SECTION 400

FUNDABLE SERVICES--
DEFINITIONS AND STANDARDS

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SECTION 400: FUNDABLE SERVICES--DEFINITIONS AND STANDARDS

401. Purpose of Section

The purpose of this section is to address the service definitions and standards for Older Americans Act Programs as funded by the Area Agency.

The twenty-four services delineated in this section are fundable under Title III of the Older Americans Act and/or Illinois General Revenue Fund monies. Funding for other services will require special in-depth justification to the Area Agency on Aging.

Each fundable service and each unit of service is defined in this section. All units of service based upon one hour of time must be recorded to the nearest quarter hour (0.25, 0.75, 1.0). The one unit of service based upon a day of service per client (adult day care) must be recorded as days (one unit) or half days (0.5 unit).

The standards set forth in this section are minimum requirements for services provided through Area Agency on Aging funding.

The term "reserved" found under the section "Service Standards" means that service standards may be developed for that service at a later date. Adequate prior notice will be given to service providers before any new service standards are placed into effect.

402.

EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.1

FUNDABLE SERVICE: ADULT DAY CARE

SERVICE DEFINITION:

Provision of personal care 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 and medication assistance.

SERVICE ACTIVITIES:

1) development of a participant care plan appropriate to any recommendations by the individual's personal physician;
2) assistance with, or arrangements for, personal care and hygiene, including self-care training;
3) leisure time activities and recreation;
4) preparing and administering medications, changing dressings, on-going physical assessments, and retroactive exercises and treatment may be included as an integral, but subordinate, part of the service;
5) a daily congregate meal which meets a minimum 33 1/3 percent of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of Institute of Medicine of the National Academy of Sciences and supplementary nutritious snacks;
6) transportation to and from the Day Care Center;
7) maintenance of an individual participant's record;
8) provision of information on, and referral to, other service resources; and,
9) optional service components may include: rehabilitative services (e.g., physical therapy, occupational therapy, speech and hearing therapy, etc.); skilled nursing services (e.g., irrigations, oxygen therapy, suction/posturing, dressings, etc.); shopping assistance; and escort to medical and social services.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

One unit of documented adult day care transportation, provided by the adult day care provider, is defined as a one-way trip per client to or from the adult day care site and the client's home.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.2

FUNDABLE SERVICE: ASSISTED TRANSPORTATION

SERVICE DEFINITION:

Provision of assistance, including escort, to a person who has difficulties (physical or cognitive), using regular vehicular transportation.

SERVICE ACTIVITIES:

1) Activities that support the direct provision of transportation service to a person who has difficulties (physical or cognitive) using that transportation service without such assistance and area related to the provision of trips to and from community resources.

UNIT OF SERVICE:

One (1) one-way trip to or from community locations per client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.3

FUNDABLE SERVICE: CAREGIVER ADVISORY SERVICES UNDER THE OLDER AMERICANS ACT TITLE IIIE NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

SERVICE DEFINITION:

Caregiver Advisor: The provision of information, assistance in gaining access to services, individual counseling/consultation and support services to help caregivers and grandparents raising grandchildren cope with their caregiving roles and/or develop and strengthen capacities for more adequate social and personal adjustments, and to also assist the caregivers and grandparents raising grandchildren/relative caregivers in the areas of health, nutrition, and financial literacy, and in making decision and solving problem relating to their caregiving roles;

Caregiver Support Groups: The development, implementation and ongoing maintenance of support groups for caregivers and grandparents raising grandchildren which emphasize coping strategies, peer support and resource education.

Caregiver Training & Education: The provision of services which provide caregivers and grandparents raising grandchildren with opportunities to acquire knowledge and skills which address their caregiving roles through personalized in-home instruction and/or formally structured, group oriented lectures, classes, workshops or conferences.

CAREGIVER DEFINITION:

An adult family member, or another individual, who is an informal provider of in-home care to an older individual.

GRANDPARENT OR OLDER INDIVIDUAL WHO IS A RELATIVE CAREGIVER DEFINITION:

A grandparent or step-grandparent of a child, or relative of a child a relative of a child by blood, or marriage, or adoption, who is fifty-five (55) years of age or older and: 1) lives with the child, 2) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child, and, 3) has a legal relationship to the child, as such legal custody or guardianship, or is raising the child informally. NOTE ADDITIONAL

CLARIFICATION: Caregivers in this section cannot be the child's parent.

CHILD DEFINITION: An individual who is not more than 18 years of age or who is an individual with a disability.

PRIORITY POPULATION:

1. For family caregivers who provide care for individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction, the State involved shall give priority to caregivers who provide care for older individuals with such disease or disorder; and, are older individuals with greatest social need, and older with greatest economic need; and

2. For grandparents or older individuals who are relative caregivers, the State involved shall give priority to caregivers who provide care for children with severe disabilities.

FRAIL AS PRIORITY ELIGIBILITY FOR RESPITE AND SUPPLEMENTAL SEVICES: The term "frail" means that the older individual is determined to be functionally impaired because the individual –

a. Is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or
b. Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

UNIT OF SERVICE DEFINITION:

The unit of service measurement is one session. This includes sessions (programs) provided to individuals or groups. For example, if one session is provided to ten individuals, ten units of service have been provided.

Newsletters or mass mailings do not count as service units. Internet web site "hits" are to be counted only if information is requested by older individuals and/or family members and supplied by the provider. For example: an older person may request by e-mail on a provider's web site that they want information on support groups for caregivers. If the provider provides this information by e-mail, or by traditional mail, or by telephone, this is one contact (one unit of service).

SERVICE ACTIVITIES/EXPECTATIONS:

1. The sponsoring agency for the Caregiver Advisory Services will serve as the recognized expert/contact agency where caregivers can call to obtain needed information, assistance, counseling/consultation and supportive services in the approved geographic service area.

2. The Caregiver Advisor will establish and maintain a Caregiver Support Team

comprising of local organizations, professionals and consumers who can provide valuable assistance/information to caregivers. Membership for the Caregiver Support Team will be recruited to provide an important professional contribution to support caregivers, and not recruited as paid positions. Caregiver Support Team membership will include, at minimum: Current/former caregivers, mental health professionals, medical professionals, hospital discharge planners, churches/synagogues, Alzheimer's Association Chapters, Aging Network Providers (including CCU's and Respite Demonstration Project Representatives), Centers for Independent Living, and legal service representatives. Additional members can be recruited from Grandparents Raising Grandchildren Support Groups, banking community, local health departments, major employers, housing authorities, media, etc. Meetings of the Caregiver Support Team shall be conducted quarterly with the pledged availability to provide consultation/assistance as needed between quarterly meetings.

3. The Caregiver Advisor will implement a caregiver screening process within TCARE, a cloud-based application with case management tools that utilizes information input to identify needs of unpaid family caregivers for support resources whenever possible. The TCARE Screener will be utilized to identify needs of the unpaid family caregiver. The goal is to not only evaluate the needs of the caregiver, but also recognizes the contributions/attributes of the caregiver. The screening process shall identify the caregiver as the client, but efforts to adhere to the 60+care-receiver's right to self determination must also be honored. The Caregiver Advisor shall utilize the caregiver screening instrument including the Service Plan, developed by the Area Agency when it is not possible to utilize TCARE. The Caregiver Advisor should document in the client file why they were unable to utilize TCARE.

4. The caregiver screening process shall culminate into a caregiver service plan which includes strategies to support and strengthen the capacities of the caregiver. The service plan shall be developed in conjunction with the caregiver ensuring that the right to self-determination of the 60+care-receiver is also honored. The TCARE system will generate a Care Plan that takes the place of the service plan.

5. The Caregiver Advisor shall provide information to enable the caregiver to understand the progression of chronic diseases and disabilities. In addition, upon discharge from a hospital, information shall be provided to the caregiver on what role they will be expected to play in helping their loved one recuperate from an acute illness or manage a chronic disease or disability.

6. The Caregiver Advisor will provide information, assistance, and support to older adults raising grandchildren needing to know where to turn for answers about legal issues, financial assistance, support groups, and childcare.

7. The Caregiver Advisor shall coordinate with other community and voluntary organizations providing caregiver support services and caregiver training services. In addition, the Caregiver Advisor will accept referrals from other community and voluntary organizations

for the provision Caregiver Advisory Services.

8. Based on the needs identified in the Caregiver's Service Plan, the Caregiver Advisor will refer to the PSA 05 Respite Demonstration Projects for the provision of a wide array of Respite Care Services which can include one or a combination of the following services: companion care, comprehensive respite care (homemaker), home health, adult day care services and institutionalized respite services (nursing home respite). The expressed purpose of the PSA 05 Respite Care Demonstration Projects is to provide temporary relief for the caregiver.

9. The Caregiver Advisor shall access the CAREGIVER GAP FUND for immediate/emergency services that cannot be provided through any other local resource. Services to be accessed through the CAREGIVER GAP FUND can include, but are not limited to, the following: medical transportation/assisted transportation that is not readily available through tradition transportation services; medication management; supplemental meals (such as weekend or special diet meals that do not replace Title III-C meal services); assistive devices that are not reimbursable under Medicare; child care for grandparents raising grandchildren; and, repair and renovation services to assist the caregiver in carrying his/her caregiving responsibilities.

10. The Caregiver Advisor will conduct follow-up activities to ensure that services provided met the caregiver's expectations. If warranted, additional follow-up assistance will be provided to the caregiver in an effort to ensure the caregiver's satisfaction of services.

11. The Caregiver Advisor will initiate and/or coordinate with other community organizations in the development and/or implementation and ongoing maintenance of support groups for family caregivers and grandparents raising grandchild which emphasizes coping strategies, peer support and resource education.

12. The Caregiver Advisor will initiate/coordinate/collaborate with other community organizations in the development of Caregiver Training and Education to provide family caregivers and grandparents raising grandchildren with opportunities to acquire knowledge and skills which address their caregiving roles through personalized in-home instruction and/or formally structured, group oriented lectures, classes, workshops or conferences.

13. The Caregiver Advisor will initiate/coordinate/collaborate Caregiver Training & Education for caregivers. Subjects may include, but not limited to, the following: personal care training, emotional/family dynamics of caregiving situations, home safety, infirmity, progression of different diseases and conditions, financial planning, legal and insurance issues, long-term care options and planning.

14. The Caregiver Advisor will initiate/coordinate Caregiver Training & Education for grandparents raising grandchildren. Subjects may include, but not limited to, child development, children with special needs (e.g., physical, learning or mental disabilities, emotional and behavioral problems), available financial assistance programs, alcohol and drug abuse among children, sexuality, respite, housing, insurance, guardianship, custody, and other legal issues.

15. The Caregiver Advisory Program will integrate evidence-based healthy aging programs in to the Caregiver Advisor Training Component as directed by the Area Agency.

SERVICE STANDARDS: (Reserved)

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.4

FUNDABLE SERVICE: CASE MANAGEMENT

SERVICE DEFINITION:

Assistance either in the form of access or care coordination in circumstances where the older person and/or their caregivers are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers.

SERVICE ACTIVITIES:

Case management service activities minimally include the following components:

1) Case Finding Activities: The identification of individuals for intake.
2) Intake: Through the administration of a defined intake process approved by the Area Agency on Aging, an individual with potential case management needs, as defined below, shall be identified.

    a) An individual must be age 60 or older; and

    b) An individual must demonstrate a need which requires development of a coordinated case plan, follow-up, and/or advocacy; and/or

    c) An individual has multiple or complex problems which are often chronic in nature and which may affect the ability of that individual to live independently, and/or

    d) An individual has potential need for multiple services; and/or

    e) An individual has presented problems which are vague or ill-defined; and/or

    f) An individual has insufficient informal supports to care for his/her needs.

3) Needs Assessment: A comprehensive needs assessment, preferably conducted in the home or place of residence of the client, must be conducted for each Title III case management client utilizing a standardized tool, developed by the Area Agency on Aging, to evaluate the conditions of the client and to identify goal oriented needs for services and/or problems needing resolution.

4) Care Plan Development: A written goal-oriented case plan shall be prepared for all individuals determined to be in need of case management services. A written plan of care shall be prepared for each client utilizing appropriate and available formal and informal resources, using a standardized form approved by the Area Agency on Aging. The case plan shall identify available services and problem solving efforts to meet the client's determined needs and to enable the client to live with maximum possible independence. A copy of the case plan shall be given to the client and/or client's family and/or significant individual, and so documented in the client's file.

5) Care Plan Implementation: A referral of the applicant/client to an appropriate resource for service provision and/or problem resolution shall be made and documented in the applicant's/client's file. If the referral is made to an informal network (family, friends, etc.), the service and/or problem-solving arrangement agreed to regarding duties and responsibilities shall be documented in the client's case plan. The following activities shall be performed for each client, as appropriate and needed:

   a) Active intervention and advocacy on behalf of the client to access necessary services from community organizations and to resolve problems experienced by the client;

   b) Establishment of linkages with service providers for the prompt and effective delivery of services needed by the client, including submission of instructions for service delivery to the appropriate service providers;

   c) Encouragement of informal care given by individuals, family, friends, neighbors, and community organizations, so that publicly supported services supplement rather than supplant the roles and responsibilities of these natural support systems.

6) Review and Evaluation of Client Status:
   a) Follow-up: Periodic monitoring shall be conducted through telephone or face-to-face contact to ensure prompt and effective service delivery and response to changes in the client's needs and status. All follow-up shall be documented in the client's file.

   b) Reassessment: A face-to-face reassessment of the client's condition and needs must be conducted, preferably in the home of the client, no later than the 12th month from the last completed (re)assessment, or more frequently as dictated by change in the client's circumstances.

7) Case Closure: Case closure shall occur in the following instances.

   a) Death of the client;

   b) Relocation out of the case management service provider's service area;

   c) Client cannot be located;

   d) Client is hospitalized, enters a group care facility, is institutionalized or is not available for services for more than ninety consecutive calendar days;

e) Client is no longer in need of case management services because of changes in the client's condition or circumstances;

f) Client refuses services;

g) Client requests termination; and,

h) Client refuses to cooperate in the provision of case management services.

8) Transfer: When a client moves from the case management service provider's geographic service area, the case management service provider shall, with the client's and/or client's family and/or significant individual's documented consent, refer the client to the case management provider serving the area to which the client has moved.

UNIT OF SERVICE:

One hour of staff time expended on behalf of a client constitutes one unit of service.

TARGET POPULATION:

Persons sixty (60) years of age and older who are multi-impaired, (resulting in a high level of functional impairment), who lack on-going and/or appropriate support from family and/or formal and informal support networks, and who could benefit from the provision of service coordination and delivery by a trained professional case manager.

AWARD STANDARDS:

To be designated as a Case Coordination Unit (CCU) for a specific geographic area, as identified by the Area Agency on Aging in a specified planning and service area, an agency shall enter into a contract or grant with the Area Agency to provide Title III (Older Americans Act) case management services pursuant to 89 Illinois Administrative Code 230 (Subpart G) and with the Department on Aging to provide Community Care Program (CCP) case management services pursuant to 89 Illinois Administrative Code 240.260 and 240.1400 et seq.

1) The agency shall be a free-standing, single purpose agency, or shall be part of a multi-purpose agency. A multi-purpose agency shall have a separate, clearly definable organizational unit functioning as the CCU.

a) An Area Agency shall not be designated a CCU except in an emergency situation as specified in Section 220.655 (g) of the 89 Illinois Administrative Code.

b) A CCP vendor may not serve as a CCU in the same contract service area except in temporary situation as specified in 89 Illinois Administrative Code 240.1400 (f).

2) The designation of CCUs shall be accomplished by the Area Agency and the Department on Aging as described in Sections 220.610 through 220.645 of the 89 Illinois Administrative Code.

3) Only one designated CCU shall have jurisdiction in a particular geographic area.

SERVICE STANDARDS:

1) Case management service providers must adhere to the Senior Access System requirements as outlined in Section 900 of this Manual. Case management service providers must have a resource/service directory that includes case management services as well as other community based long term care services available within their service area, and has access to information on resources outside of the service area. The resource/service directory shall be kept current, including a mechanism for exchanging updated information.

2) An agency providing Title III case management services shall meet all Case Coordination Unit (CCU) Standards pursuant to 89 Ill. Adm. Code 220.600 et seq. upon completion of the procurement as specified in 89 Ill. Adm. Code 220.615.

3) An agency providing Title III case management services shall meet service standards pursuant to 89 Illinois Administrative Code 230.630.

