

**NEW YORK STATE OFFICE FOR THE AGING**

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Andrew M. Cuomo, Governor

Corinda Crossdale, Acting Director

An Equal Opportunity Employer

**PROGRAM INSTRUCTION**

**Number: 14-PI-02**

**Supersedes: 13-PI-07**

**Expiration Date:**

**DATE:** February 4, 2014

**TO:** Area Agency on Aging Directors

**SUBJECT:** Revised Client / CAARS Forms and Instructions

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**ACTION REQUESTED:** CAARS/Client Data Reporting for the period April 1, 2014 through March 31, 2015

**RESPONSE DUE DATE:** Based on the quarterly reporting schedule with the following due dates for submission: July 21, 2014, October 20, 2014, January 20, 2015 and April 20, 2015

**PURPOSE:** To transmit revisions to the COMPASS, client file specifications for data submission and CAARS web pages.

**BACKGROUND:** The attached files include revisions to NYSOFA's reporting requirements for the program year April 1, 2014 through March 31, 2015. These revisions have been developed to respond to questions, suggestions and requests raised both internally at NYSOFA and by the AAAs.

These revisions have been sent to the software vendors and a number of AAAs for review and comment prior to implementation.

Many of these revisions/additions will require steps to be taken by both the vendor and the Area Agency.

## **Key Changes**

### **Data Quality Review**

The allowable percent for missing data used for review and evaluation has been changed from 15% to 10%. Levels exceeding 10% will require correction and/or explanation as to reasons why this level has been exceeded. This change is being made to ensure NYSOFA's data meets the review requirements set by Administration on Community Living (ACL). Further details regarding this can be found on page 13 of the Reporting Guide Consolidated Area Agency Reporting System (CAARS) and Client Data Systems, Section II, General Requirements/Information for Client Specific Data C. Quarterly Data Quality Review.

### **CAARS Report**

Page 3, Part III - Program Services Expenditure Breakdown – Federal/State Programs, line 2 Consumer Directed In-home Services open cells for expenditures under Title III-B and Title III-E.

### **COMPASS**

#### Section I. Client Information

P. Living Arrangement (modified the language to add clarity).

S. Is the client a. frail, b. disabled. (Definitions for these can be found in the Reporting Guide CAARS and Client Data).

#### Section VII. IADLs and Section VIII. ADLs

Added: "Is need met at the time of assessment" to be consistent with vendor provided assessment forms.

#### Section X. Informal Supports

Last April a question was added to the Primary and Secondary Informal Support sections - Is the informal support being provided by a caregiver using the (Title III-E definition)? The response to the question was very good. After discussions with several AAAs we have added two additional questions. The first provides four services and asks if any of these will provide respite to the caregiver. This question is not required but will provide valuable information on assistance being provided to caregivers who may not be funded by the Title III-E program.

The second question asks if the person providing informal support would like information on the caregiver program. A number of AAAs asked that this be added because it may be used to generate reports on who needs follow up on the caregiver program.

Example:

Questions added for Primary and Secondary Informal Support:

1. f. Which of these services could be provided as respite for the caregiver?

- Adult Day Services
- Personal Care Level 1
- Personal Care Level 2
- In Home Contact & Support (Paid Supervision)

g. Would the caregiver like to receive information about other caregiver services?

Question added for a Second Informal Support.

2. f. Which of these services could be provided as respite for the caregiver?

- Adult Day Services
- Personal Care Level 1
- Personal Care Level 2
- In Home Contact & Support (Paid Supervision)

g. Would the caregiver like to receive information about other caregiver services?

XI . Monthly Income

The original COMPASS only included income information for the person being assessed. This has become somewhat problematic as systems become more automated. The EISEP Financial Agreement Form includes the couple and spouse in addition to the person being assessed which became a problem in relating the two documents. The monthly income table has been modified to mirror the EISEP financial form. The other area of confusion dealt with poverty. Whereas EISEP cost share calculation looks at the person being assessed and their spouse, the HHS Poverty Guidelines use household income.

Revised: Monthly Income table to follow a format similar to the Financial Agreement Form and to incorporate the information necessary to determine poverty status.

