awareness of the impact of disability and illness on aging and, a knowledge of community resources and consumer rights.
- Skills: Area Agency on Aging staff should have skills in establishing and sustaining interpersonal relationships and in problem solving.
- Ability: Area Agency on Aging staff should have the ability to communicate with persons of different socioeconomic backgrounds and to work independently and in groups. Staff should have the ability to assess functional limitations and determine necessary tasks to ensure the safety and well-being of the client.

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

- A current and complete job description which shall cover the scope of a the staff member's duties and responsibilities, and
- A current description of the minimum entry-level standards of performance for each job.

Service Provider Staff Qualifications:

- Knowledge: Service provider staff should have an awareness of the biological, psychological, and social aspects of aging; an awareness of the impact of disability and illness on aging and an awareness of community resources and consumer rights.
- Skills: Service provider staff should have skills in establishing and sustaining interpersonal relationships and in assessing what skills and equipment are essential to performing needed personal care services.
- Ability: Service provider staff should have the ability and training required to perform personal care services as needed by the client.

Job Description:
For each paid position, the service provider shall maintain:

- A current and complete job description which shall cover the scope of a personal care worker's duties and responsibilities, and
- A current description of the minimum entry-level standards of performance for each job.

Service provider agencies shall meet or exceed all personnel requirements as set forth by the provider agency's certifying entity.

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 by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (All hours spent assessing the need for; and, arranging and delivering personal care services for the client)
- Persons served (Unduplicated)

Program Reports:

- Aging Monthly Report (AMR) to DARS 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 DARS 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.
- A written Policies and Procedures Manual will be maintained for the service.

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.[4] There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations.

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service. A fee scale for personal care services shall be updated annually and shall include the full cost of providing one unit of service.

Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive. Such contributions shall be

[4] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

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.[5]

Quality Assurance

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

Staff training:

- At hiring, personal care workers should receive orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting allowable activities under this service;
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- Workers shall receive a minimum of twelve (12) hours per year of in-service training based on the need for professional growth and upgrading of knowledge, skills, and abilities. In addition, training policies of the licensing agency should be followed.

Service providers shall meet or exceed all requirements for staffing as set forth by the provider agency's certifying entity.

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 completed in the approved DARS electronic data system.

Program evaluation:
The agency or contractor should conduct regular and systematic analysis of the persons served and the impact of the service.

- Service providers shall be monitored annually. A written copy of the monitoring report must be maintained by the agency.
- Anonymous client surveys shall be conducted annually. A file of annual anonymous client surveys with a summary of the surveys shall be maintained by the agency.

Client Records:
Area Agencies on Aging are to maintain specific client records in the approved DARS electronic database that include:

- Full Uniform Assessment Instrument
- Federal Poverty Level
- Care Plan
- Service Reassessment, as needed
- Progress Notes
- Consent to Exchange Information Form

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

- A Caregiver Form, if this service is funded by OAA Title III E.

Area Agencies on Aging are also to maintain the following additional client records:

- Service documentation, including any fee charged the client
- Signed Client Bill of Rights/ Appeals Process
- Other forms as required by the provider's certifying entity.
- Denial or Termination of Service Notice

Service providers shall meet or exceed all record requirements as set forth by the provider agency's certifying entity.

Personal Care
FAQ's

1. **What activities can be performed when providing personal care?**
   Service activities listed in the Virginia Department for the Aging Personal Care Service Standard or services listed in the Department of Medical Assistance Services or other services as noted by the provider's certifying body.

2. **What activities should be included in the time reported for personal care services?**
   All hours spent in assessing the need for; and, arranging and delivering personal care services for the client.

PREPARATION AND ADMINISTRATION OF THE AREA PLAN
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Encompasses the overall planning and implementation of the Area Plan and management of the agency, as well as the lead role for providing a coordinated and comprehensive system for older persons to locate and access needed services.

Service/Administrative Elements

Preparation and Administration of the Area Plan includes all of the following components:[1]

- Monitoring, evaluating, and commenting on policies, programs, hearings, levies, and community actions that affect older persons and their families.
- Soliciting comments from the public on the needs of older persons and their caregivers.
- Representing and advocating for the interests of older persons to local level and executive branch officials, public and private agencies and organizations.
- Coordinating plans and activities with all other public and private organizations with responsibilities affecting older persons and their caregivers.
- Promoting new or expanded benefits and opportunities for older persons and their caregivers.
- Planning, including such responsibilities as needs assessment; plan development, budgeting analysis, inventory, standards development and policy analysis.
- Development includes such responsibilities as resource development, training and education, and research and development activities.
- Administration includes such responsibilities as bidding, contract negotiation, reporting, accounting, auditing, program monitoring, and quality assurance.

Staffing Elements

Staff Qualifications:

- Knowledge: Should have an awareness of the basic principles including budget preparation and administration; current issues, trends, and problems in aging; service planning; advocacy strategies; consumer rights; community resources; public benefits eligibility and principles of record management.
- Skills: Should have skills in establishing and sustaining productive relationships; leading and effectively managing personnel; negotiating with consumer and service providers; coordinating the provision of services by diverse public and private providers.
- Ability: Agency managers should have the ability to communicate with persons of different socio-economic and ethnic backgrounds; work independently, performing position duties under general supervision; work as a team member, maintaining effective inter- and intra-agency working relationships; and communicate effectively, verbally and in writing.

Job Descriptions

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging shall maintain:

[1] Older Americans Act of 1965, as amended, Section 304(d)(1)(A)

- A current and complete job description which shall cover the scope of duties and responsibilities of the position; and
- A current description of the minimum entry-level standards of each job.[2]

Quality Assurance

Staff Training

- Administration staff should receive in-depth orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Administration staff should receive at least annual in-service training, the content of which to be based on the need for professional growth and upgrading of knowledge, skills and abilities.
- Administration staff must attend training provided by the Virginia Department for the Aging

Program Evaluation

The agency should conduct regular systematic analysis of the persons served and the impact of the service.

Records

Record keeping and documentation should comply with guidelines established by the Virginia Department for the Aging.

Units of Service

Not applicable

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.

Allowable Costs

Cost for Preparation and Administration of the Area Plan may not exceed the limits prescribed by 45 CFR 1321.