4) The case management service provider shall:

   a) Coordinate services with the following types of organizations in the contractual area:
      i. Information and Assistance and Outreach Providers
      ii. Nursing Facilities
      iii. Health Care Providers (including all hospitals in the geographic area)
      iv. Social Service Providers
      v. Public Assistance/Financial Assistance Organizations
      vi. Elder Abuse and Ombudsman Provider Agencies

   b) Coordinate services to individual clients and shall, at a minimum, include a process for handling information requests, referrals, and follow-up activities. The process must be clearly defined in written policy and procedures.

   c) Establish and follow procedures, which must be retained on file, to assure that each client has an assigned case manager to contact, including back-up procedures for assigning a substitute case manager, who meets the minimum requirements specified in Section 220.605 of this Part and in 89 Ill. Adm. Code 240.1440, in the absence of the assigned case manager.

   d) Establish and follow procedures, which must be retained on file to assure maintenance of and safeguard the use of and disclosure of information relating to applicants and clients as required by Federal or State laws, rules and regulations and the requirements specified in Section 220.100 of this Part and in 89 Ill. Adm. Code 240.340.

   e) Present service options and information about available services and resources to each client and/or client's authorized representative in an objective manner.

   f) Establish and follow a written procedure for coordinating the CCU intake system with

the Title III Senior Information Service Providers (formerly known as Information & Assistance and Outreach providers).

g) Arrange services to non-English speaking and hearing impaired applicants and/or clients.

h) Provide information to the Area Agency on aging about gaps in services;

I) Client contribution/donation procedures for case management services must meet the requirements set forth in Section 500 of this Manual. Client contribution/donations may not be solicited for any CCP activity;

j) Based on needs identified during the completion of the comprehensive needs assessment, case management service providers shall refer potentially eligible home delivered meal clients to the appropriate Title III home delivered meal nutrition providers;

k) Have a TTY or assist the applicant and/or client in using the Illinois Relay Center to accommodate the hearing and/or speech impaired.

l) Comply with the Illinois Human Rights Act [775 ILCS5], the Equal Employment Opportunity Act of 1974, the Federal Rehabilitation Act of 1973, the Federal Immigration and Relocation Act of 1986, the Americans with Disabilities Act of 1990 and the Department's Civil Rights Program.

m) Perform service activities and responsibilities for which a contract/grant is in effect.

5) The case management service provider shall establish personnel policies, job descriptions, and wages for each job category. The case management service provider shall assure that:

a) Personnel policies include hours of work, benefits, and promotion and evaluation criteria.

b) There is a written job description for each job category for all paid and volunteer staff positions which are part of the service.

c) Personnel records are maintained for each employee and shall include at least the following:
i. Employee application or resume;
ii. Annual performance evaluation;
iii. Supervisory reports regarding case managers; and,
iv. Documentation of meeting all training requirements specified in Number 27 below.

6) The case management service provider shall demonstrate that:

a) A copy of the employee's specific job description has been provided to the employee;
b) The employee has received a copy of current written personnel policies for his/her

specific job category at the time of employment and any subsequent revisions;

c) The employee has been informed of the wages for the specific job category at the time of employment and any subsequent revisions; and,

d) The employee benefits and grievance procedures, which meet applicable Federal and State regulations, have been clearly stated and provided in writing for each employee.

7) The case management service provider shall assure each individual employed by the CCU having face-to-face contact with clients in the client's residence, in the hospital and/or nursing facility shall be free from communicable disease.

8) The case management service provider shall be located to provide accessibility to older persons and their families and other organizations providing services to the elderly in the agency's jurisdiction.

9) Any satellite office(s) operated by the CCU shall comply with all rules and regulations, as set forth in 89 Ill. Adm. Code 220, 230 and 240.

10) The case management service provider shall maintain books, records, documents and other evidence of accounting procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature expended in performance of the contract(s) and/or grant(s). These records shall be subject at all reasonable times to inspection, review, and/or audit as specified in 89 Ill. Adm. Code 230 and 240.

11) The case management service provider shall provide for financial audits in accordance with requirements specified in 89 Ill. Adm. Code 230.360 and 89 Ill. Adm. Code 240.1420.

12) The case management service provider shall comply with all applicable Federal, State and local laws, rules, regulations and ordinances as well as all specified requirements as set forth in this Part and in 89 Ill. Adm. Code 230 and 240.

13) All program records, reports, and related information and documentation, including files of terminated clients, which are generated in support of a contract/grant between the CCU and the Department/AAA shall be maintained by the CCU for a minimum of five years after the completion of the contract/grant. If any litigation, claim or audit is started prior to the expiration of the five year period, the records shall be retained until all litigation, claims or audit findings involving the affected records, information or documentation has been resolved.

14) Each case management service provider shall carry general liability insurance in the single limit minimum amount of $100,000 per occurrence. The policies or current letters documenting all insurance coverage shall be available in the CCU files.

15) The case management service provider shall not subcontract for the direct provision of case management services unless prior written approval has been obtained from the Department and the Area Agency, as appropriate.

16) The case management service providers are expressly prohibited from assigning either their

contract with the Department or their contract/grant with the Area Agency on Aging.

17) All records, case notes or other information maintained on persons served under the contract shall be confidential and shall be protected by the CCU from unauthorized disclosure pursuant to Section 220.100.

18) A case management service provider shall permit access to case files by the Area Agency on Aging or its designee, the Department on Aging or its designee, and appropriate Federal agencies. The Department on Aging shall notify the Area Agency on Aging when access to Title III case management case files by the Department on Aging and/or appropriate Federal agencies is required.

19) A case management service provider shall maintain individual client records in a central file. The case file for each client shall minimally include the following information:

    a) Intake Form(s);
    b) Comprehensive Needs Assessment;
    c) Case Plan(s);
    d) Record of referrals and requests;
    e) Correspondence related to the case;
    f) Formal case notes, which include documentation of the follow-up and/or case closure.

20) Upon change in CCU and case management designation (specified in 89 Ill. Adm. Code 220), the CCU which has been de-designated shall transfer all specified records as prescribed by the Area Agency on Aging to the newly designated CCU.

21) The agency shall have sufficient staff to perform all activities and to fulfill all responsibilities outlined in 89 Illinois Administrative Code 230 Subpart G and 240 Subpart N for which a contract/grant is in effect. A case management service provider shall have specified staff to carry out the following functions:

    a) Case management, and
    b) Supervision of case managers.

22) Case management supervisor activities shall include:

    a) Consultation on case management activities as needed to provide proper supervision;
    b) Documented provision of training on Illinois Department on Aging and Area Agency on Aging policies, procedures and case management techniques, including those specified in Number 27 below.
    c) Annual written performance evaluations of case managers for whom they serve as supervisor.

23) Case management supervisor minimum qualifications shall:

    a) Be either a RN, or have a BSN or a BA/BS degree in health or social sciences, social work, or health service administration;

b) Have at least two years experience in health or human services. This experience shall include one year of supervisory experience or program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly; or
c) Be waived for persons hired/serving in this capacity prior to rule adoption (December 13, 1991).

24) Case manager Title III-related service activities shall include:

a) Administration of the appropriate intake form, including the comprehensive needs assessment;
b) Development of a case plan;
c) Making appropriate referrals and responding to applicant/client requests;
d) Authorization of services; and,
e) Maintaining case records, including documentation of follow-up and of termination.

25) Case manager CCP-related service activities and responsibilities shall, at a minimum, include:

a) administration of the Determination of Need;
b) development of a CCP Client Agreement-Plan of Care;
c) performance and/or approval of nursing home prescreening;
d) authorization of CCP services;
e) performance of Illinois Department of Human Services (DHS), OBRA-1 (Level I ID Screen); and,
f) attendance at appeal hearings.

26) Required activities which may be performed by a case manager or other CCU staff include:

a) screening of inquiries;
b) arranging for service implementation in accordance with each specific Client Agreement--Plan of Care;
c) completing Case Authorization Forms;
d) reviewing and correcting Case Authorization Forms;
e) assisting vendors with Vendor Request for Payment rejects;
f) timely provision of documents requested by the Department on Aging for client appeals or other matters;
g) implementing case transfers; and,
h) assisting with referral of applicants/clients to the Illinois Department of Public Aid for Medicaid applications as requested.

27) Case manager minimum qualifications shall:

a) be a RN, or a BSN or a BA/BS degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree;

b) a LPN with one year of program experience which defined as assessment of and provision of formal services for the elderly and/or authorizing service provision; or

c) be waived for persons hired/serving in this capacity prior to rule adoption (December 13, 1991).

28) Case Coordination Units (CCUs) in the performance of their Community Care Program (CCP) contract, shall adhere to the following training requirements:

a) Case Management Supervisors

I. either prior to or within sixty calendar days from the date of employment with the Case Coordination Unit (CCU), each cash management supervisor shall successfully complete:

A) Department-sponsored Community Care Program (CCP) training on the Determination of Need (DON), eligibility determination, care planning, nursing home prescreening, and IDMHDD OBRA-a (Level I ID Screen).

B) Successful completion of the above training shall be established by certification.

II. Each case management supervisor shall meet the following in-service training requirements:

A) Recertification of CCP training within eighteen months from the month anniversary of each previous recertification (e.g., recertification in September, subsequent recertification no later than March of the second following year); and,

B) Eighteen hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training and/or local, state, regional or national conferences on aging related subjects, and the recertification required in subsection (A) above, will qualify as in-service training on an hour-for-hour basis.

b) Case Managers

I. Prior to performing CCP eligibility determinations and developing plans of care, each case manager and each supervisor acting as a case manager shall successfully complete:

A) Department on Aging sponsored CCP training on the DON, eligibility determination, care planning, nursing home prescreening and IDMHDD OBRA-1 (Level I ID Screen).

B) Successful completion of the above training shall be established by preliminary certification which shall expire six months from completion of

training.

II. Each case manager and each supervisor acting as a case manager shall meet the following in-service training requirements:

A) Recertification of CCP training within six months from the preliminary certification (e.g., preliminary training in January, full certification no later than July); and,

B) Recertification of CCP training within the eighteen month anniversary of each previous certification (e.g., full certification in April, subsequent recertification no later than October of the second following year); and,

C) eighteen hours of documented in-service training on aging related subjects within each calendar year. For partial years of employment, training shall be prorated to equal 1.5 hours for each full month of employment. Documented participation in in-house staff training an/or local, state, regional or national conferences on aging related subjects, in addition to the certification required in subsection (A) above, will qualify as in-service training on an hour-for-hour basis.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.5

FUNDABLE SERVICE: CHORE/HOUSEKEEPING

SERVICE DEFINITION:

Providing assistance to persons having difficulty with one or more instrumental activities of daily living (e.g., household tasks, personal care and yard work) under the supervision of the client or other responsible person.

SERVICE ACTIVITIES:

1. Assistance with the uncapping of medication containers and provide water;

2. prepare supplies for and monitor non-medical personal care tasks such as shaving, hair shampooing and combing, assistance with sponge bath, assisting with tub bath only when clients are able to enter and exit tub themselves, dressing, brushing and cleaning teeth and/or dentures under specific direction of client or responsible individual;

3. Perform housekeeping tasks (cleaning, laundry, shopping, simple repairs, meal preparation, seasonal tasks); and,

4. Escort or arrange for transportation (to medical facilities, errands and shopping, miscellaneous family/individual business.)

   NOTE: Service providers are not required to perform all of these allowable activities as described in this section as a part of their service design.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service (face-to-face).

AWARD STANDARDS:

SERVICE STANDARDS:

A. CLIENT ELIGIBILITY -- In order to be eligible for Area Agency-funded services under this section a person must:

1. be 60 years of age or older;
2. exhibit some level of functional impairment which would indicate a clear need for the service.

B. TARGETING OF SERVICE -- The Service Provider shall, in consultation with the Area Agency, develop written procedures for the prioritization of clients to be served. In establishing these procedures consideration should be given to the applicant's level of impairment as well as social and economic factors.

C. CLIENT SCREENING, ASSESSMENT AND PLAN OF CARE -- The Service Provider shall, in consultation with the Area Agency, establish written policies and procedures for conducting initial client screening to determine eligibility, to assess the needs of the client and to prepare a plan of care. Whenever a client, in the judgment of the Provider, has a high level of impairment and/or multiple impairments, the Service Provider shall then refer the client to the local Case Coordination Unit for a comprehensive assessment.

D. CASE RECORDS -- A case record must be developed for each client receiving services which shall include, at a minimum:

1. an initial screening/intake tool signed and dated by the client which documents the client's age, residency, need for the service and any demographic information (e.g. - sex, race, income level, living situation) as required for Area Agency reporting;
2. an assessment tool to be developed in consultation with the Area Agency;
3. the plan of care;
4. updates to the plan(s) of care which are to be developed annually or more often if the client's circumstances or condition changes significantly;
5. updated demographic information as indicated by changes in the client's circumstances;
6. written documentation of Units of Service and types of services provided; and
7. any other notes or documents which might be necessary to provide a clear and complete record of the history of service to the client.

This case record must be kept in a secure location and maintained in a manner consistent with the Area Agency's general administrative standards regarding record keeping and confidentiality.

E. STAFFING REQUIREMENTS --

1. The Service Provider will maintain adequate and appropriate staff to administer the service and to meet the needs of all cases accepted. A minimum ratio of one full-time Supervisor (or equivalent) for every thirty full-time (or equivalent) Chore/Housekeepers will be maintained.

2. Supervisor's activities shall include, but shall not be limited to:
   a. preparation or review of case notes and maintenance of the case records in a timely manner;
   b. preparation or review of reports on client circumstances and conditions;
   c. preparation or review of the client plans of care;
   d. planning and supervision of quarterly worker training and/or conferences as required;
   e. supervisory visits with each worker in a client's home at least semi-annually or more often as circumstances warrant; and,
   f. any other activities deemed necessary or appropriate by the Service Provider to ensure the successful delivery of the service.

3. Supervisory staff must possess the following minimum qualifications:
   a. a high school diploma or equivalent;
   b. two years' experience in health service or related field; and,
   c. one year of supervisory experience (may have been completed concurrent with b. above)

4. Chore/Housekeepers under this section must possess the following minimum qualifications:
   a. demonstrated housekeeping skills;
   b. demonstrated positive attitude toward the elderly and impaired;
   c. the ability to communicate effectively;
   d. the ability to follow written and oral directions; and,
   e. a record of physical examination, including a tuberculosis test, within six months prior to assignment on the job, with re-certification if the worker has contracted a communicable disease after the initial exam.

5. Each Chore/Housekeeper will receive a minimum of twelve hours training (exclusive of agency orientation) within a week from date of hire, unless prior equivalent related training and/or experience can be documented. Each worker shall also receive, at a minimum, three hours of in-service training per calendar quarter.

F. For those providers under this section whose service designs include provision of only chore services and/or home/yard maintenance to older persons who are basically self-sufficient, and exclude provision of personal assistance and service to older persons with greater levels of impairment, the following standards apply:

1. **CLIENT ELIGIBILITY** - In order to be eligible for Area Agency-funded services under this section a person must:

   a. be 60 years of age or older;
   b. have a clear need for the service.

2. **TARGETING OF SERVICE** - The service provider shall, in consultation with the Area Agency, develop written procedures for the prioritization of clients to be served,

taking into consideration the client's needs as well as social and economic factors.

3. **CLIENT SCREENING AND ASSESSMENT** - The service provider shall, in consultation with the Area Agency, establish written policies and procedures for conducting initial client screening to determine eligibility, to assess the needs of the client and to prepare a plan of service. Whenever an older person applying for service, in the judgment of the Provider, has a high level of impairment and/or multiple impairments, the service provider shall then refer the client to a local Case Coordination Unit for a comprehensive assessment.

4. **CASE RECORDS** -- A case record must be developed for each client receiving services which shall include, at a minimum:
   a. an initial screening/intake tool signed and dated by the client which documents the client's age, residency, need for the service and any demographic information (e.g., sex, race, income level, living situation) as required for Area Agency reporting;
   b. an assessment tool to be developed in consultation with the Area Agency;
   c. the plan of service;
   d.updated demographic information as indicated by changes in the client's circumstances;
   e. written documentation of Units of Service and types of services provided; and,
   f. any other notes or documents which might be necessary to provide a clear and complete record of the history of service to the client.