A.		Monthly Income			
		A. Individual Being Assessed	B. Person's Spouse	C. Other Family/ Household Income	D. Total Family/ Household Income
1.	Social Security (net)				
2.	Supplemental Security Income: (SSI)				
3.	Personal Retirement Income				
4.	Interest				

5.	Dividends				
6.	Salary/Wages				
7.	Other				
	Total:				

Added two questions to be consistent with vendor provided assessment forms:

- B. Number of people in household?
- C. Is client a veteran?

**Client Data Files**

Several fields have been added to the file specifications which your vendor will be implementing and will appear in the software.

The first is the addition of a date field for the six-month contact for noncase managed home delivered meal clients. Clients only receiving a home delivered meal must be contacted six months from the date of the assessment/reassessment. This field will be used to record the date of that contact. Attachment M lists the nine areas to be explored to determine if any changes have occurred since the last assessment /reassessment.

This requirement was implemented by **97-PI-20**, Program and Policy Changes Related to Implementation of MDS: (A) Home Delivered Meals; (B) EISEP and CSE EISEP-Like Services; and (C) All Six Community-Based Long Term Care Services dated July 10, 1997.

Two other client type tags have been added for persons receiving eligible meals. The first covers those clients receiving HDM for 10 consecutive days or less. The added tag would allow enough information to be added into the system to create a unique client ID but ensure that the additional assessment data requirements are not applied during NYSOFA review. We believe this will eliminate many false error messages.

The second applies to Title III-E Caregivers Age 60 or older receiving HDM who have not been assessed. We have been told of many instances where the caregiver is age 60 and older and refuses to be assessed. Certainly that person should be assessed but if they refuse, it is still in the best interest of the care receiver that those people receive a meal.

**Standard Definitions of Service**

Although there are no major changes to the definitions and no new services that have been added, there are two changes which need to be pointed out.

The definition for Information and Assistance (I&A) has been revised to make better use of the original services which make up I & A. I & A is made up of three components; the provision of information, providing assistance to individuals and the referral follow up. The provision of I & A may include one or all of these components. The important change

affects what constitutes a unit of service. More and more we've been hearing from the AAAs that usually a contact did not adequately reflect what was being provided and that more often than not calls could easily take a half hour or more. To reflect this, the unit definition is being changed to one hour. Quick contacts, where for example a question is asked and answered, can be reported as 0.25. Note units of service which are one hour can be reported in increments of 0.25.

A notation has been added to the definition for Counseling, Support Groups & Training to separate out those events which are better reported under information. Counseling, Support Groups & Training is a group 1 service where recipients must be registered and certain demographic information collected and reported. We have found that many AAAs have attempted to report events that do not require preregistration and are open to the general public under this service, resulting in a large numbers of errors because of the missing data. To correct this, the following notation has been added; "Note training events that do not require preregistration and are open to the public should be reported as Information." We believe this will allow for more accurate reporting and eliminate many errors.

Also included are two updated brochures that were created several years ago that can be helpful in explaining why information is collected, how it is used and how it is protected. The brochures are Caring Respect Trust and Dining Together.

**Attachments Included:**

Reporting Guide CAARS and Client Data 2014
CAARS 2014 Quarterly Report Forms
Minimum Data Set (MDS)
Att. A: Client Data Specifications 2014 Provides description of the allowable file layout.
Att. B: Client File Codes 2014 Provides codes to be used in data reporting.
Att. C: Fields Required by Cluster 2014
Att. D: COMPASS Instructions 2014
Att. E: COMPASS Form 2014
Att. K: CAARS Client Reports 2014
Att. L: Examples of Case Managed and Non Case Managed Clients
Att. M: Areas To Be Covered During the Six-Month Contact for Non-Case Managed Home Delivered Meals Clients
Att. N: Quarterly Data Quality Review Provides methodology for client data review with examples.
Sample III-E Registration Form
Sample Congregate Services Intake Form
<u>Caring Respect Trust</u> and <u>Dining Together</u> – Brochures for use at congregate sites on the collection and use of data.
Standard Definitions for Service 2014