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[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

FAQ'S
Preparation and Administration

1. What is the definition of Prep and Admin?

Prep and Admin encompasses the overall management and supervisory functions of the Area Plan, as well as the lead role for providing a coordinated and comprehensive system for older persons to locate and access needed services.

2. What is the match for Prep and Admin?

75% federal, 25% non-federal.

3. What is the maximum you can spend of your Title III funding?

Can spend up to 10% of federal award, but must come from Title III B, III CI, III C2 or E.

PUBLIC INFORMATION/EDUCATION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Public Information/Education service is the process of informing older persons and the general public about the programs, services, and resources available to elderly persons and their caregivers. Service activity involves a contact with several elderly clients or potential clients (group services). The service may incorporate the development of special information campaigns to inform older people and the general public about issues, problems and benefits important to older people.

Eligible Population

Individuals are eligible for Public Information/Education service if they are 60 years of age or older. Preference shall be given to older individuals with greatest economic need or older individuals with greatest social need, with preference given to low-income minority individuals, and to those older persons residing in rural or geographically isolated areas.[1] Families, friends and referral sources may also receive information and suggestions for needed services.

Service Delivery Elements

Agencies providing Public Information/Education service must perform all of the following components:

Information: The process of informing older persons and the general public of available opportunities, services and resources. This may be done by preparing and distributing agency newsletters, brochures, facts sheets, and resource guides; making presentation to community groups; and preparing and distributing media releases and public service announcements.

Electronic Media: The process of receiving and soliciting information via the Internet and e-mail.

Planning and Evaluation: The process of aggregating and analyzing information collected through the provision of the service. Collecting and reporting data on unmet needs are also part of the service delivery element. There should be an evaluation process to determine the overall effectiveness of the program.

Administrative Elements

Staff Qualifications: Staff proving Public Information/Education service shall possess the following qualifications:

- Knowledge: Public Information/Education service staff should have an awareness of the problems and needs of older persons; community resources for older persons; community organizations who may wish to schedule presentations or receive written information; community media resources; group dynamics; how to reach older people in the community; basic journalistic writing techniques; and desktop publishing, brochure preparation, etc.

[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

- Skill: Public Information/Education service staff should have skills in interviewing; working with groups; effective oral and written communication techniques; an overview of community services; preparation of audio-visual materials; lay-out of written materials.
- Ability: Public Information/Education service staff should have ability to conduct an effective interview; arrange and negotiate service referrals; communicate effectively orally with groups of persons, with persons of different socio-economic backgrounds, including persons with disabilities; write creatively, using correct grammar, spelling, and punctuation; and work independently.

Job Descriptions:
For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on aging shall maintain:
- A current and complete job description which shall cover the scope of duties and responsibilities of service staff; and
- A current description of the minimum entry-level standards of each job.[2]

Units of Service:
- Contacts: the number of people in a group or circulation counts for a publication.

Optional Group Units (Not Entered into AIM)
- Group Participants – The number of people attending the presentation, meeting or program (activity provided to more than one person or in a group setting).
- Number of Group Presentations – Number of presentations.
- Number of Publications Distributed

Group Units – These activities cannot be entered into the AIM system.

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.

Quality Assurance
Staffing Training:
- Staff should receive orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting the allowable activities under the service.
- Staff should receive a minimum of 10 hours of in-service training per year, the content of which to be 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.

[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

Program Evaluation:
The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Service Records:
Service providers must maintain specific program records that includes;

- compilation of presentations conducted year-to-date;
- the number of publications distributed year-to-date;
- compilation of individual contacts year-to-date.

REGISTERED DIETITIAN NUTRITIONIST SERVICES
VIRGINIA DEPARTMENT FOR AGING AND REHABILITATIVE SERVICES
VIRGINIA DIVISION FOR THE AGING
SERVICE STANDARD

Definition

The Older Americans Act (OAA) requires that meal providers utilize the expertise of a dietitian or other individual with equivalent education and training in nutrition science, or if such an individual is not available, an individual with comparable expertise in the planning of nutritional services;[1] and ensure that the project provides for nutrition screening and nutrition education, and nutrition assessment and counseling if appropriate.[2]

The Administration on Aging defines nutrition counseling as the provision of individualized guidance to persons who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illness, or medication use; or to their caregivers. Nutrition counseling is provided one-to-one by a registered dietitian nutritionist (RDN), and addresses the options and methods for improving nutrition status.

In order to meet the OAA requirements for nutrition counseling, each Area Agency on Aging (AAA) nutrition program must create a policy on how this OAA requirement will be met. The AAA must employ or retain the services of a RDN through a contract or a partnership agreement. The program RDN must be available to the program in sufficient time to perform nutrition counseling and other nutrition related responsibilities, as determined by the AAA.

Credentials/Qualifications

Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) is an individual who has:

- completed the minimum of a Baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent;
- met current minimum academic requirements (Didactic Program in Dietetics) as approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- completed a supervised practice program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- successfully completed the Registration Examination for Dietitians;
- complied with the Professional Development Portfolio (PDP) recertification requirements.

[1] Older Americans Act of 1965, as amended through P.L. 114-144, enacted 4-19-2016, Section 339 (A) (1)2 Older Americans Act of 1965, as amended through P.L. 114-144, enacted 4-19-2016, Section 339 (A) (2) (J)
[2] https://nutritionandaging.org/wp-content/uploads/2017/01/DetermineNutritionChecklist.pdf

In addition, it is preferred that the RDN have work experience or specialized training in gerontology or geriatrics, and the planning and supervision of food and nutrition services in home and community-based or facility-based settings.

Individual of Comparable Expertise

If a Registered Dietitian is not available through reasonable recruitment means, the AAA may use an individual with comparable expertise in the planning of nutrition services.

Individuals with comparable expertise will be defined as follows:

- An individual who has completed a minimum of a bachelor's degree at a US regionally accredited university or college and course work accredited or approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics, or

- A dietetic technician, registered (DTR), who has met the following criteria to earn the DTR credential:
    - Completed a dietetic technician program accredited by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics, that includes 450 hours of supervised practice experience in various community programs, health-care and foodservice facilities and has completed at least a two year associate's degree at a U.S. regionally accredited college or university, or
    - Completed an ACEND accredited didactic program or coordinated program in dietetics and has completed at least a bachelor's degree at a U.S. regionally accredited college or university or foreign equivalent, and
    - After completing the degree and dietetics coursework, passing a national examination administered by the Commission on Dietetic Registration (CDR), and
    - Completed continuing professional educational requirements to maintain registration status.