5. **STAFFING REQUIREMENTS** --

   a. The Service Provider will maintain adequate and appropriate staff to administer the service and to meet the needs of all cases accepted. A minimum ratio of one full-time Supervisor (or equivalent) for every thirty full-time (or equivalent) Chore/Housekeepers will be maintained.

   b. Supervisor's activities shall include, but shall not be limited to:

      1. preparation or review of case notes and maintenance of the case records in a timely manner;
      2. preparation or review of reports on client circumstances and conditions;
      3. preparation or review of the client plans of service;
      4. planning and supervision of quarterly worker training and/or conferences as required;
      5. supervisory visits with each worker in a client's home at least semi-annually or more often as circumstances warrant; and,
      6. any other activities deemed necessary or appropriate by the Service Provider to ensure the successful delivery of the service.

   c. Supervisory staff must possess the following minimum qualifications:

1. a high school diploma or equivalent;
2. one year of supervisory experience.

d. Chore/Housekeepers under this section must possess the following minimum qualifications;

1. demonstrated housekeeping skills;
2. demonstrated positive attitude toward the elderly and impaired;
3. the ability to communicate effectively;
4. the ability to follow directions of supervisor and client;
5. a record of physical examination, including a tuberculosis test, within six months prior to assignment on the job, with re-certification if the worker has contracted a communicable disease after the initial exam.
6. Each Chore/Housekeeper will receive such orientation and training as is deemed necessary, in the judgment of the Provider, to maintain the proper delivery of the service, and to promote the safety and welfare of both the worker and the older person to be served. Training and orientation activities must be described in the Provider's Program Design section of the AAA grant document.

Providers will be judged on a case-by-case basis to determine which set of standards will apply. The Area Agency reserves the right to require or to waive these or other standards as may be necessary to ensure client safety, welfare and satisfaction, as well as effectiveness of programming funded under this section.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.6

FUNDABLE SERVICE: COUNSELING

SERVICE DEFINITION:

Counseling service shall include personal counsel to help individuals and families cope with personal problems and/or develop and strengthen capacities for more adequate social and personal adjustments.

DESCRIPTIVE NARRATIVE:

Counseling is direct interaction between a trained counselor and an individual, family or group providing purposeful assistance in coping with personal problems and improving social functioning.

Modalities: Individual Intervention
Group Intervention
Family Intervention

The supportive nature of the interaction between client(s) and counselor is to be particularly stressed, and should be adapted to meet the individual needs of the client(s). Work may be short term, (including brief crisis assistance). On-going or long term cases (more than one year) may more appropriately be handled by referring the client on for therapeutic or clinical counseling.

Case finding is encouraged as it relates to locating and attracting to the program, those in need of the program's particular type of assistance.

Program focus on prevention and life adjustment is highly recommended and desirable.

Strategies which could be addressed in administration of assistance:

1. Dealing with anxiety or depression.
2. Guardianship issues.
3. Coping/corrective issues centered around elder abuse.
4. Issues of life/role transitions.

5. Interpersonal relationships.
6. Emotional or mental or health problems stemming from improper or over-medication.

SERVICE ACTIVITIES:

1. Intake to determine the appropriateness of the counseling service for the individual older person;
2. Initial assessment of need;
3. Preparation of a written goal oriented plan of care for the client;
4. Evaluation of the client's progress with projected time frames and due dates for the achievement of goals as outlined in the plan of care;
5. A team, ideally comprised of representatives from the local CCU, the fields of health, psychological well-being and social service, drawn together in consultation to design a care plan is strongly encouraged.
6. Personal counseling;
7. Formal and informal group experiences;
8. Advocacy and environmental intervention;
9. Client-focused intervention with family members;
10. Coordination and monitoring of services; where related to possibly alleviate and/or reduce stress identified in the initial evaluation process and integrated into the care plan is permissible. Further, if coordination or monitoring is indicated and necessary for maintenance of the long term emotional stability of the client, appropriate follow-up may be advisable.
11. Follow-up activities; and,
12. Reassessment of client's need for the counseling service at least twice a year and when a client's need and/or status changes.

UNIT OF SERVICE:

The unit of measurement is one counseling session. This includes counseling sessions provided to individuals or groups. For example, if one counseling session is provided to ten individuals, ten units of service has been provided.

AWARD STANDARDS:

Counseling program shall be provided under the provisions of Gerontological Counseling under the Title III-D - Disease Prevention and Health Promotion Services as developed by the Illinois Department on Aging.

SERVICE STANDARDS:

The following standards for counseling service partially funded by the Area Agency on Aging are minimum service standards, and do not prohibit a service provider from developing additional standards beyond the minimum required set forth herein.

1. Eligibility for Area Agency-funded counseling service will be based on the following:
   a. 60 years of age and older;
   b. the potential client has a presenting problem of an emotional nature requiring assistance.

2. Counseling providers must maintain the capacity to provide in-home visits in order to assure service delivery for homebound, handicapped or frail persons.

3. The counseling provider must, at minimum, meet the **General Requirements Applicable to All Services** (refer to Section 500 of this Manual) with specific reference to the following:

   a. licensure and safety requirements;
   b. outreach, training, and coordination requirements;
   c. preference for older persons with greatest economic or social need;
   d. contributions for services;
   e. maintenance of non-federal support for services;
   f. advisory role to service providers;
   g. service definitions and standards for Older Americans Act programs;
   h. confidentiality of client information;
   I. record keeping and reporting;
   j. emergency disaster plan;
   k. utilization and training of volunteers.

4. The counseling provider must have an updated written cooperative working agreement with any agency from which counseling is part of the agency's service delivery plan; especially, for the provision of higher level therapeutic or clinical counseling when the provider agency does not have in-house referral capacity for these services; however, the service provider must have the ability to recognize possible indications which require actual diagnosis and treatment beyond the skills of the staff providing service. Indications would thus be for appropriate referral as expediently as is possible for the benefit of the client.

5. With the consent of the older person, or his or her representative, the counseling provider must bring to the attention of appropriate officials for follow-up, the conditions or circumstances which place the older person or the household in imminent danger.

6. Service priority must be provided to those who are isolated, and to those who have problems severe enough so as to be potentially life threatening.

7. A standardized initial intake tool shall be utilized in determining the appropriateness of counseling services for each potential applicant. Intake must be completed in a timely manner after receiving a request for service. Written intake procedures must be established by each service utilizing an interview by an appropriate staff member.

8. An assessment must be conducted for all counseling clients, utilizing a standardized assessment tool, to evaluate the functional, emotional, financial, and environmental conditions of the client, and to identify service needs. The client must be assessed within a period of time adequate to the relative urgency of the case. In cases of clients with multiple impairments, the counseling provider is strongly encouraged to conduct the assessment with the local Case Coordination Unit.

9. A reassessment of the client's condition and needs must be conducted at least twice a year, and when there is a significant change in a client's status or circumstance, and supporting documentation recorded in case notes.

10. Each client shall have a case record, which includes a written goal oriented plan of care that documents the presenting problem requiring assistance, and records service provision and progress for the achievement of goals as outlined in the plan of care.

11. Record keeping: For each unduplicated person 60 years of age and older requesting and/or receiving counseling service, the service provider is required to keep individual records in a case file. The following outlined information must be included in the client's personal folder:

    a. The following client specific demographic information must be found in the case records:
        i. Name;
        ii. Birth date;
        iii. Address;
        iv. Phone number;
        v. Sex;
        vi. Race;
        vii. Whether income is below or above poverty guidelines;
        viii. Status of personal living situation, i.e., living alone, living with children, congregate living arrangement, etc.; and,
        ix. Client's signature and date of signature.

    Counseling providers are to update the above client-specific information on an annual basis at minimum, or more often, if a change in a client's situation/status results in a change in information being brought to the attention of the counseling provider. This information is to serve as a source of service documentation, and to assist service providers in targeting counseling service to older persons in greatest need;

    b. intake instrument;

    c. assessment instrument;

    d. plan of care;

e. reassessment instrument; and,

f. case notes.

12. Program staff of the counseling provider must have the authority to conduct the day-to-day management and administrative functions of the program:

a. Project Director - must be employed by and responsible to the agency awarded the counseling grant or contract, and must have demonstrated experience in management and supervision;

b. Counselors must meet the following standards:

i. education and/or experience in interviewing functionally impaired elderly;
ii. knowledge of the aging process;
iii. have at minimum, a bachelor's degree from an accredited institution of learning or an equivalent amount of experience in the field of counseling. Degree examples could include: Social Work, Community Service, Nursing, Human Service, Psychology, Counseling, Rehabilitation Counseling, Psychiatric Nursing. Any personnel having final responsibility for the care of the client(s) in a therapeutic or clinical setting must have a Masters Degree in a field whose educational curriculum clearly demonstrates training and experience in therapeutic or clinical work with individuals, families and groups. This staff is not necessarily to be funded by the Area Agency, and can be accessed through in-agency or inter-agency referral.

c. Volunteers:

i. All volunteers must be carefully screened to determine appropriateness for serving the functions to which they are assigned; and,

ii. Volunteers may not perform the functions listed under the degreed personnel categories unless it can be demonstrated that the individual has comparable experience and training.

13. Liability: Counseling service providers are required to maintain malpractice insurance for their personnel, governing board, and volunteers. (Also, refer to Section 600 for other insurance requirements.)

14. Licensure: All licenses, certifications and registrations must be prominently displayed in the location where the staff member works with a majority of his/her clients. Copies of the licenses, certifications and registrations must be available for review on request.

15. Confidentiality: The assurance of complete confidentiality is the responsibility of the Area Agency-funded service provider, due to the nature of this service. Special emphasis must be placed on the need for this confidentiality on behalf of the client when coordinating with other services. Example: Care Plan Design Team.

16. Evidence-based healthy aging programs: The counseling program will integrate evidence-based healthy aging programs as directed by the Area Agency on Aging.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.7

FUNDABLE SERVICE: CRIME PREVENTION AND VICTIM ASSISTANCE

SERVICE DEFINITION:

The provision of assistance to older persons who are crime victims and provision of necessary programs to protect them from being victims of crime in the future.

SERVICE ACTIVITIES:

1) advocacy in behalf of individual crime victims;

2) counseling; and,

3) education and training

UNIT OF SERVICE:

One hour of staff time spent in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.8

FUNDABLE SERVICE: EDUCATION

SERVICE DEFINITION:

Service provides individuals with opportunities to acquire knowledge and skills suited to their interests and capabilities through formally structured, group oriented lectures or classes. Subject areas for adult education may include nutrition, health, mental health, personal care, consumerism, crime prevention, legal rights/entitlements, home maintenance and repair, retirement orientation, and life enrichment, etc.

SERVICE ACTIVITIES:

1) arrangement for and provision of academic courses, classes, seminars, lectures, and other presentations;
2) developing teaching aids and/or informational materials;
3) arranging for group tours or nutrition-related and other organizations as deemed appropriate; and,
4) nutrition education: facts are made available about the kinds and amounts of food required to maintain good health and nutrition, foster good eating habits, and to develop better food purchasing practices, preparation, and selection.

UNIT OF SERVICE:

One hour of staff time spent in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.9

FUNDABLE SERVICE: EMPLOYMENT ASSISTANCE

SERVICE DEFINITION:

Assistance in solving employment problems of older persons to enable them to obtain, retain, or improve employment. The service excludes financial support to establish programs whose primary purpose is paid employment with Title III funds.

SERVICE ACTIVITIES:

1) provision of information on employment opportunities;

2) preparatory employment guidance;

3) referral to prospective employers; and,

4) making contacts to increase job lists or develop job opportunities.

UNIT OF SERVICE:

One hour of staff time spent in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.10

FUNDABLE SERVICE: FRIENDLY VISITING

SERVICE DEFINITION:

Regular visits by staff or volunteers to socially and/or geographically isolated individuals for purposes of providing companionship and social contact with the community. The program is for the older person who is unable to leave his/her own residence often, if at all, and who has few to no friends, family, or neighbors that can visit them.

SERVICE ACTIVITIES:

1) visits to individual's residences;

2) arranging for maintaining the service;

3) provision of training to ensure competent, ethical, and qualified staff and volunteers; and,

4) assisting older persons during times of disaster (e.g., flooding, hot weather, tornadoes, sever weather, man made emergencies, etc.) by conducting special visits to assure older persons are safe and have access to services to meet their needs.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.11

FUNDABLE SERVICE: GRANDPARENTS RAISING GRANDCHILDREN/CAREGIVER LEGAL FUND

SERVICE DEFINITION:

Legal assistance shall include the arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research, and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney) for grandparents and other kinship caregivers who are 55 years of age and older and raising children 18 years of age and younger and/or children who have a disability and/or caregivers in obtaining needed legal services.

GRANDPARENT OR OLDER INDIVIDUAL WHO IS A RELATIVE CAREGIVER DEFINITION:
A grandparent or step-grandparent of a child, or relative of a child by blood or marriage, who is fifty-five (55) years of age or older who: 1) lives with the child, 2) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child, and, 3) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

CHILD DEFINITION: An individual who is not more than 18 years of age or who is an individual with a disability.

CAREGIVER DEFINITION: An adult family member, or another individual, who is an informal provider of in-home care to an older individual.

PRIORITY POPULATION:

Services are to be targeted to older individuals in greatest social and economic need (with particular attention to low-income older individuals) and older individuals providing care and support to a person with mental retardation and related development disabilities.

UNIT OF SERVICE DEFINITION:

One (1) hour of staff time spent on behalf of a grandparent/older person raising grandchildren/children and/or caregivers, constitutes one unit of service.

SERVICE ACTIVITIES:

1. Educating grandparents/older persons raising grandchildren/children and caregivers concerning their legal rights.

2. The provision of legal advice and information to establish formal caregiving relationships, including visitation, custody, guardianship and adoption.

3. The provision of legal assistance to obtain orders of protection, housing, healthcare, child support, financial assistance under the Temporary Assistance to Needy Families (TANF), and food stamps.

4. Conducting legal research on behalf of the client regarding grandparents raising grandchildren issues and/or caregivers.

5. The representation by an attorney at law, a trained paralegal and/or law student.

6. The provision of client advocacy for the caregivers and grandparent/older person raising grandchildren.

AWARD STANDARDS:

1. The Area Agency shall award funds to the legal assistance provider(s) that most fully meet the standards in 45 CRF Section 1321.71.

2. The Area Agency must award social service funds for legal assistance to older persons with economic and social needs. The purpose of awards under this section is to increase the availability of legal assistance with priority placed on older persons with the greatest economic or social need in order to assist them in securing their rights, benefits, and entitlements, and to assist them in achieving the objectives of the Act. Legal assistance provided with funds under this part must be in addition to any legal services already being provided to older persons in the planning and service area.

3. An Area Agency must award funds to a legal assistance provider which is either: a) an organization that receives funds under the Legal Services Corporation Act; or, b) an organization that has a legal assistance program or the capacity to develop one.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.12

FUNDABLE SERVICE: HEALTH SCREENING AND EVALUATION

SERVICE DEFINITION:

Services provided to assist individuals to secure and maintain a favorable condition of health by helping them identify and understand their physical and mental health needs and to secure and utilize necessary medical treatment. The focus of this service is on identifying and evaluating the health needs of older persons and linking them to the health care system, not on diagnosis, monitoring, and treatment.

SERVICE ACTIVITIES:

1) physical screening and evaluation of medical needs;
2) referral, follow-up, and arrangement for necessary care from health facilities (i.e., private physicians, hospitals, clinics, health departments, home health agencies, etc.);
3) individual health consultation and education;
4) health screening and evaluation activities may include: blood pressure, vision, hearing, podiatry, dental, vaccinations, and other health care activities; and,
5) coordination of the administration of flu shots.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.13

FUNDABLE SERVICE: HOME HEALTH

SERVICE DEFINITION:

Services provided to an individual, who is at risk of institutionalization, at his/her residence, according to a plan of care and/or treatment for illness or infirmity prescribed by a physician inclusive of part-time and intermittent nursing services and other therapeutic services such as physical therapy, occupational therapy, speech therapy, medical social services, or services provided by a home health aide.

SERVICE ACTIVITIES:

1) medication supervision, assistance with medication, and teaching of self-administration of medication with follow-up;
2) observation and recording of vital signs;
3) catheter maintenance;
4) non-sterile dressing change(s);
5) tube feeding;
6) colostomy care;
7) continued emphasis on teaching therapeutic diet management and maintenance (anyone on special diet, i.e., diabetic, gall bladder, ulcer, high residue, etc.);
8) continued emphasis on teaching medical equipment use and maintenance (i.e., to teach proper use and transfers relating to wheelchair, walker, crutches, and other assistive devices);
9) performance of simple procedures as an extension of therapeutic services, ambulation, and exercise;
10) reporting of changes in client's condition and needs to supervisor; and,
11) completion of appropriate records for each home visit.

NOTE: While some of these activities may be performed by home health aides, additional specialized services may be provided by a registered nurse, licensed practical nurse, or therapist. Service providers are not required to perform all of these allowable activities as described in this section as a part of their service design.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

A. GENERAL REQUIREMENT

If the Service Provider includes skilled nursing care as a part of the overall service design under this Section, they must then comply with the applicable state law, specifically, the Illinois Home Health Agency Licensing Act (Illinois Code Title 77, Chapter I, Subchapter b, Part 245).