**PROGRAMS AFFECTED:**

- |   |   |   |   |   |
|---|---|---|---|---|
| <input checked="" type="checkbox"/> Title III-D | <input checked="" type="checkbox"/> Title III-E | <input checked="" type="checkbox"/> Title III-B | <input checked="" type="checkbox"/> Title III-C-1 | <input checked="" type="checkbox"/> Title III-C-2 |
| <input checked="" type="checkbox"/> EISEP       | <input checked="" type="checkbox"/> NSIP        | <input checked="" type="checkbox"/> CSE         | <input checked="" type="checkbox"/> SNAP          | <input type="checkbox"/> Energy                   |
| <input type="checkbox"/> Other:                 |   | <input type="checkbox"/> Title V                | <input type="checkbox"/> HIICAP                   | <input type="checkbox"/> LTCOP                    |

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**Reporting Guide  
Consolidated Area Agency Reporting System (CAARS)  
and  
Client Data Systems**



**April 2014**

**Date Last Revised: 2/5/2014**

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***Attachments are available for download at AAARIN site under Reporting.***

- Attachment A - Client Data Specification
- Attachment B - Client File Codes
- Attachment C - Fields Required by Cluster
- Attachment D - Instructions for Comprehensive Assessment for Aging Network  
Community-Based Long Term Care Services (COMPASS)
- Attachment E - COMPASS Form 2014
- Attachment F - Title III-E Program Frequently Asked Questions
- Attachment G - Title III-E Reporting Scenarios
- Attachment H - Definitions of Caregiver, Counseling and Assistance under Title III-E
- Attachment I - Title III-E Coding Examples
- Attachment J - Client Status
- Attachment K - CAARS\Client Reports
- Attachment L - Examples of Case Managed and Non-Case Managed Clients
- Attachment M - Six-Month Contact for Non-Case Managed HDM Clients**
- Attachment N - Quarterly Data Quality Review**

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Contact Information: Bob Miller, Coordinator Reporting Unit  
518.473.1947**

## CAARS Data Entry Tool Instructions

Accessing the tool requires the following equipment and software:

- A computer with access to the Internet
- Internet Explorer 9.0 or later

**Multiple users** – The system was designed so that more than one person from an AAA can login and input data at the same time.

However, multiple users should NOT work on the same page at the same time. Doing so will likely lead to lost data and create re-work for your agency.

Every time the page is saved by one user, it will overwrite the changes made by others working on the same page.

To avoid this potential problem, coordinate with others in your AAA working on the quarterly report forms. There is no conflict if multiple users are working on different pages. The tool treats each page as a separate document and will only save changes to that page.

### General Instructions for Submission\Revision

#### 1. Login and Select the Quarter

To access the tool, we recommend using Internet Explorer ver. 7 or greater. Go to <http://reporting.aging.ny.gov>. This site uses a User Name and Password like that used for the AAARIN web site. If you do not have a User Name and password your Director can request one through your ASR.

- Once on the NYSOFA Budgeting and Reporting Systems Main Menu, you can select CAARS Quarterly on the left.
- Once you've made your selection a dialog window will appear in the center of the screen.
- The CAARS Quarterly Main Menu page will open.
- From this page you have three choices: review Reference Material, do Data Entry or use the Tools section to check for errors:

#### 2. Enter Data and Navigate through the Pages

- From the Main Menu, select a page to begin.
- Fill in the data fields on each page, note you need to open and save each page even if no data was entered.
- SAVE CHANGES FREQUENTLY.
- If you enter data and save, but do not see the data you entered, click on View and Refresh or View and Reload.
- Navigate to other pages and the Main Menu using the links at the top of the page.

#### 3. Submit Forms

From the Main Menu, you can check for errors by individual page or for all pages.

- Clicking on the "Submit" button will show a notification on the screen that your report has been submitted.
- An e-mail will be sent to the e-mail address entered on page one of the report saying that the report has been submitted.

#### 4. Print Forms

Click on "Print This Page" (a selection on the toolbar). A separate window (a PDF file) of the page will open. Users can save or print this PDF file. Once you close out of the PDF file, the original screen will still be up.