Either category of individual with comparable expertise shall be expected to have work experience or specialized training in gerontology or geriatrics, and the planning and supervision of food and nutrition services in home- and community-based or facility-based settings.

Individuals who are not considered to have comparable expertise are nurses, dietary managers, dietary supervisors, chefs, cooks, diabetes educators, home economists, food service managers, food service sanitarians, or extension agents unless they also meet one of the two sets of criteria listed above for individuals with comparable expertise.

Eligible Population

Nutrition services will be available to older individuals and to their caregivers, and may be made available to individuals with disabilities who are not older individuals but who reside in housing

facilities occupied primarily by older individuals at which congregate nutrition services are provided.[3]

Nutrition Screening, Nutrition Assessment and Nutrition Counseling Service Delivery Elements

Screening

Screening is used to identify characteristics associated with dietary or nutrition deficiencies, and to differentiate those at high risk for nutrition related deficiencies who should be referred for further assessment or counseling.

The "Determine Your Nutritional Health" Nutrition Screening checklist developed and distributed by the Nutrition Screening Initiative must be completed during assessment and re-assessment for both congregate and home delivered meal services. This screening can be self-administered or conducted by anyone that interacts with older adults. It highlights the warning signs of poor nutritional status.

Questions to which the client answers "YES" may trigger the staff to ask additional questions regarding the client's nutritional health. The results of the Nutrition Screening checklist guides the following actions:

Score of 0-2 = Low nutritional risk; no further action needed at this time.

Score of 3-5 = Moderate nutritional risk; based on the answers to the questions, may need further screening or referral to community based resources; refer as appropriate.

Score of 6-10 = High nutritional risk; based on the answers to the questions, may need further screening or referral to a health care provider, social services, an RDN or other community based resources; refer as appropriate.

Score of 11 or higher and a "Yes" answer to question 9, "Without wanting to, I have lost or gained 10 pounds in the last 6 months," requires a referral to the AAA's RDN. In addition to other service requirements, AAA staff or contractors must also complete page 5 of the Uniform Assessment Instrument (UAI) as part of the RDN referral and maintain this additional documentation in the DARS approved client database. If the individual accepts the referral for nutrition counseling, then the RDN must complete page 6 of the Uniform Assessment Instrument (UAI) and maintain this additional documentation in the DARS approved client database. The RDN may use additional malnutrition screening and assessment tools.[4] If the client refuses individual nutrition counseling, this must be documented within the program notes in the DARS approved client database.

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[3] Older Americans Act, as amended through P.L. 114-144, enacted 4-19-2016, Section 339(A) (2) (I)

[4] A list of such tools can be found at: https://www.ncoa.org/assesssments-tools/malnutrition-screening-assessment-tools/

Information such as additional questions and answers shall be documented on the NSI screen, in the comments section, in the DARS approved client database. Service referrals are completed as a *New Encounter*, then as a *CRIA2 Encounter* in the DARS approved client database.

Assessment/Reassessment

Assessment is a measurement of dietary or nutrition-related indicators, such as body mass index or nutrient intake, used to identify the presence, nature, and extent of impaired nutritional status.

Individuals screened by assigned AAA staff that are identified at highest nutritional risk will be offered additional assessment by the RDN for appropriate nutrition intervention and/or referral to other programs.

The "Determine Your Nutritional Health" Nutrition Screening checklist shall be updated when the individual's condition or situation has changed, but at least annually as part of the reassessment process.

Nutrition Counseling

All congregate and home delivered meal clients of the AAA will receive written information at orientation on the availability of the nutrition counseling service for those deemed high risk.

Based on the assessment, the RDN determines individual client nutrition needs, develops and implements a nutrition care plan, evaluates the client's outcomes and maintains documentation. Counseling may be provided to the client and/or caregiver at a congregate site, in home, office, or by phone. Written instruction and/or handouts are provided, as needed. Nutrition counseling sessions must be documented in the DARS approved client database within the program notes. Nutrition counseling notes are NEVER to be entered as *General Comments*.

Administrative Elements

Units of Service (Sessions)

Units of service must be reported in the DARS approved client database for each client receiving the nutrition counseling service.

- Sessions – Service activities provided to a specific client one-to-one. A unit is one (1) session. A session is one event that lasts any part of an hour, up to one full day.

- Persons served (unduplicated) - The number of persons who participate in a session. (Nutrition counseling is one to one.)

Job Description

The AAA must maintain a current and complete job description, which shall cover the scope of nutrition services provided by the RDN.

Optional Responsibilities of the RDN

The following is a non-inclusive list of responsibilities that may be expected of the RDN. The responsibilities of the RDN may vary depending on the hours employed/contracted, the structure of the AAA's nutrition program, whether meals are planned and prepared onsite or contracted out, etc.

- Menu Planning: the RDN plans menus considering individuals' preferences, meal satisfaction, dietary needs, dietary guidelines, food availability, and cost. The RDN reviews menus if other staff or contractors are responsible for planning menus.

- Menu Verification: the RDN reviews menus and performs nutrient analyses or completes meal pattern worksheets to verify that meals comply with menu planning guidelines, provide nutrient content requirements and are appropriate for the program and participants. The RDN reviews nutrient analyses or meal pattern worksheets if performed by others and verifies that meals comply with requirements.

- Monitoring Kitchens: the RDN monitors directly operated or subcontracted kitchens, caterers, and HDM packaging sites. The RDN reviews food and supply specifications, food quality and cost, food preparation methods, adherence to menu, use of standardized recipes and portion control, HDM and bulk food packaging, handling of leftovers, inventory and storage, temperature monitoring, compliance with the sanitary code and equipment maintenance.

- Monitoring Congregate Sites: the RDN checks food services including portion control and the serving of food, checking temperatures taken by site staff, compliance with the sanitary code, condition of equipment, handling of leftovers, serving of meals, and client satisfaction. The RDN checks that sites with kitchens are monitored and monitors client records and program functions such as meal records, assessments, contributions, etc.