B. CLIENT ELIGIBILITY -- In order to be eligible for Area Agency-funded services under this section a person must:

1. be 60 years of age or older;
2. be at risk of institutionalization due to his or her level of impairment(s) and/or the unavailability of home health service from other sources.

There must be a reasonable expectation that the client's needs can be met by the Service Provider at the client's place of residence.

C. TARGETING OF SERVICE -- The Service Provider shall, in consultation with the Area Agency, develop written procedures for the prioritization of clients to be served. In establishing these procedures consideration should be given to the applicant's level of impairment as well as social and economic factors.

D. CLIENT SCREENING, ASSESSMENT AND PLAN OF CARE

1. The Service Provider shall, in consultation with the Area Agency, establish written policies and procedures for conducting initial client screening to determine eligibility, to assess the needs of the client and to prepare a written plan of care. This plan of care shall be established in consultation with the client's personal physician or primary health care provider. Whenever a client, in the judgment of the Service Provider, has a clear need for other available community services which are not authorized in this Section, the Service Provider shall then refer the client to the local Case Coordination Unit for a comprehensive assessment.

2. The plan of care shall include, at a minimum:
   a. diagnosis;
   b. expected outcomes for the client (where applicable);
   c. the client's physician regimen of medications, treatments, activities, diet, procedures deemed essential for the client's health and safety, required frequency of visits and instructions for timely referral and/or discharge from the program; and,
   d. the client's physician's signature and date.

3. Consultation with the client's physician on any modifications in the plan deemed necessary shall be documented. The plan shall be reviewed every sixty days or more often should the patient's condition warrant.

4. Initial assessment and subsequent review and update of plans of care shall be made:
   a. by a registered nurse;
   b. by another health care professional on the specific orders of the client's physician; or,
   c. at the request of a registered nurse.

E. CASE RECORDS -- A case record must be developed for each client receiving services which shall include, at a minimum:

1. an initial screening/intake tool signed and dated by the client which documents the client's age, residency, need for the service and any demographic information (e.g. - sex, race, income level, living situation) as required for Area Agency reporting;

2. an assessment tool to be developed in consultation with the Area Agency;

3. the plan of care;

4. updates of plan(s) of care which are to be reviewed every sixty (60) days, or more often if the client's circumstances or condition changes significantly;

5. updated demographic information as indicated by changes in the client's circumstances;

6. written documentation of Units of Service and types of services provided;

7. a case summary prepared at discharge to include a review of service provided, the client's status, reason(s) for discharge and plans to arrange for the post-discharge needs of the client; and,

8. any other notes or documents which might be necessary to provide a clear and complete record of the history of service to the client.

This case record must be kept in a secure location and maintained in a manner consistent with the Area Agency's general administrative standards regarding record keeping and confidentiality.

F. STAFFING REQUIREMENTS --

1. The Service Provider will maintain adequate and appropriate staff to administer the service and to meet the needs of all cases accepted. A minimum ratio of one full-time Supervisor (or equivalent) for every twenty full-time (or equivalent) Home Health workers will be maintained.

2. Supervisor's activities shall include, but shall not be limited to:

    a. preparation or review of case notes and maintenance of the case records in a timely manner;
    b. preparation or review of reports on client circumstances and conditions;
    c. preparation or review of the client plans of care;
    d. planning and supervision of worker training and/or conferences as required;
    e. supervisory visits with each worker in a client's home at least semi-annually or more often as circumstances warrant;
    f. any other activities deemed necessary or appropriate by the Service Provider to ensure the successful delivery of the service.

3. Supervisory staff must be, at minimum, one of the following:

    a. a physician;
    b. a registered nurse;
    c. an individual with at least one year of supervisory or administrative experience in home health care or in related health provider programs; or,
    d. an individual who meets the requirements for Public Health Administrator as contained in 77 Illinois Administrative Code 600, Rule 3.00.

4. Staff providing direct service to clients in the home under this section must be, at a minimum, one of the following:

    a. a licensed practical nurse;
    b. a certified nurses aide;
    c. a related health care professional as described in 77 Illinois Administrative Code, Chapter 1, Subchapter b, Part 245.40.

Additionally, direct service staff must possess a record of physical examination, including tuberculosis test, within six months prior to assignment on the job, with recertification if the worker has contracted a communicable disease after the initial exam.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.14

FUNDABLE SERVICE: HOMEMAKER

SERVICE DEFINITION: Providing assistance to persons with the inability to perform one or more instrumental activities of daily living and general support by trained and professionally supervised homemakers to maintain, strengthen, and safeguard the functioning of individuals and families in their own homes when no responsible and capable person is available for this purpose. Such support includes teaching of and assistance with household management, and self-care.

SERVICE ACTIVITIES:

1. teaching meal planning and preparation, housekeeping skills, money management and budgeting, shopping skills, and home maintenance;

2. information sharing assistance with accessing of community resources;

3. assistance with self-administered medication (i.e., remind client to take his or her medication, read instructions for utilization, or uncap medication containers); these activities should be done as necessary or if they are not being met by another source;

4. assistance with following a written special diet plan and reinforcement of diet maintenance (special diets such as diabetic, low sodium, gall bladder, ulcer, high residue, etc.);

5. supervision, assistance with and/or performance of activities of daily living in the items listed above and items b) through c) as indicated below; and,

6. observation of client functioning and notification of changes in functioning to the staff member's professional supervision as required; NOTE: The service activities as follows are considered only when provided in conjunction with the above-mentioned service activities and when integral to the client's service plan: a) non-medical personal care tasks (shaving, hair shampooing and combing, assistance with sponge bath, assistance with tub bath limited to preparing and monitoring only when clients are able to enter and exit tub themselves, dressing, brushing, and cleaning and/or dentures). (Services in addition to (a) are only possible when appropriate training and professional RN supervision is available); b) housekeeping tasks (cleaning, shopping, meal preparation, and simple repairs); and, c) transportation or escort to medical facilities, errands, shopping, and miscellaneous

family/individual business necessary to client's welfare.

NOTE: Service providers are not required to perform all of these allowable activities as described in this section as a part of their service design.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service (face-to-face).
AWARD STANDARDS:

SERVICE STANDARDS:

A. CLIENT ELIGIBILITY -- In order to be eligible for Area Agency-funded services under this section a person must:
   1. be 60 years of age or older;
   2. exhibit some level of functional impairment which would indicate a clear need for the service.

B. TARGETING OF SERVICE -- The Service Provider shall, in consultation with the Area Agency, develop written procedures for the prioritization of clients to be served. In establishing these procedures consideration should be given to the applicant's level of impairment as well as social and economic factors.

C. CLIENT SCREENING, ASSESSMENT AND PLAN OF CARE -- The Service Provider shall, in consultation with the Area Agency, establish written policies and procedures for conducting initial client screening to determine eligibility, to assess the needs of the client and to prepare a plan of care. Whenever a client, in the judgment of the Provider, has a high level of impairment and/or multiple impairments, the Service Provider shall then refer the client to the local Case Coordination Unit for a comprehensive assessment.

D. CASE RECORDS -- A case record must be developed for each client receiving services which shall include, at a minimum:
   1. an initial screening/intake tool signed and dated by the client which documents the client's age, residency, need for the service and any demographic information (e.g., -sex, race, income level, living situation) as required for Area Agency reporting;
   2. an assessment tool to be developed in consultation with the Area Agency;
   3. the plan of care;
   4. updates to the plan(s) of care which are to be developed annually or more often if the client's circumstances or condition changes significantly;
   5. updated demographic information as indicated by changes in the client's circumstances;
   6. written documentation of Units of Service and types of services provided;
   7. any other notes or documents which might be necessary to provide a clear and complete record of the history of service to the client.

This case record must be kept in a secure location and maintained in a manner consistent with the Area Agency's general administrative standards regarding record keeping and confidentiality.

E. STAFFING REQUIREMENTS --

1. The Service Provider will maintain adequate and appropriate staff to administer the service and to meet the needs of all cases accepted. A minimum ratio of one full-time Supervisor (or equivalent) for every twenty full-time (or equivalent) Homemakers will be maintained.

2. Supervisor's activities shall include, but shall not be limited to:

   a. preparation or review of case notes and maintenance of the case records in a timely manner;
   b. preparation or review of reports on client circumstances and conditions;
   c. preparation or review of the client plans of care;
   d. planning and supervision of quarterly worker training and/or conferences as required;
   e. supervisory visits with each worker in a client's home at least semi-annually or more often as circumstances warrant;
   f. weekly contact with each Homemaker and face-to-face supervision with each Homemaker every calendar quarter;
   g. home visits or documented direct client contact to revise the plan of care annually or more often if a significant change in the client's circumstances or condition is noted; and,
   h. any other activities deemed necessary or appropriate by the Service Provider to ensure the successful delivery of the service.

3. Supervisory staff must possess the following minimum qualifications:

   a. a high school diploma or equivalent plus two years experience in health service or a related field, one year of which must have been supervisory experience; or,
   b. RN or LPN certification plus a minimum of one (1) year of supervisory experience in health service or related field.

4. Homemakers under this section must possess the following minimum qualifications:

   a. High School Diploma or equivalency (or demonstrate continued progress toward a General Education Diploma) or one year of prior experience as a Homemaker;
   b. basic knowledge of home management skills; and,
   c. a record of physical examination, including tuberculosis test, within six months prior to assignment on the job, with recertification if the worker has contracted a communicable disease after the initial exam.

5. Staff activities shall include, but shall not be limited to:

   a. provision of service in accordance with the client's plan of care;

b. observation of the client's functioning and reporting same to the supervisor;
c. making records of daily activities, observations, progress toward goals and direct hours of service;
d. participation in training, in-service training and staff conferences; and,
e. other duties as assigned.

6. Each Homemaker will be provided a minimum of fifteen hours training (exclusive of agency orientation) within a week from date of hire, unless prior equivalent related training and/or experience can be documented. Each worker shall also receive, at a minimum, three hours of in-service training per calendar quarter.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.15

FUNDABLE SERVICE: HOUSING ASSISTANCE

SERVICE DEFINITION:

Technical help to relocate or obtain more suitable housing. The service excludes direct financial assistance to individuals for the purpose of obtaining housing.

SERVICE ACTIVITIES:

1) assistance in locating suitable and adequate housing which the individual can afford; and,

2) relocation assistance.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.16

FUNDABLE SERVICE: INDIVIDUAL NEEDS ASSESSMENT

SERVICE DEFINITION:

This social service provides for direct face-to-face contact with a potential or existing recipient of supportive and/or nutrition services to examine medical, social, and psychological factors relating to the need for service. This determination will include analyzing, evaluating, and verifying (when necessary) current, full, and complete information obtained at this personal assessment, in addition to any information from collateral sources as necessary. The personal assessment will be accomplished through the use of a standardized assessment tool (approved by the Area Agency) to obtain medical, social factors including availability of informal support.

SERVICE ACTIVITIES:

1) home delivered meals assessment;
2) assessment of the individual's need;
3) verification of pertinent information;
4) completion of necessary reporting and authorization of assistance; and,
5) referral to sources of assistance.

UNIT OF SERVICE:

One hour of staff time expended in behalf of a client constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.17

FUNDABLE SERVICE: LEGAL ASSISTANCE

SERVICE DEFINITION:

Legal Assistance shall include arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research, and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney) for an older person (or his/her representative.)

SERVICE ACTIVITIES:

1) provision of legal advice and information;

2) legal research on behalf of client(s);

3) education concerning legal rights;

4) representation by an attorney at law, a trained paralegal; and/or a law student;

5) provision of client advocacy to secure needed and entitled benefits.

UNIT OF SERVICE:

Representation by an Attorney, a Paralegal, and/or a Law Student:

One hour of time spent by one person working on a case constitutes one unit of service.

Legal Information and Community Education:

One hour of staff time expended in behalf of a client(s) constitutes one unit of service.

AWARD STANDARDS:

1) The Area Agency shall award funds to the legal assistance provider(s) that most fully meet the standards in 45 CFR Section 1321.71.

2) The Area Agency must award social services funds for legal assistance to older persons with

economic or social needs. The purpose of awards under this section is to increase the availability of legal assistance with priority placed on older persons with the greatest economic or social need in order to assist them to secure their rights, benefits, and entitlements, and to assist them in achieving the objectives of the Act. Legal assistance provided with funds under this part must be in addition to any legal services already being provided to older persons in the planning and service area; and,

3) An Area Agency must award funds to a legal assistance provider which is either: a) an organization that receives funds under the Legal Services Corporation Act; or, b) an organization that has a legal assistance program or the capacity to develop one.

SERVICE STANDARDS:

See the full text of 45 CFR Section 1321.71. (Legal Assistance) from the OAA Rules and Regulations. The following summarizes 45 CFR Section 1321.71:

1) The legal assistance provider(s) selected must be the agency which most fully meet(s) the following standards: a) has staff with expertise in specific areas of law affecting older persons in economic or social need; for example, public benefits, institutionalization and alternatives to institutionalization; b) demonstrates the capacity to provide effective administrative and judicial representation in the areas of law affecting older persons with social or economic need; c) demonstrates the capacity to provide support to other advocacy efforts; for example, the long term care ombudsman program; d) demonstrates the capacity to effectively deliver legal assistance to institutionalized, isolated, and home-bound individuals; e) has offices and/or outreach sites which are convenient and accessible to older persons in the community; f) demonstrates the capacity to provide legal assistance in a cost effective manner, and, g) demonstrates the capacity to obtain other resources to provide legal assistance to older persons.

2) Each legal assistance provider must make efforts to involve the private bar in legal assistance provided under this part, including groups within the private bar that furnish legal services to older persons on a pro bono and reduced fees basis;

3) In areas where a significant number of clients do not speak English as their principal language, the legal assistance provider must adopt employment policies that ensure that legal assistance will be provided in the language spoken by those clients;

4) The legal assistance provider must ensure that legal assistance is not provided in fee generating cases, as defined in 45 CFR 1609.2 unless adequate representation is unavailable from private attorneys;

5) Each legal assistance provider that is not a Legal Services Corporation grantee must agree to coordinate its services with Legal Services Corporation grantees in order to concentrate legal assistance funded under this part on older persons with the greatest economic or social need who are not eligible for services under the Legal Services Corporation Act. In carrying out this requirement, legal assistance providers may not use a means test or require older

persons to apply first for services through a Legal Services Corporation grantee; and,

6) A legal assistance provider may not require an older person to disclose information about income or resources as a condition for providing legal assistance under this part. A legal assistance provider may ask about the person's financial circumstances as a part of the process of providing legal advice, counseling and representation, or for the purpose of identifying additional resources and benefits for which an older person may be eligible.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.18

FUNDABLE SERVICE: MEDICATION MANAGEMENT

SERVICE DEFINITION:

Medication Management services are provided to help older persons who have limited ability to manage prescription drugs. The goal of medication management is to promote and prolong independent living for older persons who are at risk of losing their independence due to the inability to manage prescription medications.

SERVICE ACTIVITIES:

1. Organizing medications assists the client with the following:

    a. Obtaining and refilling medications;
    b. Storing and controlling medications;
    c. Sorting doses of medication in medication organizers;
    d. Disposing of medication.

2. Supervision of self-administered medication assists the client with self-administered medication using any combination of the following:

    a. Reminding the client to take medication;
    b. Observing the client;
    c. Confirming that the client has obtained and is taking the prescribed dosage;
    d. Reading the medication label to the client;
    e. Checking the self-administered medication dosage against the label of the medication;
    f. Opening the medication container for a client who is physically unable to do so;
    g. Instructing the client how to administer the medication;
    h. Documenting in writing that the client has taken (or refused to take) the medication.

UNIT OF SERVICE

One hour of staff time (face-to-face) expended on behalf of a client constitutes one unit of service.

SERVICE STANDARDS

1. Medication Management services shall be provided by a licensed health care professional.

2. The service provider shall establish medication policies and procedures approved by a physician, pharmacist, or registered nurse. The policies and procedures shall address:

    a. Obtaining and refilling medication;
    b. Storing and controlling medication;
    c. Disposing of medication;
    d. Assisting in the self-administration of medication;
    e. Recording of medication assistance provided to clients and maintenance of client records.

3. If the service provider supervises self-administered medication, a drug reference guide, no older than 2 years from the copyright date, shall be available and accessible for use by employees.

4. Except for medication organizers, client medication shall not be pre-poured. Medication organizers may be prepared up to 4 weeks in advance by a licensed health care professional.