- Monitoring Home Delivered Meal Delivery: the RDN checks food portions, temperature monitoring, and meal delivery including driver techniques, such as the handling of meals and carriers. The RDN observes client condition and solicits comments on meals and service. The RDN reviews assessment records, verifies eligibility, checks contribution procedures, etc.

- Nutrition Education Development: the RDN develops or reviews and approves nutrition information (handouts and/or presentations) and develops an annual nutrition education plan.

- Nutrition Education Presentations: the RDN provides group nutrition presentations at congregate sites. Other staff may present under the direction of the RDN. Dietetic students or interns may present under the direction of the RDN.

- Administration: the RDN prepares reports on monitoring activities, findings, recommendations, and nutrition education and counseling units of service. The RDN

attends staff meetings to review monitoring activities, provides technical assistance on program development, and comments on program policies and procedures. The RDN participates in statewide conference calls and trainings with other AAA RDNs and nutrition directors.

- Technical Assistance and Training: the RDN provides technical assistance and training in food service practices, food and equipment specifications, sanitary code, new products, production efficiency, staff requirements, kitchen plans, and the nutritional needs of the elderly.

- Staff Management: Other staff, under the direction of the RDN, may assist in the above, as well as, provide assistance with areas such as the use of computer software, networking with other agencies, initiating new services, contracting, client screening/assessments, application of program standards, developing job descriptions and job tasks, and reviewing and evaluating program costs and recommending cost saving measures.

- Diet Prescription Review: the RDN evaluates the diet orders, if any, and determines the type of diets to be provided by the program. The RDN reviews the appropriateness and necessity of nutrition supplements, if provided by the program.

- Case Management/Client Team Review: the RDN may participate in the team review and discussion of the client's assessment and care plan.

- Contract Management: the RDN may review, update, and procure new contracts related to food.

RESIDENTIAL REPAIR & RENOVATION
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Provides for home repairs and/or home maintenance to persons 60 years of age and older, includes weatherization provided with Older Americans Act funds to assist them in maintaining their homes in conformity with minimum housing standards and/or to adapt their homes to meet their needs.

Eligible Population

Individuals are eligible for Residential Repair and Renovation service if they are 60 years of age and older. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements

Agencies providing Residential Repair & Renovation service must perform all of the following component:

Repairs or modifications to the homes of person, that are essential to the health and safety of the older occupants. The types of repairs or modifications may include repairs to the structure itself, electrical and plumbing repairs, weatherization, accessibility modifications, security modifications, and yard work and home maintenance essential to maintaining the health and safety of the older person.

Administrative Elements

Qualifications:

- Knowledge: Residential Repair and Renovation service staff, subcontractor or volunteers should have an awareness of biological, psychological and social aspects of aging; the impact of disabilities and illnesses on aging; the housing needs of older persons.
- Skill: Residential Repair and Renovation Services staff, subcontractor or volunteers should have skills in repairing or modifying the homes of older persons to meet their specialized needs.
- Ability: Residential Repair and Renovation staff, subcontractor or volunteers should have the ability to communicate with persons of different socio-economic backgrounds; conduct an effective interview; complete an assessment; arrange and negotiate service referrals; and work independently.

Job Descriptions:

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on aging shall maintain:

[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)

- A current and complete job description which shall cover the scope of duties and responsibilities of service staff; and
    - A current description of the minimum entry-level standards of each job.[2]

Units of Service:
Units of service must be reported in AIM for each client receiving the service.

- Number of homes repaired
- Persons served (unduplicated): the client/caregiver who is to receive a service(s)

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 client level data transmitted to VDA by the last day of the following month.

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.[3]

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[4]

And/or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[5]

Allowable Costs:
Costs associated with activities of this service are allowable.

Quality Assurance

Staff Training:
- Staff should receive orientation on agency policies and procedures, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Staff should receive a minimum of 10 hours of in-service training, the content of which to be based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision/Case Review:

[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code
[4] Older Americans Act of 1965, as amended, Section 315(a)
[5] Older Americans Act of 1965, as amended, Section 315(b)

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

Program Evaluation:
The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

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

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- 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.
- Other housing assessment documents.

Residential Repair & Renovation Program
Frequently Asked Questions

1. Q - Who is eligible to receive residential repair & renovation services through the Area Agency on Aging

   A - Applicants must be age 60 and older. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas

2. Q - How can I apply for home repair services?

   A - Contact your local Area Agency on Aging who will inform you of residential repair & renovation programs in your community. Area Agency on Aging that provide home repair services will complete a client assessment to determine your home repair needs. There is a limit on how much can be spent on each project. A program brochure will be provided, if available.

3. Q - What repair and renovations services are available through the Area Agencies on Aging?

   A - The types of repairs or modifications may include repairs to the structure itself, electrical and plumbing repairs, weatherization, accessibility modifications, security modifications, and yard work and home maintenance essential to maintaining the health and safety of the older person.

4. Q - I am in a wheelchair and I need a ramp built. Where can I get assistance with this?

   A - Consult your local Area Agency on Aging, Community Action Program or other non-profit housing programs that provide home modification/rehabilitation services.

5. Q - I need grab bars in my bathroom, but I do not have anyone to install him. Where can I get assistance?

   A - Some Area Agencies on Aging provide residential renovation and repair services to individuals who are age 60 and older and meet service requirements. Also local Community Action Programs may be a resource for installing grab bars and other home modifications.

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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.

- 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 posses a minimum of an undergraduate degree in a human service field, or be a licensed nurse. In

addition, it is preferable that the service coordinator will have two years of satisfactory experience in the human services field working with older adults or individuals with disabilities.

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

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

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

Program Monthly Reports

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

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

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

Supervision/Case Review:

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

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

- 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.

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 in non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is at or above 185 percent of the poverty line, at contribution levels based on the actual

cost of services. [2]

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 in non-coercive. Such contributions shall be encouraged for individuals whose self-declared income is

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

Gap-Filling Services

Purchase of Gap-Filling Services Form

Gap-filling services provide a mechanism to fill critical gaps in services which are short term and essential, but unavailable through any other means. These services are necessary to maintain the care coordination client safely in the community and may be purchased on behalf of care coordination clients.