5. A case record must be developed for each client receiving medication management services, which shall include, at a minimum:

    a. An initial screening/intake tool signed and dated by the client which documents the client's age, residency, need for the service and any demographic information (e.g. sex, race, income level, living situation) as required for Area Agency reporting;
    b. A list of contacts to be reached in case of a medical emergency;
    c. A list of diagnosed medical conditions;
    d. A list of medications prescribed by the client's physician(s);
    e. The name, address, and telephone numbers of the client's primary care physician and other physicians who have prescribed medications for the client;
    f. The name, address and telephone numbers of pharmacies which have dispensed prescription drugs to the client;
    g. Written documentation of units of service and types of medication management services provided;
    h. Any other notes or documents which might be necessary to provide a clear and complete record of the history of service to the client.

6. Direct service staff must possess a record of physical examination, including tuberculosis test, within six months prior to assignment on the job, with re-certification if the worker has contracted a communicable disease after the initial exam.

7. Medication Management programs shall integrate evidence-based healthy aging interventions as directed by the Illinois Department on Aging.

AWARD STANDARDS: (Reserved)

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.19

FUNDABLE SERVICE: MONEY MANAGEMENT

SERVICE DEFINITION:

Money Management services are provided to help low income older persons who have difficulty budgeting, paying routine bills, and keeping track of financial matters. The goal of money management services is to promote and prolong independent living for older persons who are at risk of losing their independence due to the inability to manage their financial affairs. Service options may include Bill Payer services and Representative Payee services.

SERVICE ACTIVITIES:

A. **Bill Payer** services which provide assistance to low-income older persons who are able to make responsible decisions about their financial affairs but who may be physically or mentally impaired.

   Service activities include:

   1. Establishing a budget;
   2. Opening, organizing and sending out mail;
   3. Assisting the client with record keeping, correspondence and check writing (all checks signed by the client); and,
   4. Balancing the checkbook.

   NOTE: All services are to be provided in the client's home.

B. **Representative Payee** services may only be provided by persons who have been appointed by a government agency to receive and manage a government benefit, such as Social Security benefits, Supplemental Security Income, VA pension benefits, etc., when the client has been determined by a physician to be incapable of handling his or her own funds. Representative Payee services involve the complete financial management of a government benefit(s) on behalf of a client.

   Service activities include:

   1. Receiving benefit checks;

2. Depositing benefit checks in a bank;
3. Paying the bills for the client; and,
4. The Representative Payee may make decisions about how benefit payments will be spent to ensure the basic needs of the client are met.

UNIT OF SERVICE:

One hour of staff time (face-to-face) expended on behalf of a client constitutes one unit of service.

SERVICE STANDARDS:

A Money Management service provider will comply with the standards established by AARP/Legal Council for the Elderly's Money Management Program.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.20

FUNDABLE SERVICE: MULTI-PURPOSE SENIOR CENTER

SERVICE DEFINITION:

A multipurpose senior center is defined as a community facility with regular operating hours and staff that provide for a broad spectrum of health, social, nutritional and educational services and recreational activities for older persons. Funds may be awarded to a public or nonprofit organization for the acquisition, alteration, renovation, construction (where appropriate), or operation of a facility that meets federal, state and local regulations and/or ordinances, which serves as a multipurpose senior center.

SERVICE ACTIVITIES MAY INCLUDE:

A. FACILITY DEVELOPMENT-

Acquisition--obtaining ownership of an existing facility in fee simple or by lease for ten (10) years or more for use as a multipurpose senior center. (45CFR Section 1326.3)

Alteration or Renovation--making modification to or in connection with an existing facility which are necessary for its effective use as a center. These may include renovation, repair or expansion which is not in excess of double the square footage of the original facility and all physical improvements. (45CFR Section 1321.3)

Construction--building a new facility, including the costs of land acquisition and architectural and engineering fees, or making modifications to or in connection with an existing facility which are in excess of double the square footage of the original facility and all physical improvements. (45CFR Section 1321.3)

B. OPERATIONS-

The costs associated with the day-to-day physical operation of a facility that serves as a multipurpose senior center, including equipment and the professional and technical personnel of a multipurpose senior center necessary for its operation.

UNIT OF SERVICE:

A. FACILITY DEVELOPMENT-

There is no unit of service measurement for the development of a facility other than the quarterly reporting of each facility receiving funding for this service activity.

B. OPERATIONS-

There is no unit of service measurement for the operation of a facility other than the quarterly reporting of each facility receiving funding for this service activity.

AREA AGENCY AWARD STANDARDS:

1. The Area Agency may award funds to a public or nonprofit organization for the following purposes:

   a. Acquiring, altering, leasing or renovating a facility, including a mobile facility, for use as a multipurpose senior center;

   b. Constructing a facility, including a mobile facility, for use as a multipurpose senior center, subject to the provisions of this Section;

   c. Assisting in the operation of a facility that serves as a multipurpose senior center, including equipment and meeting all or part of the costs of professional and technical personnel required to operate a multipurpose senior center.

2. In making awards, the Area Agency must give preference to facilities located in communities with the greatest incidence of older persons with the greatest economic or social need, with particular attention to low-income minority individuals.

3. Special conditions for acquiring by purchase or constructing a facility are:

   a. The Area Agency must obtain the approval of the Department on Aging before making an award for constructing a facility.

   b. The Area Agency may make an award for purchasing or constructing a facility only if there are no suitable facilities available for leasing.

4. The Area Agency must ensure that the facility complies with all applicable state and local health, fire, safety, building, zoning, and sanitation laws, ordinances or codes. (45CFR Section 1321.75a).

5. The Area Agency must ensure the technical adequacy of any proposed alteration or renovation of a multipurpose senior center assisted under Title III of the Older Americans Act, by requiring that any alteration or renovation of a multipurpose senior center that affects the load bearing members of a facility is structurally sound and complies with all applicable local or State ordinances, laws, or building codes. (45CFR Section 1321.75b).

6. The Area Agency will notify the Department on Aging of any proposed alteration or renovation so that the Department can consult with the Secretary of Housing and Urban Development with respect to the technical adequacy of any proposed alteration or renovation.

SERVICE STANDARDS:

1. The recipient of any multipurpose senior center award must comply with all applicable state and local health, fire, safety, building, zoning, and sanitation laws, ordinances and codes.

2. The recipient of any multipurpose senior center award must install, in consultation with state or local fire authorities, an adequate number of smoke detectors in the facility.

3. The recipient of any multipurpose senior center award must have a plan for assuring the safety of older persons in a natural disaster or other safety threatening situation.

4. In a facility that is shared with other age groups, funds received under Title III of the Older Americans Act may support only:

   a. That part of the facility used by older persons; or
   b. A proportionate share of the costs based on the extent of use of the facility by older persons.

5. A multipurpose senior center program must be operated in the facility. The recipient of any multipurpose senior center award, at a minimum, must provide four services on a regular basis. One of these four services must be nutrition.

8. Any facility which is altered or renovated using Older Americans Act and related grant funds must be used for the purpose for which the alteration and/or renovation was completed for at least five (5) years if the Federal cost of the alteration and/or renovation is $5,000 or less or for at least ten (10) years if the Federal cost of the alteration and/or renovation is over $5,000.

7. The recipient of an award for acquisition, alteration or renovation of existing facilities of a multipurpose senior center must assure that (Older Americans Act--Section 307-14):

   a. For not less than ten (10) years after acquisition, or not less than twenty (20) years after the completion of construction, the facility will be used for the purpose for which it is to be acquired or constructed, unless for unusual circumstances the Commissioner of the Administration on Aging waives this requirement;

   b. Sufficient funds will be available to meet the non-Federal share of the cost of acquisition or construction of the facility;

   c. Sufficient funds will be available when acquisition or construction is completed, for effective use of the facility for the purpose for which it is being acquired or

constructed;

d. The facility will not be used and is not intended to be used for sectarian instruction or as a place for religious worship;

e. In the case of purchase or construction, there are not existing facilities in the community suitable for leasing as a multipurpose senior center;

f. The plans and specifications for the facility are in accordance with regulations relating to minimum standards of construction, promulgated with particular emphasis on securing compliance with the requirements of the Architectural Barriers Act of 1968; and,

g. Any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the facility will be paid wages at rates not less than those prevailing for similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276A, commonly known as the Davis-Bacon Act), and the Secretary of Labor shall have, with respect to the labor standards specified in this clause, the authority and functions set forth in reorganization plan numbered 14 of 1950 (15 FR 3176; 64 Stat. 1267) and Section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

8. The recipient of a multipurpose senior center award must assure that the multipurpose senior center has a sufficient number of personnel (paid and volunteer) to implement the activities and services planned to meet the multipurpose senior center's goals and objectives, and to insure adequate paid or volunteer staffing for the number of persons served and the frequency of services provided.

9. Multipurpose senior center staff whose salaries or wages are paid in whole or in part through multipurpose senior center operations dollars awarded by the Area Agency on Aging must meet, at minimum, the following criteria:
   a. Be employed by and responsible to the governing board of the organization receiving Area Agency funding for multipurpose center operations;
   b. Have the authority, as determined by their governing board referenced in (9a) above, to conduct the day-to-day operations of the multipurpose senior center and the programs offered from the multipurpose senior center; and,
   c. Have demonstrated experience to carry out the functions of the specific job position for which they are employed in accordance with a written job description.

10. The multipurpose senior center governing board must assure that quality services are available to participants by effective utilization of multipurpose senior center staff, and/or other service providers.

11. A multipurpose senior center shall make use of community resources to supplement its personnel by:
    a. recruiting older people to participate in the work of the multipurpose senior center;

and,

b. recruiting volunteers of all ages representing service, civic, and professional organizations.

12. A multipurpose senior center shall attempt to encourage interaction between multi-generational age groups by scheduling activities and/or programs which promote understanding, sharing and exchanging of thoughts, ideas and/or philosophies indigenous to particular age groups. The use of younger volunteers is also encouraged by the Area Agency on Aging.

13. A multipurpose senior center shall have a written plan of action by which to recruit and/or attract active participation by young (age 55-65) seniors.

NOTE: The Area Agency strongly encourages service providers to review the entire National Institute of Senior Center Standards (available from the Area Agency) and utilize them as a self-assessment tool in the interest of setting goals and promoting consistent quality senior center programming across the planning and service area and the state.

RECAPTURE OF PAYMENTS:
(Older Americans Act--Section 312)

If, within ten (10) years after acquisition, or within twenty (20) years after the completion of construction, of any facility for which funds have been paid under Title III of the Older Americans Act:

1. The owner of the facility ceases to be a public or nonprofit agency or organization; or

2. The facility ceases to be used for the purposes for which it was acquired (unless the Commissioner of the Administration on Aging determines in accordance with regulations that there is good cause for releasing the applicant or other owner from the obligation to do so);

The Area Agency shall be entitled to recover from the applicant or other owner of the facility an amount which bears to the then value of the facility (or so much thereof as constituted an approved project or projects) the same ratio as the amount of such Federal funds bore to the cost of the facility financed with the aid of such funds. Such value shall be determined by agreement of the parties or by action brought in the United States district court for the district in which such facility is situated.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.21

FUNDABLE SERVICE: NUTRITION SERVICES

PURPOSE: Nutrition services are provided to assist older Americans to live independently by promoting better health through improved nutrition and reduced isolation through a program coordinated with other supportive services. As outlined in the Older Americans Act, the purposes of Title III-C funds are:

1. To reduce hunger and food insecurity;
2. To promote socialization of older individuals; and,
3. To promote the health and well-being of older individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

SERVICE DEFINITION:

Provision of nutritious meals in a congregate meal site or to older persons who are homebound because of illness or incapacitating disability or otherwise isolated.

SERVICE ACTIVITIES:

1) Preparation of Meals;
2) Service of Meals;
3) Transport of Meals;
4) Nutrition Education;
5) Outreach and,
6) Other Nutrition Services as Appropriate Based on the Needs of Meal Recipients.

UNIT OF SERVICE:

Each meal provided to an eligible person constitutes one unit of service.

AWARD STANDARDS:

1. Contracts awarded for the provision of nutrition services shall be awarded through a competitive process. Whenever there is no evidence of improved quality of services or cost

effectiveness on the part of another bidder, a provider of services who received funds under Title VII of the Older Americans Act of 1965 as in effect on September 29, 1978, shall be given preference.

2. Primary consideration shall be given to the provision of meals in a congregate setting, except that each Area Agency (a) may award funds made available under title to organizations for provision of home delivered meals to older individuals in accordance with the provision of Title III-C2, based upon determination of need made by this title, without requiring that such organizations also provide meals to older individuals in a congregate setting; and, (b) shall, in awarding such funds, select such organizations in manner which complies with the provisions of paragraph 3 below.

3. Consideration will be given where feasible, in the furnishing of home delivered meals to the use of organizations which (a) have demonstrated an ability to provide home delivered meals efficiently and reasonably; and (b) furnish assurances to the Area Agency that such an organization will maintain efforts to solicit voluntary support and that funds made available under this title to the organization will not be used to supplant funds from non-federal sources.

ELIGIBILITY STANDARDS:

A. Congregate Meals

1. Individuals eligible to receive a meal at a congregate nutrition site include individuals aged 60 or older and the spouses of those individuals, regardless of age, if the eligible spouse is or has been an active participant of the program.

2. A meal may be available to:

    a. Disabled individuals (as defined in OAA Section 102(8)(9) who have not attained 60 years of age but who reside in housing facilities occupied primarily by the elderly at which congregate nutrition services are provided; and,

    b. Individuals with disabilities who reside at home with and accompany older individuals who are eligible under the OAA.

3. Other individuals eligible to receive a congregate meal:

    a. Each service provider shall establish procedures, in consultation with the project's advisory council, that will allow nutrition project administrators the option to offer a meal, on the same basis as meals are provided to elderly participants, to individuals providing volunteer services during the meal hours; and,

    b. Staff or guests under age 60 may be offered a meal, if doing so will not

deprive an older person of a meal. Staff or guests shall pay for the full cost of the meal. Full cost of the meal includes: raw food; labor (personnel); equipment; supplies; utilities/rent; and other. Policies regarding contributions may allow that the full cost of the meal be considered that cost which a cash cost (excluding in-kind). The project administrator may offer a meal to staff as a fringe benefit. These meals should be included as employee fringe benefit costs in the budget. Employees are responsible for any tax liability on the value of the fringe benefit.

B. Home Delivered Meals:

1. Individuals aged 60 or over who are frail, homebound by reason by illness, incapacitating disability as defined in OAA section 102(8)[9] or are otherwise isolated. The spouse of the older person, regardless of age or condition, may receive a home delivered meal if, according to criteria determined by the Area Agency, receipt of the meal is in the best interest of the homebound person;
2. Disabled individuals (as defined in OAA Section 102 (8)[9] who have not attained 60 years of age but who reside in housing facilities occupied primarily by the elder at which congregate nutrition services are provided; and,
3. Individuals with disabilities who reside at home with older individuals who are eligible under the OAA.

SERVICE STANDARDS

A. Each Congregate Meal Provider Must:

1. Provide a hot or other appropriate meals in a congregate setting at least once a day, five or more days a week (except in a rural area where such frequency is not feasible, and a lesser frequency is approved by the Department.) An Area Agency may grant exception(s) when the provider:

   a. Submits documentation of need for the exception(s); and,

   b. Serves meals at least 5 days per week throughout the service area, but not necessarily 5 days per week at each site; or serves a low-income minority target population.

2. Locate congregate nutrition services in a site in as close proximity to the majority of eligible individuals' residences as feasible, with particular attention upon a multipurpose senior center, a school, a church, or other appropriate community facility, preferably within walking distance where possible, and where appropriate, transportation to such site is furnished;

3. Establish outreach activities, which assure that the maximum number of eligible individuals may have an opportunity to participate;

4. Coordinate with other appropriate services in the community; and,

5. If operated by special interest groups, such as churches, social organizations, homes of the elderly, senior housing developments, etc., shall not limit participation to their own membership or otherwise show preferential treatment for such membership.
6. Provide each participant the Food Allergies and Special Diets Notification document.

B. Each Home Delivered Meal Provider Must:
1. Service providers conducting the assessment for home delivered meals must determine the most appropriate form of meal delivery in communities where cold or frozen meals are offered in addition to hot meals.

2. Service providers must assess all participants receiving cold and frozen meals to ensure they have the proper equipment (freezer, oven, microwave, and refrigerator) and physical and cognitive skills to store and re-heat the meals.

3. An older adult eligible to receive home delivered meals should not be denied services based on the individual's inability to safely store and prepare a frozen meal. If the older adult does nto have the capacity to heat the frozen meal or family members or others are not able to heat the frozen meal for the older adult, the nutrition provider should attempt to deliver hot meals to the older adult if the older adult resides within a community where home delivered meals are provided. In isolated rural areas where the nutrition provider only has the capacity to provide frozen meals, the nutrition provider should make a referral for Medicaid Waiver in-home or adult day services or other community services as appropriate for the older adult to receive assistance with meals.