The purchase of gap-filling services is subject to the same client cost sharing as applies to care coordination services. Further, no expenditure for service acquisition shall replace existing funding through other service programs. The percentage of care coordination funds that can be used to purchase services is given in the contracts between the projects and the Virginia Department for Aging and Rehabilitative Services.

Medicaid eligible and non-Medicaid eligible elderly care coordination clients may benefit from the purchases of services with state care coordination funds. If a Medicaid eligible client is receiving elderly care coordination through a Medicaid certified care coordination agency other than a CCEVP agency, the Medicaid care coordination may submit requests for the purchase of gap-filling services to the CCEVP team.

Appropriate Purchase of Goods/Services Include, but are not limited to:

1. Assistive transportation to medical appointments /services.
2. Nutritional supplements, ordered by a physician.
3. Incontinence supplies.
4. Durable medical equipment (not covered by insurance) ordered by a physician. Rentals should be encouraged when needed for limited use.
5. Prescription assistance.
6. An interim in-home service while Medicaid application is in process.
7. Adaptive equipment (i.e., microwaves, raised commode seats, special eating utensils) when documented that this equipment allows the client to maintain or increase functioning.
8. Minor home repairs (such as hand rails, steps) when documented that this repair is necessary in order for the client to remain safely at home.
9. Cleaning of the home or extermination of pests and rodents so that home services can be delivered.
10. Smoke detectors, and/or hearing aids (not covered by insurance) ordered by a physician.
11. Glasses, dentures, and/or hearing aids (not covered by insurance) ordered by a physician.
12. Utility assistance for the clients subject to disconnection when loss of service would affect the safety, health and well-being of the client. This would also include heating assistance with oil, coal and wood.
13. Rent, groceries, blankets, clothes in order to provide time to receive assistance from other sources.
14. Purchase of services such a homemaker, personal care-type services, companion/chore and respite care.
15. Purchase of services (listed above) to leverage additional service support for the client.

Gap-Filling Services

It is inappropriate to purchase services that are provided by the same agency providing care coordination (i.e., homemaker, home delivered meals). Exceptions will be allowed for emergency situations and for agencies that document in the client's file that there are no other agencies providing the needed service in the area or that other agencies cannot serve the client. Documentation must include other funding sources explored and the reason why each source would not fund part or all of the service or equipment.

Gap-Filling Services Allocation

Purchases must be prioritized based on the necessity of the service in allowing the client to remain safely in the community setting. Gap-filling funds shall be made available to care coordination clients throughout the funding cycle. Each agency shall develop a cap on the maximum allowable expenditures per care coordination client. The agency shall retain documentation of how the cap was determined and any situations in which the cap is waived.

Care coordination and gap-filling funds must not be offered to individuals who have a one-time need and who do not require coordination of multiple services (e.g., Individuals not receiving care coordination service). All gap-filling fund purchases shall be approved by one of the following: a committee, the care coordination case supervisor or the agency director. However, agencies may allow care coordinators the flexibility in approving the use of gap-filling funds for purchases. The agencies must develop written criteria under which care coordinators can authorize purchases. Such purchases must be monitored on a periodic basis by the care coordination supervisor.

Questions to ask before allocating funds for goods or services:

1. Has the client received gap filling funded goods or services in the past? If so, why does the client need them again? Is this the most cost effective approach for this client? Does the total service package cost less than institutional care?
2. Are services/goods available through any other funding sources?
3. Is it necessary to maintain or increase the person's level of independence?
4. Is it truly a one-time purchase or an interim measure? Is there a long-range plan for meeting the need? What are the long-term benefits of the purchase?
5. Are there any cost sharing options – family, other service groups, etc?
6. Does the service/equipment provided require assistance from others or training? If yes, is it available? Will the client use it?

Documentation of Gap-Filling Service Purchases

There must be documentation of each gap-filling service purchase that includes, at a minimum, the following:

- Name of client.
- Service/good received.
- Delivery date(s) of the service/good.
- Client benefits expected from purchasing the service/good.
- Total amount requested.
- Total cost of purchase.

Gap-Filling Services

- Client cost sharing amount.
- Organization (explanation required if this is the same organization which employs the case manager authorizing the service).
- Other organizations/funding sources explored.
- Purchase order number.
- Signature and title of who authorized, date signed.

Care coordination agencies may use the Purchase of Gap-filling Service Form found on the next page or develop an alternative which meets the above criteria. A copy of this form must be included in each client file if gap-filling funds are used for the client. It is acceptable to have documentation noted throughout the client file on progress notes, the care plan or other notes, but it must be consolidated on one form. A copy of the form must also be in one central location in order to have documentation of all gap-filling service purchases made on behalf of all care coordination clients. It is not necessary to include a copy of the invoice in the client's file. The invoice may be in a central location and easily retrieved by the purchase order number on the client's documentation sheet.

Purchase of Gap-Filling Service Form
(Care Coordination for Elderly Virginians Program)

Client Name: _____

Service/good received: _____

_____

Delivery Dates(s) of the service/good: _____

Client benefits expected as a result of the service or equipment: _____

_____

_____

_____

_____

Organization providing service/good (explanation required if this is the same organization which employs the care coordinator authorizing the service): _____

_____

_____

_____

_____

Other organizations/funding sources explored: _____

_____

_____

_____

_____

TOTAL COST OF PURCHASE: $ _____

TOTAL AMOUNT REQUESTED: $ _____

CLIENT COST SHARING AMOUNT: $ _____

PURCHASE ORDER NUMBER: _____

REQUIRED SIGNATURE: _____

TITLE: _____ DATE: _____

SOCIALIZATION & RECREATION
MULTIPURPOSE SENIOR CENTER
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definitions

Socialization and Recreation Services: These programs provide an opportunity for the individual to interact with others and participate in leisure time activities. They are designed to enable older individuals to attain and maintain physical and mental well-being through programs of regular physical activity, exercise, music therapy, art therapy, and dance-movement therapy. [1]

Multipurpose Senior Center: A community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.[2]

Eligible Population

Socialization and Recreation Services are targeted to persons 60 years of age or older whose lifestyle may be enhanced through opportunities for socialization and participation that may alleviate isolation and loneliness. Priority shall be given to older individuals with greatest economic and social need, with special emphasis on low- income minority individuals, older individuals with limited English proficiency, older persons residing in rural or geographically isolated areas, and older individuals at risk for institutional placement. [3]

Service Delivery Elements

Program Requirements

The area agency or service provider must provide supervised leisure time activities, including but not limited to: sports, performing arts, games, arts and crafts, and fine arts.

Assessment

- A service-specific assessment shall be performed on each potential client that determines whether the individual is eligible for the service, the amount of the individual's service-specific need, and the individual's level of priority for service delivery.
- If individual hours will be entered into the VDA-approved electronic client database, Virginia Service – Quick Form (if Part "A" Uniform Assessment Instrument is not completed) is required.
- Use of the Virginia Service – Quick Form is recommended, but not required, if there are only optional group units that will not be entered into the VDA-approved electronic client database.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded in the VDA-approved electronic client database. Any fee charged to

[1] Older Americans Act of 1965, as amended, Section 321
[2] Older Americans Act of 1965, as amended, Section 102
[3] Older Americans Act of 1965, as amended, section 306(a)(4)(A)(i)

the client shall be determined by the applicable sliding fee scale. The Federal Poverty/VDA Sliding Scale form may be used.

Reassessment

- A review of the participant's need for services, the amount of services provided and the appropriateness of the care plan (if completed) shall be performed when the participant's condition or situation changes, but at least annually.
- Virginia Service – Quick Form (if UAI – page 1-3 minimum is not required) shall be updated at the same time.
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded.
- Any fee charged to the client shall be determined by the applicable sliding fee scale. The Federal Poverty/VDA Sliding Scale Fee form may be used.

Administrative Elements

Staff Qualifications

The AAA or service provider staff shall possess the following minimum qualifications:

- Knowledge: Biological, psychological, and social aspects of aging; the impact of disabilities and illness on aging; community resources; public benefits eligibility requirements; medical conditions; activity programming.
- Skills: Establishing and sustaining interpersonal relationships; problem solving; activity planning.
- Abilities: Communicate with persons with varying socioeconomic backgrounds; work independently.

Job Descriptions[4]

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on Aging must maintain:

- A current and complete job description which shall cover the scope of socialization and recreation services staff duties and responsibilities; 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 VDA-approved electronic client database for each client receiving the service. Service units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month.

- Hours (individual hours are required for the VDA-approved electronic client database) – The number of hours the individual participates in the activity at the senior center.
- Persons served (unduplicated) – The number of persons who participate in the activity at the senior center.

[4] 22 VAC 5-20-250, Grants to Area Agencies on Aging, Department for the Aging Regulations, Virginia Administrative Code.

Individual hours – Service activities provided to a specific individual; individual hours are required for the VDA-approved electronic client database.

Optional Group Units (Not entered into the VDA-approved electronic client database)

- Group Participants – The number of people attending the presentation, meeting, or program (activity provided to more than one person or in a group setting).
- Number of Group Presentations – Number of programs on socialization and recreation topics

Group Units – These activities cannot be entered into the VDA-approved electronic client database. They are reported on the Optional Units page of the AMR.

Program Reports

- Aging Monthly Reports (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.
- Client level data from the VDA-approved client database shall be transmitted to VDA by the last day of the following month.

Consumer Contributions/Program Income

There must be a written policy on handling of Client Program Income (CPI) and other gratuities and donations[5]

Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service. [6]

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. Voluntary 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.[7]

Quality Assurance

Staff Training

- At hiring, staff shall receive orientation on agency and departmental policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Workers shall receive a minimum of 10 hours of in-service or other training per year based on the need for professional growth and upgrading of knowledge, skills, and abilities.

Supervision

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

[5] 22 VAC 5-20-410, Grants to Area Agencies on Aging, Department for the Aging Regulations, Virginia Administrative Code

[6] Older Americans Act of 1965, as amended, Section 315(a)

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

Program Evaluation

The AAA shall conduct regular and systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Client Records

The AAA or service provider must maintain specific client records in the approved VDA electronic database that include:

- Consent to Exchange Information, if information is shared with other agencies.
- Virginia Service - Quick Form (if Part "A" Uniform Assessment Instrument – page 1-3 minimum is not completed).
- The answer to the question "Is Client in Federal Poverty?" (answer Yes or No) must be asked and recorded

Service providers must maintain the following additional records:

- Service documentation, such as activity calendars or service records documenting that the social or recreational programs took place.
- Cost Sharing (Fee for Service) calculations, if applicable.

FAQ'S
Socialization and Recreation

Question: My AAA provides socialization and recreation, but we don't have a senior center. What do I report?

Answer: Annually, each AAA completes a plan that describes services to be provided and reported
to VDA. Checking your AAA's Area Plan should answer your question.

Question: Do we fill out Part "A" Uniform Assessment Instrument, Virginia Service – Quick Form, or both, for seniors that participate in socialization and recreation activities at congregate nutrition sites and senior centers?

Answer: An assessment must be done on each potential client**.** Virginia Service – Quick Form is required if Part "A" Uniform Assessment Instrument is not completed.

Question: What are the Units of Service for Socialization and Recreation?

Answer: The Units of Service are Individual Hours and Persons Served. Individual hours are the number of hours the individual participates in the activity at the senior center. Persons served (unduplicated) are the number of persons who participate in the activity at the senior center.

TRANSPORTATION SERVICES
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition

Transportation is the provision of a means of going from one location to another. It does not include any other activity.[1]

Eligible Population

Individuals are eligible for Transportation Services if they are 60 years of age or older, lack the ability to transport themselves, and lack other means of transportation. Priority shall be given to older individuals who are in the greatest economic and social need, with preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[2]

Service Delivery Elements

Area Agencies providing transportation service either directly, through contract or a combination of means must satisfy the following:

Assessment:

Assessment should determine at least the following, utilizing the Virginia Service - Quick Form:

- Individual is at least age 60.
- Individual cannot drive and lacks other modes of transport by self, community support group or public transportation.
- Whether the individual has significant economic or social need.
- Whether individual requires any special assistance.
- Reassessment determining the client's level of need for the service shall the service shall be done at least annually.