4. Provide for home delivered meals at least once a day, five or more days a week (except in a rural area where such frequency is not feasible and a lesser frequency has been approved by the Area Agency). Meals may be hot, cold, frozen, canned or supplemental foods with satisfactory storage life;

5. With the consent of the older person, or his or her representative, bring to the attention of the personnel of appropriate agency(ies) for follow-up, conditions or circumstances which place the older person or the household in imminent danger; and,

6. When feasible and appropriate, make arrangements for the availability of meals to older person in weather related emergencies.

C. Each Nutrition Service Provider Must:

1. Have procedures for obtaining the views of participants about the services they receive;

2. Solicit the expertise of an Illinois Licensed Dietitian Nutritionist (or Illinois licensed healthcare practitioner whose license includes nutrition services) based on the requirements of the state Dietetic and Nutrition Services Practice Act, Section 15. An individual licensed to practice dietetic or nutrition services in another state that has

licensure requirements considered by the Illinois Department of Financial and Professional Regulation to be at least as stringent as the requirements for licensure under the Illinois Act, may review and approve menus.

Although nutrition service providers do not have to include licenses dietitians on staff, state rules do require that licensed dietitians are involved in the review and approval of menus. Menu planning and review can be arranged through subcontracts or volunteer agreements.

3. Solicit the advice and expertise of other individuals knowledgeable with regard to the needs of older individuals.

4. Follow appropriate procedures to preserve nutritional value and food safety in purchasing and storing food, and preparing, serving and delivering meals;

5. Provide special menus, where feasible and appropriate, to meet the particular dietary needs arising from the health requirements, religious requirements, ethnic or cultural backgrounds of eligible individuals; and,

6. Have available for use upon request appropriate food containers and utensils for person with disabilities.

D. Assess for Home Delivered Meals

1. An assessment of each person requesting home delivered meals must be completed to determine the individual's need for service. The HDM provider must utilize the 1272 *Universal Nutrition Referral Assessment for Home Delivered Meals* form, provide the *Nutritional Risk and Your Health* brochure as well as the *Food Allergies and Special Diets Notification* document.

2. A periodic reassessment of the home delivered meal recipient must also be completed at least annually, or sooner if circumstances change.

E. Nutrition Education Services

1. The nutrition provider shall provide nutrition education on at least a semiannual basis to the participants in the nutrition programs.

2. It is strongly recommended that nutrition education be provided quarterly to congregate and home delivered meal participants and more frequently if possible and may include information about the SNAP program and benefits.

3. The purpose of nutrition education is to inform individuals about available facts and information that will promote improved food selection, eating habits, nutrition and health-related practices. These activities are designed to:
   a. assist older persons in obtaining the best nutritional services available within

their resources;

b. aid older persons in making sound food choices consistent with the dietary Guidelines for Americans, and in obtaining the best food to meet nutrition needs;

c. increase awareness of community-sponsored health programs that encourage and promote sound nutritional habits and good health; and,

d. assist older persons, where feasible, in the area of therapeutic diets as required by health or social condition.

e. provide 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.

4. Coordination with community resources is encouraged in the provision of nutrition education services.

F. Meal Requirements

Meals provided through the nutrition program must comply with the dietary Guidelines for Americans, published by the secretary of Health and human Services and the Secretary of Agriculture; and, provide each participant:

1. 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 the participant is offered one meal per day;

2. A minimum of 66 2/3 percent of the allowances if the participant is offered two meals per day; and,

3. 100 percent of the allowances if the participant is offered three meals per day.

When planning breakfast for congregate meal participants, the meal must meet 1/3 of the DRI in and of itself, unless it is assured that the breakfast participant will also receive lunch (or dinner) that day at the meal site. In the case of home delivered meal participants; however, where the same participant is being provided with two or three meals on a given day, menus can be planned so that the combined nutritional content meets 2/3 or 1 full DRI respectively.

G. Nutrition Services Incentive Program (formerly USDA) for the Elderly

1. Nutrition service providers are eligible to receive Nutrition Services Incentive Program (NSIP) cash assistance in the form of reimbursement for meals served through NSIP's Nutrition Program for the Elderly. Allocated funding may be claimed for meals that:

a. Meet the dietary guidelines as specified in Item F above;

b. Are served to eligible participants, which include persons 60 years of age or older, their spouses, disabled persons and volunteers, as described in the Eligibility

Standards, A & B above; (NSIP reimbursement may NOT be claimed for meals served to guests or staff under 60 years of age.)

c. Are served by an agency that has received a grant under Title III of the Older Americans Act and is under the jurisdiction, control, management, and audit authority of an AAA or the Department; and,

d. Are provided with no set fee charged to the recipients.

2. NSIP funds:

a. Shall be used to increase the total number of meals served;

b. Shall only be used to purchase United States agricultural commodities and other U.S. grown foods; and,

c. Shall not be used to off-set program costs or as non-federal matching funds for any other federal program.

H. Voluntary Contributions

1. Each project providing nutrition services may solicit voluntary contributions for meals, taking into consideration the income ranges of eligible individuals in local communities and other sources of income of the project.

2. Each project must protect the privacy of each older person with respect to his or her contributions; establish appropriate procedures to safeguard and account for all contributions; and may not deny an older person a service because the older person cannot or will not contribute to the cost of the service.

3. Voluntary contributions must be used to increase the number of meals served by the project, facilitated access to such meals, and provide other supportive services directly related to nutrition services.

I. Illinois Link

The nutrition service provider must assist participants in taking advantage of benefits available to them under the Illinois LINK program. The nutrition service provider must coordinate its activities with the local Illinois Department of Human Services office administering the LINK program to facilitate participation of eligible older persons in the program.

J. Menu Planning

Menus must be:

1. Planned in advance for a minimum of one month with repetition of entrees and other menu items kept at a minimum. If a cycle menu is utilized, there shall be at least three cycles per year. If the cycle is at least 6 weeks or greater in length, there shall be at least 2 cycles per year.

2. Approved by the provider's licensed dietician nutritionist as defined in the Service Standards above;
3. Posted with serving dates indicated in a location conspicuous to participants at each congregate meal site as well as in each preparation area;
4. Legible and easy to read (it is recommended that menus be printed in the language(s) of the participant group);
5. Adhered to, subject to season availability of food items; and,
6. Kept on file, with any changes noted in writing, for at least one year.

K. Menu Pattern

1. Service providers who chose not to complete a nutritional analysis of their menus will follow the meal pattern described in this section.

Requirements for One or Two Meal(s) Daily

Each meal must provide*:

(1) Serving of lean meat or meat alternate: 3 ounces of edible cooked meat, fish, fowl, eggs, or meat alternate

(2) Serving(s) vegetables: ½ cup equivalent – may serve an additional vegetable instead of a fruit.

(3) Serving fruit: ½ cup equivalent – may serve an additional fruit instead of a vegetable

(4) Servings grain, bread or bread alternate, preferable whole grain: for example, 2 slices of whole grain or enriched bread 1 ounce each or 1 cup cooked pasta or rice.

(5) Serving fat free or low fat milk or milk alternative: 1 cup equivalent

*Margarine and dessert are optional and must be counted in the calories, fat and sodium totals, if served in addition to the above components.

Requirements for Three Meals Daily
The three meals combined must provide:

(1) Servings of lean meat or meat alternate: 6 ounces of edible cooked meat, fish, fowl, eggs or meat alternate

(3-4) Servings vegetables

(2-3) Servings fruit

(6-9) Servings whole grain/enriched grain, bread or bread alternative

(3) Servings fat free or low fat milk or milk alternate

Meat or Meat Alternate

- Three ounces (providing at least 19 g protein) of lean meat, poultry, fish or meat alternate should generally be provided for the lunch or supper meal. Meat serving weight is the edible portion, not including skin, bone, or coating.

- Meat (1 ounce) alternates include:
  1 medium egg
  1-ounce cheese (nutritionally equivalent measure of pasteurized process cheese, cheese food, cheese spread, or other cheese product)
  ½ cup cooked dried beans, peas or lentils
  2 tablespoons peanut butter or 1/3 cup nuts
  ¼ cup cottage cheese
  ½ cup tofu
  1 ounce of soy type burger

- A one ounce serving or equivalent portion of meat, poultry, fish, may be served in combination with other high protein foods.
- Protean/lean meat/meat alternate items containing textured vegetable protein and providing at least 19 g protein in a (3 oz) serving may be served.
- Except to meet cultural and religious preferences and for emergency meals, serving dried beans, peas or lentils, peanut butter or peanuts, and tofu for consecutive meals or on consecutive days should be avoided.
- Imitation cheese (which the Food and Drug Administration defines as one not meeting nutritional equivalency requirements for the natural, non-imitation product) cannot be served as meat alternates.
- To limit sodium content of the meals, serve no more than once a week cured and processed meats (e.g., ham, smoked or Polish sausage, corned beef, wieners, luncheon meats, dried beef).
- To limit the amount of fat, especially saturated fat, and cholesterol in meals, regular ground meat should be served no more than twice weekly when one meal is provided, four times weekly if two meals are provided, and no more than 6 times a week if three meals are provided.

Vegetables

- A serving of vegetable (including cooked dried beans, peas and lentils) is generally ½ cup cooked or raw vegetable; or ¾ cup 100% vegetable juice, or 1-cup raw leafy vegetable. For pre-packed 100% vegetable juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.
- Fresh, frozen or unsalted canned vegetables are preferred instead of canned vegetables

containing salt.

- Vegetables as a primary ingredient in soups, stews, casseroles or other combination dishes should total ½ cup per serving.
- At least one serving from each of the five vegetable subgroups must be included in a weekly menu. The five vegetable subgroups include dark green vegetables, orange vegetables, cooked dry beans and peas, starchy vegetables, and "other" vegetables.
- A serving of cooked legumes (dried beans, peas and lentils) must be included twice each week, if one meal is provided: 4 servings per week must be included, if two or three meals are provided.

Fruits

- A serving of a fruit is generally a medium apple, banana, orange, or pear; ½ cup chopped, or canned fruit; or ¾ cup 100% fruit juice. For pre-paced 100% fruit juices, a ½ cup juice pack may be counted as a serving if a ¾ cup pre-packed serving is not available.

- Fresh, frozen, or canned fruit will preferably be packed in juice, without sugar or light syrup.

Grain, Bread or Bread Alternate

- A serving of grain or bread is generally 1 slice (1 ounce), whole grain or enriched; ½ cup cooked whole grain or enriched pasta or grain product; or 1 ounce of ready-to-eat cereal. ***Priority should be given to serving whole grains.*** Grain, bread and bread alternates include:

  1 small 2 ounce muffin, 2" diameter
  2 mini muffins
  2" cube cornbread
  1 biscuit, 2" diameter
  1 waffle, 4" diameter
  1 slice French toast
  ½ slice French toast from "Texas toast"
  ½ English muffin
  1 tortilla, 4-6" diameter
  1 pancake, 4" diameter
  ½ bagel
  1 small sandwich bun (<3" diameter)
  ½ cup cooked cereal
  4-6 crackers (soda cracker size)
  ½ large sandwich bun
  ¾ cup ready to eat cereal
  2 graham cracker squares
  ½ cup cooked pasta, noodles or rice
  Prepared pie crust, 1/8 of a 8" or 9" two-crust pie
  ½ cup cooked grain product in serving of fruit "crisp" or cobbler

A variety of enriched and/or whole grain products, particularly those high in fiber, are recommended.

Two servings who grain products must be served at least twice a week when one meal is provided: 4 servings who grain products must be served per week when 2 meals are provided; 6 whole grain products must be served per week when 3 meals are provided.

Grain/bread alternates do not include starchy vegetables such as potatoes, sweet potatoes, corn, yams, or plantains. These foods are included in the vegetable food group.

Milk or Milk Alternates

One cup skim, low fat, whole buttermilk, low-fat chocolate, or lactose-free milk fortified with Vitamins A and D should be used. Low fat or skim milk is recommended for the general population. Powdered dry milk (1/3 cup) or evaporated milk (1/2 cup) may be served as part of a home delivered meal.

Milk Alternatives for the equivalent of one cup of milk include:

1 cup fat free or low fat milk
1 cup yogurt, fat free or low fat
1 cup fortified soymilk
1 ½ cups cottage cheese, low fat
8 ounces tofu (processed with calcium salt)
11/2 ounces natural or 2 ounces processed cheese

Nutrient values for Meal Planning and Evaluation

The table below presents the most current DRIs and other nutrient values to use when planning and evaluating meals. Values are provided for service 1, or a combination of 2 or 3 meals for 1-day consumption for the average older adult population served by nutrition programs.

Menus that are documented ** as meeting the nutrition requirements through menu analysis must have written documentation, which supports the following nutrients, are provided:

Nutrient	Amount Required	Notes
Calories (cal)	685 calories per meal averaged over one week	No one meal may be less than 600 calories
Protein (gm)	19	

Carbohydrate (gm)	43	
Fat (gm)	15-23 ≤ 30% calories averaged over one week	No one meal may be more than 35% fat
Fiber (gm)	10	
Vitamin A (ug)	300	
Vitamin C (mg)	30	
Vitamin E (ug)	5	
Vitamin B6 (mg)	.6	
Folate (ug)	133	
Vitamin B12 (ug)	.8	
Calcium (mg)	400	
Magnesium (mg)	140	
Zinc (mg)	3.7	
Potassium (mg)	1567	
Sodium (mg)	<800, averaged over one week	No one meal more than 1000 mg

**A Menu Approval Sheet is provided to Nutrition Services providers for the licensed dietitian nutritionist (as defined in G (3)(b) of this section) to use in documenting that nutritional requirements are met by the menu through meeting the meal pattern requirements or through carrying out a nutritional analysis of menus.

1. Specific Nutrient Sources

a. Vitamin A***

Each day each meal must provide at least 300 mg vitamin A through foods served.

- To ensure this amount of vitamin A is provided when the meal pattern is followed, vitamin A rich foods must be served 2 to 3 times per week for

one meal per day.

- When serving 2 meals per day, vitamin A rich foods must be served 4 to 6 times per week.

- One rich source or two fair source servings may be used to meet the requirements.

- Some examples of **rich** sources of vitamin A include:

Apricots	Cantaloupe	Collard greens
Kale	Mango	Spinach

Turnip greens & other dark greens
Winter squash (Hubbard, Acorn, Butternut)
Carrots and sweet potatoes

- Some examples of **fair** sources of vitamin A include:

Apricot Nectar	Broccoli
Tomato Sauce	
Pumpkin	Vegetable Juice

b. Vitamin C***

Each day each meal must provide at least 30 mg vitamin C through foods served.

- To ensure this amount of vitamin C is provided when the meal pattern is followed, vitamin C may be provided as one serving of a rich source, 2 half servings of rich sources or 2 servings of fair sources.

- When serving one meal per day, 1 rich or 2 fair sources must be served.

- When serving 2 meals per day, 2 rich or 4 fair sources must be served.

- When serving 3 meals per day, 3 rich or 6 fair sources must be served.
- Fortified, full-strength juices, defined as fruit juices that are
- 100% natural juice with vitamin C added, are vitamin C-rich foods.

- Partial-strength or simulated fruit juices or drinks, even when fortified, may not count as fulfilling this requirement, except cranberry juice.

Some examples of **rich** sources of vitamin C include:

Broccoli	Brussels sprouts	Cantaloupe
Cauliflower	Fruit juices, fortified	Grapefruit
Grapefruit juice	Green pepper	Honeydew

Kale	Kiwi	Mango
Mandarin oranges	Oranges/orange juice	Strawberries
Sweet potatoes	Yams	Tangerines
Sweet red pepper		

Some examples of **fair** sources of vitamin C include:

Asparagus	Cabbage	Collard greens
Mustard greens	Pineapple	Potatoes
Spinach	Turnip greens	Watermelon
Tomato/tomato juice/sauce		

***These are a few examples of vitamins A and C sources. A listing of vitamin A and C content of common vegetables and fruits will be available to service providers as additional information. **Note: this document will be released in the near future.** By consulting this listing and ensuring that a minimum of 300 mcg vitamin A and 30 mg vitamin C are included through vegetables and fruits in meals on a daily basis, providers will meet these vitamin requirements.

L. Food Preparation Recommendations

1. When cooking, use salt sparingly or eliminate entirely by using spices, herbs or other seasoning. To flavor foods, use salt-free seasoning, lemon juice, lime juice or vinegar.

2. Minimize the use of fat in food preparation. Fats should be primarily vegetable sources and in a liquid or soft (spreadable) form that is low in hydrogenated fat, saturated fat, and cholesterol. Limit fat to no more than 20-35 percent of the calories average for the week.