Federal Poverty/VDA Sliding Fee Scale is required, unless all information needed to determine federal poverty is documented on the Virginia Service - Quick Form.

Safety Policies:

Written policies must be adopted by the governing board and include at least the following:

- All passengers must wear safety belts and when, where available and practical.
- Each vehicle must be equipped with a fire extinguisher, first aid kit, and emergency signaling devices.
- Inspection procedures for safety equipment, including the method and frequency of inspection.

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

[2] Older Americans Act of 1965, Section 306(a)(4)(A)(i)

Administrative Elements

Driver Testing:

- The Area Agency or its provider must adopt and implement a behind-the-wheel driving test to be administered to each potential driver prior to transporting passengers.

Driver Record Check:

- The Area Agency or its provider must adopt a written policy regarding a minimum acceptable driving record for all drivers who transport passengers.
- At hiring and at least annually thereafter, drivers must provide the Agency with a copy of their driving records from the Virginia Department of Motor Vehicles.
- VDA strongly recommends that the AAA adopts a policy for driver alcohol and drug testing.
- At hiring the Area Agency and its providers must complete drug and alcohol testing of drivers. Drug and alcohol testing of drivers shall be conducted when the driver is involved in an accident, if indicated.

Records:

The following records, at a minimum, must be maintained either by the Area Agency or its provider(s), with access permitted in accordance with VDA contract requirements:

1. For each vehicle:
   - Vehicle maintenance/repair history
   - Pre-trip checklists
   - Vehicle logs (mileage, passengers, etc.)
   - A certificate of insurance showing the vehicle identification number (VIN)
   - Vehicle accident records
   - Service plans
   - Safety inspection logs
2. For each driver:
   - Behind-the-wheel testing results
   - Annual DMV record checks
   - Drug and Alcohol testing upon hiring.

Job Descriptions:

For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on aging or provider shall maintain:

- A current and complete job description of the duties, responsibilities of each transportation services staff position; and
- A current description of the minimum entry-level standards of each job.[3]

[3] 22VAC5-20-250, Grants to Area Agencies on Aging, Department for the Aging Regulations, Virginia Administrative Code

Maintenance:

- The Area Agency or its provider must perform preventive maintenance procedures, including daily pre-trip vehicle inspections and an appropriate plan for regularly scheduled maintenance of vehicles.
- Written documentation of maintenance and repairs performed on each vehicle must be maintained.
- Maintenance standards must meet or exceed the manufacturer's recommendation for the vehicle, or those standards of the Virginia Department of transportation, whichever may be applicable.

Insurance:

- Appropriate fleet liability insurance or, when utilizing volunteers, ensuring possession of adequate personal liability coverage.
- The Area Agency must possess a governing board-approved policy that addresses the issue of volunteer liability, including situations of volunteers driving personal as well as agency vehicles.

Vehicle Accidents:

- The Area Agency or its provider must develop and implement written procedures for drivers to respond to and report accidents.
- Procedures must include instructions for accidents without injuries and with injuries; accidents involving one or more other vehicles; single vehicle accidents; preparing written accident report; and post-accident testing.

Units of Service:

Units of service must be reported in AIM for each client receiving services. Services units can be reported by client on a daily basis, but not aggregated (summarized) more than beyond one calendar month. Units of service for required VDA reports are as follows:

- Unit 1: Total number of one-way trips Y-T-D: carrying one eligible passenger from one location to another for an eligible purpose.
- Unit 2: Total number of unduplicated persons served Y-T-D: the client who receives at least one (1) one-way trip for an eligible purpose.

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 client level data transmitted to VDA by the last day of the following month.

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.[4]

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[5]

and/or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[6]

Quality Assurance

Service Personnel: All drivers must meet the following requirements:

- Prior to employment, pass an Area Agency-approved behind-the-wheel driving test.
- Maintain appropriate operator's license.
- Satisfy an annual Division of Motor Vehicles (DMV) driving record check.
- Have no physical or health limitations that interfere with the safe performance of the driver's assigned duties.
- Be sensitive to the needs aid concerns of older persons.

Staff Training

All new drivers must receive the following training within the first year of employment:

- Passenger assistance training, including assistance to developmental, physical or sensory disabilities.
- Orientation to the safe operation of the vehicle(s) in service.
- Daily vehicle inspections and record-keeping.
- Emergency procedures for responding to and reporting vehicle accidents, passenger injuries and equipment breakdowns.
- Defensive driving course and a behind-the-wheel examination.

Current drivers must complete annual refresher courses of at least one hour each in passenger assistance, emergency procedures and defensive driving.

Supervision/ Case Review:

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

Program Evaluation:

The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

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[4] 22VAC 5-20-410, Grants to Area Agencies on Aging, Department for the Aging Regulations, Virginia Administrative Code

[5] Older Americans Act of 1965, as amended, Section 315(a)

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

Client Records:

Service providers must maintain specific program records that include:

- Virginia Service - Quick Form (At a minimum, this form must be updated annually).
- 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.

Transportation Service Standards

Frequently Asked Questions

Q. Do I count the trip to deliver a hot home meal, or a shipment of frozen home meals, to a client's residence as a "Transportation Service" and thus a 1-way trip for this client?

A. No. This does not involve "carrying one eligible passenger from one location to another for an eligible purpose ", as defined under the Units of Service section of the Transportation Service Standard.

Q. What is an "eligible" purpose?

A. Any purpose for which an eligible person desires to be "carried from one location to another".

Q. If I already have a current UAI on a client, must I also complete a Quick Form?

A. No. A UAI contains even more information than is contained in the Quick Form. The Quick Form is more appropriate for individuals who are not receiving other services from the AAA and thus have never had a UAI.

Q. The manufacturer's recommended maintenance schedule is not the same as the minimum maintenance schedule published in the Transportation Service Standard. Which standard should I follow?

A. Generally, you should follow the manufacturer's recommended maintenance schedule for the type of driving conditions to which the vehicle is being subjected. However, unless your fleet is extremely uniform in make, model, year and usage, this can present difficulties in maintenance scheduling and tracking. Thus, any reasonable basic schedule developed from the manufacturer's recommendations and vehicle usage of all the vehicles in your fleet may be approved. At a minimum, this schedule should do the following:

   a. Specify the mileage interval for gauging the tire pressure and checking tire wear (should perform this as part of the daily pre-trip inspection) (tires must be replaced by the time they get to the "wear bars", earlier under some circumstances of uneven wear or sidewall damage)

   b. Specify the mileage and time intervals for inspecting, and if needed, topping off fluid levels (should perform this as part of the daily pre-trip inspection)

   c. Specify the mileage interval for inspection of belts and hoses, replacing if needed (belt and hose inspection should also be part of the daily pre-trip inspection)

d. Specify the mileage and / or time intervals for inspecting lights, signals, mirrors, signage (should perform this as part of the daily pre-trip inspection)

e. Specify the mileage interval for changes or engine oil and filter and chassis lubrication, including inspection of the oil level in the differential (rear end)

f. Specify the mileage interval for lubrication of the wheelchair lift, if so equipped

g. Specify the mileage and / or time interval for changing antifreeze / coolant

h. Specify the mileage interval for changing transmission fluid and filter

i. Specify the mileage interval for inspecting and if needed replacing the air filter, PCV valve, fuel filter and other filters

j. Specify the mileage interval for inspecting and if needed replacing shocks, struts and other suspension components

k. Specify the mileage interval for inspecting and if needed replacing tie rods, drag link, steering box and other front end components.

l. Specify the mileage interval for inspecting and if needed replacing brake pads / shoes

m. Specify the mileage interval for inspecting and if needed turning (machining on a brake lathe) or replacement with new brake rotors / drums

n. Specify the mileage interval for inspecting and if needed draining the water trap for diesel engines

o. Other items as may be specified by the manufacturer

Q. I have CDL (Commercial Drivers License) drivers and we are enrolled in the Virginia DMV Automatic Notification program, wherein we receive written notice of any motor vehicle convictions. Must I also pull an annual motor vehicle record on these drivers?

A. No, but you must still do so with any drivers not covered by this program.

VOLUNTEER
VIRGINIA DEPARTMENT FOR THE AGING
SERVICE STANDARD

Definition
Assisting older persons to obtain a suitable volunteer placement.

Eligible Population
Persons 60 years of age and older with priority given to older individuals who are in the greatest economic and social need, and preference given to low-income minority individuals and to those older persons residing in rural or geographically isolated areas.[1]

Service Delivery Elements
Agencies providing volunteer programs must perform all of the following component:

Informing the community of the need for volunteers.

Developing meaningful activities and opportunities for volunteers.

Linking older persons with appropriate volunteer opportunities.

Administrative Elements
Qualifications: Persons providing volunteer services shall possess the following qualifications:

- Knowledge: Volunteers should have an awareness of the biological, psychological and social aspects of aging; the needs of older persons for meaningful leisure-time activity.
- Skill: Volunteers should have skills in establishing and maintaining interpersonal relationships; developing meaningful volunteer opportunities for older persons.
- Ability: Volunteers should have the ability to communicate with persons with different socio-economic background; work independently.

Job Descriptions:
For each paid and volunteer position funded by Title III of the Older Americans Act, an Area Agency on aging shall maintain:

- A current and complete job description which shall cover the scope of duties and responsibilities of the volunteer; and
- A current description of the minimum entry-level standards of each job.[2]

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

- volunteer hours: the number of volunteer hours provided by a volunteer.

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[1] Older Americans Act of 1965, as amended, Section 306(a)(4)(A)(i)
[2] 22 VAC 5-20-250, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

- persons served (unduplicated): the number of volunteers who have generated a Virginia Service – Quick Form. "Persons served" does not apply to the person(s) receiving a service from a volunteer. Those persons must be counted under the Title III program that is providing the service.

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 client level data transmitted to VDA by the last day of the following month.

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.[3]

- Cost Sharing/Fee for Service: An Area Agency on Aging is permitted to implement cost sharing/fee for service for recipients of this service.[4]

And/or

- Voluntary Contributions: Voluntary contributions shall be allowed and may be solicited provided that the method of solicitation is non-coercive.[5]

Quality Assurance

Staff Training:

- Volunteers should receive orientation on agency policies and procedures, client rights, community characteristics and resources, and procedures for conducting the allowable activities under this service.
- Volunteers should receive in-service training appropriate to the position in which they are serving. Where practical the content should include opportunities that foster professional growth and increase knowledge, skills, and abilities.

Supervision/Case Review:

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

Program Evaluation:

The agency should conduct regular systematic analysis of the persons served and the impact of the service. Subcontractors shall be monitored annually.

Client Records:

- Virginia Service – Quick Form (At a minimum, this form must be updated annually).
- Federal Poverty should be determined and documented. The Federal Poverty/VDA form may be used.

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[3] 22 VAC 5-20-410, Grants To Area Agencies On Aging, Department for the Aging Regulations, Virginia Administrative Code

[4] Older Americans Act of 1965, as amended, Section 315(a)

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

- Any fee for service charge to the client shall be determined by the applicable sliding fee scale.
- For congregate meal site volunteers, see the congregate nutrition service standard.

Volunteer Program
Frequently Asked Questions

1. Q - Who is eligible to participate in Area Agency on Aging volunteer programs?

   A - Individuals must be age 60 and older.

2. Q - Will I be restricted in the amount of hours I volunteer?

   A - The number of hours you volunteer will depend on the volunteer assignment and hours the setting is open for business.

3. Q - What volunteer opportunities exist with the Area Agency on Aging?

   A - Some Area Agencies on Aging sponsor Retired Senior Volunteer Programs (RSVP) where volunteer assignments are found. Examples of volunteer opportunities within the agency might include administrative tasks, assisting at nutrition dining centers, assisting seniors with recreational and socialization activities, and telephone reassurance programs.

5. Q - I work as a volunteer for the Area Agency on Aging home-delivered meals program. Can I take a friend along when I deliver meals?

   A - Yes, your friend can also help you with the delivery, however, he may be asked to complete a volunteer application.

6. Q - Who is "persons served" for the service unit under the volunteer program.

   A - "Persons served" (unduplicated) is the number of volunteers who have generated a Virginia Service - Quick Form. "Persons served" does not apply to the person(s) receiving a service from a volunteer. Those persons must be counted under the Title III program that is providing the service