3. Each meal should contain at least 10 grams of dietary fiber. Use whole grains, meat alternatives, and fruits and vegetables to increase the fiber content of the menus. A listing of fiber content of grains, vegetables and fruits is available to service providers. By consulting this listing and ensuring that a minimum of 10 g fiber is included through foods served on a daily basis, providers will meet the fiber requirements.

4. Reflect seasonal availability of food;

5. Plan so that food items within the meat and meat alternatives, vegetable, fruit and grain/bread groups are varied within the week and menu cycle;

6. Include a variety of foods and preparation methods with consideration for color, combinations, texture, size, shape, taste and appearance;

7. Do not provide vitamin and/or mineral supplements, except as specified in Item Q below;

8. Use low-sodium meats, flavorings, and seasonings;

9. Use low-fat salad dressing, spreads, cheese and gravies (made without drippings and fats);

10. Bake, broil, steam or stew foods in place of frying food in fat;

11. Provide drinking water to encourage fluid intake. Dehydration is a common problem in older adults. Other beverages such as soft drinks, flavored (preferably sugar-free) drinks, coffee, tea and decaffeinated beverages may be used, but cannot be counted as fulfilling any part of the meal requirements. Nonnutritive beverages do not help meet nutrition requirements but can help with hydration.

12. Desserts may be provided as an option to satisfy the caloric requirements or for additional nutrients. Desserts such as fruit, whole grains, low fat or low sugar products are encouraged. Fresh, frozen, or canned fruits packed in their own juice are encouraged often as a dessert item, in addition to the serving of fruit provided as part of the meal. However, if a dessert contains as least ½ cup of fruit it may be counted as a serving of fruit. A dessert containing at least ½ cup enriched/whole grain product may be counted as a serving of grain. For example, a serving of two-crust (approx. 1/8 of 8" or 9" pie) fruit pie that contains at least ½ cup fruit is counted as one serving fruit and one serving grain.

13. Ethnic or religious menus must approximate as closely as possible (given religious requirements or ethnic background) the regular meal pattern and nutrient content of meals as previously stated.

14. Meals served in accordance with the meal standards are appropriate for persons with chronic disease, such as diabetes, heart disease and hypertension.

M. Nutrition Supplements

Nutrition supplements, including liquid or bars, may be made available to participants based on documented, assessed need as determined by a licensed dietitian, nutritionist or a physician. Such products cannot replace conventional meals unless a physical disability warrants their sole use. Nutrition supplements are not reimbursable under the Older Americans Act or by AoA.

N. Offer Versus Serve

1. Each nutrition provider shall assure that congregate meal participants are offered all the food items needed to meet the menu requirements.

2. Consistent refusal of menu items should be investigated to determine why a participant is declining menu items.

3. Assistance should be provided to assure that adequate nutrition intake is maintained by the participant (for example, providing smaller serving portions, substitutions when feasible or serving the participant first).

4. AoA reimbursement is not affected when a participant declines menu items.

O. Foods Taken from Nutrition Sites

1. Unserved leftover foods shall not be taken from kitchens or sites by employees, volunteers, or participants.

2. Safety of the food after it has been served to a participant and when it has been removed from the congregate site is the responsibility of the recipient and may be consumed as that participant deems appropriate. Providers shall post signs that warn participants of the health hazards associated with removal of food from the congregate nutrition site.

P. Food Borne Illness Complaint Reporting Requirements

1. In the event that a nutrition service provider receives a complaint or report of symptoms of food borne illness, the nutrition provider shall:

   a. Notify the local health department immediately to initiate an investigation; and

   b. Notify the Area Agency on Aging within 24 hours of the investigative procedures in progress.

2. The Area Agency on Aging shall notify the Department within three working days of a reported food borne illness. Thereafter, periodic updates shall be provided regarding the progress and findings of the investigation.

Q. Food Service Requirements

Nutrition service providers must comply 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.

1. Training

   a. Training in sanitation, health, fire and safety regulations must be provided during the orientation of staff new to the program and, at a minimum, once a year thereafter. The training will include but not be limited to: safe food handling, food borne illnesses, hygienic practices of personnel, equipment sanitation, dish washing procedures, facility sanitation, rules for safe work, and fire and safety regulations. Where feasible or possible, state or local

public health officials should be involved in the development of training materials and programs. In situations where regulations do not exist, or their applicability is questioned, the provider shall contact the appropriate State agency that establishes fire, health, or safety standards (e.g., State Fire Marshall, etc.).

b. The meal site supervisor or designee must successfully complete the Illinois Department of Public Health's ~~Food Service Sanitation Manager certification training, and have a current registration~~ Certified Food Protection Manager Certification.

~~This is a Department on Aging requirement, and is also required by the Illinois Department of Public Health.~~
Effective January 1, 2018, the Illinois Department of Public Health will no longer issue Food Service Sanitation Manager Certifications (FSSMC.) Additionally, the Illinois Department of Public Health will no longer post course listings, or certify instructors/proctors. Please note, the Illinois Food Code still requires a valid IL FSSMC per 750.540 through the end of 2017.

The Certified Food Protection Manager certification will replace the Illinois Food Service Sanitation Manager Certification. Beginning January 1, 2018, an ANSI accredited Certified Food Protection Manager (CFPM) certification obtained through a course and passing the exam are still required, but required nutrition staff will not need to apply for the additional Illinois FSSMC certificate.

The Illinois Department of Public Health and the Illinois Department on Aging require that meal site supervisors receive the above CFPM certification.

Congregate meal sites are classified as "Category I Facilities" due to the type of population served by the congregate meal site (e.g., immuno-compromised individuals such as the elderly comprise the majority of the consuming population).

Based on guidance from the Illinois Department of Public Health, the only exception for a meal site supervisor to not be required to have successfully completed the above certification training is when food is prepared in a different location within the facility and served in that same facility. An example would be a congregate meal site located in a long term care facility. Under these circumstances, the site supervisor would be supervised by a certified food service sanitation manager in the preparation area of the facility. Note: Local public health departments do not have the authority to waive this requirement.

c. All staff working in the food preparation and food serving area shall be

under the supervision of a person who will ensure the application of hygienic techniques and practices in food handling, preparation, service and delivery.

2. Food Temperatures

   a. Food temperatures at the time of service and at the time of delivery must be no less than 140° F for hot foods and no more than 41° for cold foods.

   b. For congregate meals, the temperature of the food should be checked and documented daily at the time of service and in the case of catered food, at the time of food arrival and at the time of service.

   c. For home delivered meals, the temperature of the food should be checked and documented daily both at the end of production and at the time of packaging; and on a regular basis, not less than one time per month, at the end of the delivery route requiring the longest delivery time.

3. Packaging & Packaging Standards-Home Delivered Meals

   1. All meals packaged at nutrition sites must be individually packaged first (before congregate meals are served) and packed in secondary insulated food carriers with tight fitting lids and transported or frozen immediately.

   2. Containers must be designed to maintain the integrity and safety of the food.

   c. Cold and hot foods must be packaged and packed separately.

   d. All food delivery carriers must maintain the proper temperature for the required time that the food will be in the carrier.

R. Standards for the Development of New Congregate Meal Sites

Each congregate nutrition provider shall, in consultation with Area Agency staff, and the nutrition provider's advisory council, establish and implement written policies and procedures for the development of new congregate meal sites. These policies and procedures must specify the process for setting priorities in the selection of new sites. This process must weigh several factors, including, but not limited to, the following:

1. Demographic and geographic characteristics of the site service area. In selecting new sites, preference shall be given to sites which will serve the highest proportion of older individuals in greatest economic need and social need (with particular attention to low-income minority older persons);
2. The level of expressed interest of eligible persons in the prospective service area, as evidenced by surveys, public hearing testimony, petitions, letters and other forms of solicited or unsolicited interest;

3. Demonstrative community support for the prospective site, which may include donated space, local cash match, and volunteer support; and,
4. Factors related to ease of implementation, which may include budgetary considerations, and economies of scale in the preparation and delivery of meals, etc.

S. Standards for the Evaluation of Congregate Meal Sites

Each provider shall establish and implement written policies and procedures for evaluation of congregate meal sites to assess their level of performance and viability. Such evaluations shall be conducted at minimum once every three years, or more often, as conditions warrant. Each site shall be evaluated in consultation with older persons in the site service area, including representatives of program participants. Sites shall also be evaluated on the basis of factors including, but not limited to the following:
1. Changes in the demographic characteristics of the site area;
2. Changes in the level of community support;
3. Significant reductions in site attendance or targeting performance; and,
4. The relationship between the viability of the congregate site and the delivery of home delivered meals to eligible older persons.

T. Standards for the Closure of Congregate Meal Sites

Each provider shall establish and implement written policies and procedures for determining whether a meal site should be maintained or closed. These policies and procedures shall specify the process to be used in making that determination. At minimum, this process should include the following:
1. A review of the findings of a written site evaluation conducted by the provider;
2. A public hearing to enable older persons in the site area to express their views;
3. A 30 day period to allow the site and community to address concerns identified in the site evaluation; and,
4. The nutrition provider shall provide the Area Agency with the findings of the site evaluation and notice of public hearing and shall inform the Area Agency of any follow-up activities.

U. Nutrition Program Staffing

Program staff must have the authority to conduct the day-to-day management and administrative functions of the program.
1. Project Director - must be employed by and responsible to the agency awarded the nutrition grant or contract, and must have demonstrated experience in management and supervision.
2. A Registered Nutritionist/Dietician or an individual with, at minimum, a baccalaureate degree in foods, nutrition, or dietetics and one year of experience - must be employed by or on retainer with the nutrition provider, and have an adequate of time to perform the nutrition-related responsibilities of the program. A signed, written consulting agreement specifying the hours to be worked and the responsibilities of the nutritionist must be on file if the nutritionist acts on a consulting basis;

3. Site Manager - must be in charge of designated nutrition sites, must be certified in food service sanitation within one year of employment as a Site Manager, and is responsible for coordinating the activities of volunteers assisting in the provision of home-delivered meal service; and,
4. Volunteers - must be recruited, trained, supervised, and provided recognition of their volunteer efforts.

V. General Policies & Procedures

All nutrition providers must have, and implement, written policies and procedures addressing the following: a) meal reservation system/standing meal counts; b) participant grievances and complaints; c) provision of meals to non-eligible persons; d) suspension or termination of service due to lack of participant cooperation; and, e) disciplinary measures relative to Item (d) herein; f) emergency response guidelines to be followed by a volunteer or paid staff person of the provider agency who may find a participant in need of immediate medical attention; g) mechanisms for controlling costs.

W. Working Agreements

1. Congregate Meals - Each nutrition provider must have an updated written working agreement or lease agreement with any facility wherein congregate meals are provided.
2. Home Delivered Meals - Each nutrition provider must have an updated written cooperative working agreement with any agency from which home-delivered meals are emanating for delivery to participants.

X. Evidence-based Healthy Aging Programs – nutrition providers shall integrate evidence-based healthy aging interventions as directed by the Area Agency on Aging.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.22

FUNDABLE SERVICE: RECREATION

SERVICE DEFINITION:

Activities which foster the health and social well being of individuals through social interaction and constructive use of time. In determining and developing recreational activities, older persons needs and interests should be considered.

SERVICE ACTIVITIES:

1) recreational activities for individuals and groups may include instructions and discussion in arts, crafts, hobbies, travel, games, sports, physical activities, and other activities; and,

2) group tours and outings.

UNIT OF SERVICE:

Each hour of staff or consultant time spent in behalf of a client constitutes one unit of recreation service.

AWARD STANDARDS:

SERVICE STANDARDS:

Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.23

FUNDABLE SERVICE: RESIDENTIAL REPAIR AND RENOVATION

SERVICE DEFINITION:

Assistance to older persons to maintain their homes in conformity with minimum standards or to adapt homes to meet the needs of older persons with physical problems. All repairs or renovations must meet local established standards and ordinances.

SERVICE ACTIVITIES:

1) arrangement for repairs and renovations; and,

2) follow-up provided to ensure that an older person receives satisfactory service.

UNIT OF SERVICE:

Each home repaired or renovated constitutes one unit of service.

AWARD STANDARDS:

SERVICE STANDARDS:

Refer to Section 1000 of this Manual.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.24

FUNDABLE SERVICE: RESPITE CARE

SERVICE DEFINITION:

The provision of appropriate, temporary, substitute care or supervision of functionally impaired persons aged sixty (60) and over to enable the caregiver to maintain his/her provision of assistance to the older person.

FRAIL AS PRIORITY ELIGIBILITY FOR RESPITE AND SUPPLEMENTAL SEVICES:
The term “frail” means that the older individual is determined to be functionally impaired because the individual –
A. Is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or
B. Due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual.

SERVICE ACTIVITIES:

The development of a specially designed package of services or individual services that provides the appropriate temporary, substitute care or supervision of an older person. The package may include elements of the following service:

1) Homemaker Services; and,
2) Senior Companion Services (Sitter Services).

UNIT OF SERVICE:

One unit of service is defined as one hour of time expended in the provision of care or supervision of a functionally impaired older person (includes necessary travel to serve the client when the respite care worker is paid for travel time).

AWARD STANDARDS:

SERVICE STANDARDS:

Refer to Section 1000 of this Manual.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.25

FUNDABLE SERVICE: SENIOR INFORMATION SERVICES (Defined as Information & Assistance)/Coordinated Point of Entry

SERVICE DEFINITION:

A service for older individuals that (A) provides the individuals with information on opportunities and services available to the individuals within their communities; (B) assess the problems and capacities of the individuals; (C) links the individuals to the opportunities and services that are available; and; (D) establishes adequate follow-up procedures based on the older individual's needs.

The service may be **initiated** by an older person, caregiver or service provider.

SERVICE ACTIVITIES

Information & Assistance Service Activities As A Component of Senior Information Services:

1. Provision of specific information about appropriate community resources which meet the immediate expressed need, including information relating to assistance technology;
2. Provision of assistance to older persons (or their caregiver) to identify their needs and to place them in contact with appropriate community resources or service providers;
3. Assessment of the problems and capacities of the individual;
4. Follow-up activities conducted with older persons and/or agency(ies) to determine whether services have been received and the identified need has been met following the formal referral; and,
5. Expansion of the information and assistance services on a 24 hour (if needed) basis during times of disaster (e.g., flooding, hot weather, tornadoes, sever weather, man- made emergencies, etc.) to assure older persons are safe and have access to services to meet their needs.

UNIT OF SERVICE:

Any individual client contact made for information, referral or assistance constitutes one unit of service. This unit includes all referral and follow-up contacts on behalf of the client. For example: If an older person contacts the service provider requesting information on a state pharmaceutical

assistance program, this contact constitutes one unit of service. If the service provider follows up with this same person to see if the application has been made to this program, this will constitute another unit.

The service units for information and assistance refer to individual, one-on-one contacts between an information and assistance provider and an elderly client or a caregiver. An activity that involves a contact with several current or potential clients/caregivers (what is considered group services) should not be counted as a unit of information and assistance. Group service might be defined as 'public education or public information' or a similar designation.

Internet web site "hits" are to be counted only if information is requested by older individuals and/or family members and supplied by the provider. For example: an older person may request by e-mail on a provider's web site that they want information on pharmaceutical assistance programs. If the provider provides this information by e-mail, or by traditional mail, or by telephone, this is one contact (one unit of service).

If the older individual or family member simply reviews information on the provider's web site and does not request specific information, then this situation cannot be counted as a contact (unit of service).

AWARD STANDARDS:

The Area Agency must provide Senior Information Services in a sufficient manner to ensure that all older persons within the planning and service area have reasonably convenient access to the service with particular emphasis on linking services available to isolated older individuals and older individuals with Alzheimer's Disease or related disorders (and caretakers of individuals with such disease and disorders).

Service providers funded for Senior Information Services must also comply with Standards for Coordinated Points of Entry (refer to standards contained in this section).

SERVICE STANDARDS:

Senior Information Services service providers must also adhere to Coordinated Point of Entry approved by the Older Adult Service Act Advisory Committee and Area Agency on Aging.

Senior Information Services service providers must also adhere to the following Information & Assistance Service Standards:

1. In areas in which a significant number of older persons do not speak English as their principal language, the service provider must arrange for or have the capacity to provide information and assistance in the language spoken by the older person. The service provider should develop a language assistance plan if needed in the PSA.

2. The provider of Senior Information Services must:
    a. Maintain current information with respect to the services and opportunities

available to older persons;
b. Develop current lists of older persons in need of services and opportunities;
c. Employ a specially trained staff to inform older persons of the services and opportunities which are available to assist older persons to take advantage of the services and opportunities.

3. The provider of Senior Information Services may disclose information by name about an older person only with the informed consent of the older person or his or her authorized representative. Such informed consent must be documented in the older person's case file whether it is written or verbal consent. The case file documentation must include who (older person or authorized representative) provided the written or verbal consent.

4. The provider of Senior Information Services shall provide a setting for the SIS worker to attend to each caller's questions/needs without interruption and in a confidential manner.

5. The staff of the Senior Information Services provider shall be competent, ethical, qualified, and sufficient in number to implement the policies of state programs and service objectives.

6. The staff of Senior Information Services provider must maintain accurate, up-to-date information on resources available. The Area Agency encourages service providers to use web-based tools such as Benefits Check Up and ESP – Elderly Service Program.

7. The Data Collection System shall be developed to meet client and service needs and as a resource of meeting community needs.

8. The provider of Senior Information Services shall seek to maximum the accessibility of the other needed services.

9. Facilities shall be provided in sufficient quality and quantity to insure operation of the service.

10. The provider of Senior Information Services shall have a plan in place that addresses its operations in the event of disaster conditions.

11. The provider of Senior Information Services shall provide client advocacy to secure needed benefits.

12. The provider of Senior Information Services shall provide community and/or group presentations about available resources and services.

13. The provider of Senior Information Services shall have at least one employee certified as an IR/A Specialist by Alliance for Information and Referral Systems (AIRS).

14. The provider of Senior Information Services shall integrate evidence-based health aging interventions as directed by the Area Agency on Aging.

STANDARDS FOR COORDINATED POINTS OF ENTRY (CPOE)

Older Adult Services Act CPoE Definition: *"Coordinated Point of Entry means an integrated access point where consumers receive information and assistance, assessment of needs, care planning, referral, assistance in completing applications, authorizations of services where permitted and follow up to ensure that referrals and services are accessed."*

STANDARDS

1. The CPoE shall provide basic information to clients, their families and the general public on aging topics as well as disability issues. The CPoE shall use the IDoA approved, standardized intake form/process to identify the issues and capacities of the individual beyond the presenting problem, and make appropriate referrals. The CPoE's protocols must be compatible with the Comprehensive Care Coordination system, which may be the next step for a client (intake) following information and assistance provision. The CPoE shall maintain client confidentiality and respect client privacy when providing service.

2. The CPoE shall have a working relationship and a written agreement with a local disability-related information provider, as well as the major human services providers.

3. The CPoE must have staff with appropriate qualifications, education (AA, BS, BA, LPN, RN, etc.) or experience to be further defined by the Department. The CPoE provider shall maintain SAGECare training credentials. The CPoE shall have at least one person with AIRS certification on staff. Prior to being eligible for AIRS certification or SIS staff who may not become AIRS certified, staff must have five hours of training on diversity, equity and inclusion and cultural compentency topics annually. The provider shall maintain AIRS membership.

4. The CPoE shall engage in outreach and public awareness activities in coordination with the Senior HelpLine and be full participants in statewide outreach activities.

5. The CPoE system shall utilize the State-approved brand name and logo.

6. The CPoE shall at least provide full day (at least 7 hours) M-F availability for staffing and information.

7. The CPoE must have three-way calling phone systems for 'warm transfers' of callers.

8. The CPoE must have a disability-accessible environment for meeting customers and the general public.

9. The CPoE must have an internet link to utilize the state ~~Enhanced Services Program (ESP)~~ Community Service Data (CSD) resource data base in AgingIS, the Benefits CheckUp assessment tool, illinoishousingsearch.org (IDHA), and other web tools as selected in the development of the statewide system.

10. The CPoE shall make unbiased referrals reflecting the best outcomes for the client, and shall make efforts to avoid a conflict of interest.

11. The CPoE must utilize Person-Centered-Planning procedures when advising clients or their families.

12. The CPoE must establish a relationship with an array of formal or informal access points within their catchment area to funnel contacts to the CPoE.

13. The CPoE must train staff in LTC options counseling as a priority, or make appropriate referrals so that clients are carefully prepared to make decisions.

14. The CPoE must provide individual and systemic advocacy to identify problems, barriers and successful best practices.

15. The CPoE must provide assistance in filling out applications, obtaining authorizations and shall follow up with clients to make sure that services are accessed.

16. The CPoE must participate in statewide efforts regarding the continual development process for improving the system and ongoing quality assurance for clients and the system as a whole.

17. The CPoE must participate in the IDoA Disaster Assistance Planning protocol.

18. The CPoE must follow statewide and regional protocol for coordination between the CPoE system and 211 providers, as this system is developed.

19. The CPoE must demonstrate cultural competency and have measures in place for persons of Limited English Proficiency (LEP).

20. The CPoE will meet Department reporting requirements and will be subject to IDoA evaluation. The CPoE's will be evaluated as to whether or not the access system is effectively responding to needs of older adults, family caregivers and other consumers, and targeting those in greatest social and economic need.

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.26

FUNDABLE SERVICE: TELEPHONE REASSURANCE

SERVICE DEFINITION:

Telephone calls at specified times to or from individuals who live alone, to determine if they require special assistance, to provide psychological reassurance and reduce isolation.

SERVICE ACTIVITIES:

1) procedures for supervising calls and for the caller to report a client's needs for services;

2) establishment of an emergency plan for client(s) if telephone call is unanswered;

3) activities planned for each telephone call relative to the individual's needs;

4) telephone calls to each client at specified times; and,

5) telephone calls to assure that older persons are safe and have access to services to meet their immediate needs during disaster situations (e.g., flooding, tornadoes, hot weather, severe spring and winter weather, man-made emergencies, etc.).

UNIT OF SERVICE:

Each telephone reassurance call placed or received by a client constitutes one unit of service.

AWARD STANDARDS:
SERVICE STANDARDS: Reserved

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EAST CENTRAL ILLINOIS AREA AGENCY ON AGING

SERVICE DEFINITIONS AND STANDARDS

REF. NO. 402.27

FUNDABLE SERVICE: TRANSPORTATION

SERVICE DEFINITION:

Transporting older persons to and from community facilities and resources for purposes of acquiring/receiving services, to participate in activities or attend events in order to reduce isolation and promote successful independent living.

SERVICE ACTIVITIES:

1) assistance in making travel arrangements;
2) provision of or arrangements for special modes of transportation when needed;
3) coordination with similar and related transportation in the community; and,
4) door-to-door or scheduled route.

NOTE: Assisted Transportation services are not included under transportation and those participants receiving Assisted Transportation should not be counted under this service.

UNIT OF SERVICE:

Each one-way trip to or from community locations per client constitutes one unit of service. The service unit does not include any other activity.

AWARD STANDARDS:

1) the Area Agency may enter into transportation agreements with agencies which administer programs under the Rehabilitation Act of 1973 and Title XIX and XX of the Social Security Act to meet the common need for transportation of service participants under the separate programs. Agreements entered into under this section are exempt from the restriction of an Area Agency on delegation of the authority to award or administer Older Americans Act funds.
2) the Area Agency shall prepare and develop an Area Plan which includes the identification of needs of older individuals and describes methods used by the Area agency to coordinate the planning and delivery of transportation services to assist older individuals, including those

with special needs, in the service area. Coordination with other providers of transportation shall be an expectation in PSA 05.

3) the Area Agency will provide grant assistance to Section 5311 providers of rural public transportation for older adults living in areas not served by urban mass transit providers.

SERVICE STANDARDS:

The Area Agency recognizes the fact that many providers of transportation service to older persons receive funding from a variety of sources (i.e., Illinois Department of Transportation, Donated Funds Initiative Program, County boards, etc.) and must, therefore, meet certain requirements placed on them by other entities. The Area Agency is respectful of such requirements, and strongly encourages each organization receiving funding from several sources to be cognizant of the specific requirements of each fund so as to be in compliance with all applicable codes and standards.

The standards set forth herein are such as to be applicable to any organization providing Area Agency-funded transportation service to persons 60 years of age and older. Such standards are to be adhered to regardless of whether the Area Agency has provided funds, in whole or in part, for the purchase of a vehicle and/or the operational costs of a vehicle, even if such vehicle was purchased through sources other than Area Agency funding.

1) Eligibility for Area Agency-funded transportation service will be based on the following: (a) 60 years of age and older; and, (b) ability to use the service without an escort or able to provide own escort.

2) An escort to the participant may be under the age of 60, but the escort's ride(s) may not be counted as an Area Agency unit(s) of service, if the escort is under the age of 60. Escort is defined per the following: Provision of personal physical assistance to individuals who are dependent on such assistance to reach and use community resources in order to ensure their access to local services and to allow them to maintain independent living.

3) For each new unduplicated person 60 years of age and older requesting and receiving transportation service, the provider is required to keep individual records which address, at minimum, the following information per person:
(a) Name; (b) Birth date; (c) Address; (d) Phone Number; (e) Sex; (f) Race; (g) Whether income is below or above poverty guidelines; (h) Status of personal living situation, i.e., living alone, living with children, congregate living arrangement, etc.; and, (I) Client's signature and date of signature. Transportation providers are to update the above client -specific information on an annual basis at minimum, or more often, if a change in a client's situation/status results in a change in information being brought to the attention of the transportation provider. This information is to serve as a source of service documentation, and to assist providers in targeting transportation service to older persons in greatest need.

4) Priorities for service delivery will be considered per the following, and in accordance with the Area Agency-approved program design: Priority #1: Medical needs; Priority #2:

Nutritional needs; Priority #3: Personal business and services; Priority #4: Socialization/Recreational activities which enhance emotional well-being and independence to ensure quality of life; and, Priority #5: Volunteer activities.

5) Participant Contributions: See Section 500 of this Manual.

6) Publicity/Outreach: See Section 500 of this Manual.

7) Coordination: See Section 500 of this Manual.

8) Participant Input: See Section 500 of this Manual.

9) Record Keeping: See Section 500 of this Manual. In addition to the general record-keeping requirements referred to above, the following records must be maintained by transportation providers: (a) Units of service/dates of service; (b) Contributions; and, 8 Maintenance of vehicles, including inspections, repairs, gas purchases, and mileage.

10) Transportation providers must have and implement written policies and procedures which, at minimum, address the following areas: (a) Client-specific accident/medical emergencies; (b) Vehicle accident; c) Weather-related or man-made disasters; and, (d) Disruption in service due to weather conditions.

11) Transportation providers must have and implement written policies and procedures for a dispatching system which, at minimum, provides for the following:(a) Control of vehicle operations, including, but not limited to, the rearranging of scheduled trips and insertion of new trips on the same day of service when possible; (b) Trained dispatchers who are knowledgeable of routes and the geographic area; c) The establishment of regular routes; and, (d) Methods of communication by radio (if applicable), by telephone, etc.

12) Transportation providers must have and implement written policies and procedures for a scheduling system which, at minimum, addresses the following: (a) Methods of scheduling; (b) Access to program via telephone; and, c) The publicizing of service availability.

13) Transportation providers must have and implement written policies and procedures for a routing system which, at minimum, addresses the following: (a) description/type of route(s); i.e., fixed, demand/response, combination; and, (b) rationale for routing system design.

14) The staffing pattern for the provision of Area Agency-funded transportation service must be in accordance with the Area Agency-approved program design. Each driver of a senior transportation vehicle, whether paid or volunteer, must meet the following requirements (per Ill. P.A. 82-532): (a) be 21 years of age or older; (b) have a valid and properly classified driver's license; c) have had a valid driver's license for three years prior to the application; (d) have demonstrated ability to exercise reasonable care in the safe operation of a motor vehicle on a driving test; and, (e) have not been convicted of reckless driving within three (3) years of the date of application. The Area Agency strongly encourages each driver, whether paid or volunteer, to be certified in first aid and CPR.

15) Illinois licensed drivers who transport senior citizens must have a JO5 restriction code on their licenses. The "JO5" restriction relates only to drivers of vehicles utilized solely for the purpose of providing transportation for senior citizens in connection with the activities of any public or private organization.

16) All vehicles used for transporting older persons, regardless of the source of funds received to purchase such vehicles, must meet, through State-required standards for inspection, all applicable mechanical/safety standards. Also, each provider must have and implement written policies and procedures for the daily inspection of vehicles utilized to transport older persons, so as to detect potentially dangerous conditions. At minimum, such should address the safety and condition of the following:

    (a) Tires
    (b) Brakes
    (c) All lights
    (d) Turn signals
    (e) Under vehicle leaks
    (f) Horn
    (g) Emergency exits
    (h) Visual inspection, both inside and outside of the vehicle, for potential safety hazards

    The Area Agency encourages the regular inspection of the following areas:

    Service Door
    Grab Handles
    Steps (incl. aux. step)
    Stanchions
    Floor Covering
    Seats and Glazing
    Warning Devices
    Seat Belts
    Driver's Door
    All Mirrors (adjustment)
    Sun Visor
    Neutral Safety Switch
    Steering Wheel
    Heaters and Defrosters
    Two-Way Radio
    Coolant, oil, battery, and washer fluid levels
    Gaskets around doors
    Radiator Cap
    Windshield Wipers & Washers
    All Gauges
    Body Condition & Windshield
    Reflectors
    Air Conditioner
    Left Mirror & Bracket
    Driver's Door and Step
    Exhaust System (tail pipe clear?)
    Lift or Ramp Operation
    Fuel Tank Filler Cap
    Right Mirror and Bracket
    Fan Belts
    Wiring
    Hoses
    Operation of windows
    Power steering, transmission and brake fluid levels

17) A transportation service provider must have appropriate insurance coverage for facilities, vehicles, and staff, with documentation on file attesting to such insurance coverage. In the event the service provider is involved in a contractual arrangement for transportation service with another entity(ies), documentation of appropriate insurance coverage must be on file in the office of the Area Agency-funded provider.

18) Regardless of the source(s) of funds utilized to purchase a vehicle, any vehicle of twelve (12) or more passengers used in the transportation of senior citizens shall bear placards on both sides indicating it is being used for such purposes. The placards may be permanently or temporarily affixed to the vehicle. The size of the letters must be at two (2) inches high and the strode of the brush must be at least 2 inch wide. Any such vehicle used for such purposes shall be subject to the inspections provided for vehicles of the second division, and its operation shall be governed according to the requirements of the Illinois Vehicle Code (Ill. P.A. 82-957).

19) According to the Administration of Grants Manual, Title 45, Part 74, Sub-part O, Section 74.137 (2) (b), any Federally funded program or project may share the use of equipment (e.g., transportation vehicles sponsored by the Federal government) provided, such other use will not interfere with the work of the original project or program.

    Therefore, a Title III transportation program may provide services to other programs (no age requirements) supported by the Federal government. However, the Title III provider must pro-rate the cost of this service according to program usage. This rate should be based on vehicle maintenance, operator, insurance, and all other appropriate costs for this service. All fees collected by the Title III program are considered program income. Therefore, these funds must be used for the Title III operations of the transportation provider.

*20) Any vehicle utilized to transport older persons through Area Agency funding (vehicle purchase and/or operational costs, in whole or in part), must meet applicable vehicle safety codes in accordance with Federal, State, city and local ordinances/laws, as far as can be determined.

*21) Any vehicle utilized to transport older persons through Area Agency funding (vehicle purchase and/or operational costs, in whole or in part), must meet applicable vehicle design standards as determined by law in accordance with the vehicle manufacturer's specification codes and any Federal, State, city, or local statutes governing same, as far as can be determined.

22) Transportation providers will have and implement written policies and procedures which address, at minimum, the following areas of passenger safety: (a) passengers strongly encouraged to wear seat belts, if seat belts are in place in the vehicle; (b) the assistance of passengers on and off the vehicle; c) the number of persons in the vehicle not to exceed the number of seats in the vehicle; (d) if first step exceeds twelve inches from the ground, a retractable or stable step is used; (e) steps to be non-skid surfaces; and, (f) approved and operable fire extinguisher and stocked first aid kit visible and accessible.

23) Any vehicle purchased and/or operated in whole or in part with Area Agency funding must display the logo of the East Central Illinois Area Agency on Aging denoting ECIAAA's contribution to the transportation program for older persons so as to identify a network throughout the area of services to older persons. *<u>NOTE</u>: The Area Agency recognizes that Federal, State, City and local laws, codes, and ordinances relative to transportation service,

vehicle safety, and vehicle design standards change based on the political subdivision. The Area Agency and the transportation provider understand the importance of each entity keeping the other entity informed of such changes as they become known to each entity. Such will ensure good-faith operations of Area Agency-funded transportation programs.

24) The sale of advertising space on Section 53(10), Section 53(11) and Title III funded transportation vehicles is allowable under both the Intermodel Surface Transportation Efficiency Act (IESTEA) and the Older Americans Act and related regulations.

25) All Title III transportation providers should abide by the Illinois Vehicle Code, as amended.

*Items #20 and #21 above are standards designed to ensure that vehicles utilized to transport older persons are equipped and utilized in such a manner so as to safely transport the appropriate number of persons and total weight for which they were designed.

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