#### 5. Revisions\Correction\Extensions

##### A. CAARS

Once your forms are submitted, your data is locked from editing. To unlock the forms, send an e-mail to CAARS, [caarsreports@ofa.state.ny.us](mailto:caarsreports@ofa.state.ny.us). The e-mail will respond to the same address noted on the submitted CAARS form. If another person needs to be notified, just add their e-mail address to the request.

You will receive an e-mail reply notifying you when the forms have been unlocked. When the forms are unlocked, you can make your correction(s) and submit the forms again. If you are revising several quarters, it is important to do the revisions in sequence. For example, submit 1st quarter, then 2nd, etc.

Reports/Revisions are due according to the schedule below. Note that when the due date falls on a weekend or holiday, the due date is moved to the next working day.

##### B. Client Files

Client data is updated with each submission so corrections are made to the following quarter.

##### C. Extensions

If the AAA is unable to meet the reporting due date, an extension can be requested. To make a request send an e-mail for CAARS Reporting to [caarsdata@ofa.state.ny.us](mailto:caarsdata@ofa.state.ny.us) and for client files to [clientdata@ofa.state.ny.us](mailto:clientdata@ofa.state.ny.us). The subject should say **Extension Request**. In the body of the e-mail explain why the request is being made, for example a key staff person is temporarily unavailable and when the report will be submitted. If the request extends beyond one week you will need to send an update each week describing progress being made in being able to submit.

Quarter Reported	Reports Due	First Late Notice sent Via E-mail	Letter sent to AAA Dir. & County Exec.
April – June	July 21, 2014	July 28, 2014	Aug. 4, 2014
July – September	Oct. 20, 2014	Oct. 27, 2014	Nov. 4, 2014
October – December	Jan. 20, 2015	Jan. 27, 2015	Feb. 3, 2015
January – March	Apr. 20, 2015	Apr. 27, 2015	May 5, 2015

#### Due Dates

See Schedule above.

### **Reminders/Late Notices**

Reminders/Late Notices will be sent via e-mail according to the above schedule. The reminder e-mails will be followed by a letter sent 10 business days following the due date with copies sent to Chief Executive Officer or Chairman of the Governing Board, Aging Services Representative, Aging Services Area Supervisor, Senior Accountant or Grants Management Budget Specialist 2 and the Deputy Director Aging Network Operations. The letter will inform the AAA that **NYSOFA will be withholding funding reimbursements because of two possible deficiencies.**

**The CAARS\Client data has not been received in the prescribed format.**

**Client data does not meet the data quality rules as set forth in Section C. Quarterly Data Quality Review.**

**If you have reasons that would mitigate or explain why your AAA is unable to meet this deadline, please advise us via e-mail. If you receive an E-mail late notice in error, please reply to the e-mail immediately so that reporting staff can follow-up. This ensures that you will not receive a late letter in error.**

### **View Reports**

The standard CAARS reports can be viewed by going to <http://www.boedmz.ofa.state.ny.us/infoviewapp/logon.aspx>. This system uses the same username and password as noted above. A list of CAARS\Client reports can be found in Attachment K.

## Section I - Area Agency Quarterly Report - NYSOFA #358

### Overview

- These instructions incorporate all of the CAARS reporting requirements effective April 1, 2014.
- Periods Covered: April 1, 2014 – June 30, 2014; July 1, 2014 – September 30, 2014; October 1, 2014 – December 31, 2014 and January 1, 2015 - March 31, 2015 (The CAARS system accumulates data covering the State Fiscal Year).
- Cumulative data requested is from April 1, 2014.
- These instructions have been designed to follow the layout of the reporting forms.
- Complete all appropriate questions. Use estimates until final data is available.
- For all financial questions, **round to the nearest dollar. (Round up all Non-Federal, Non-State Share and Match amounts).**
- Complete Parts I A, B; II, and III each quarter. For Part I, question C. Staffing is only reported for the first quarter. Questions D. Provider Profile and E. Focal Points/Senior occurs just once a year with the final SFY quarterly report (i.e., the report ending March 31<sup>st</sup>).
- Comments may be sent as an e-mail attachment to the CAARS e-mail address, [caarsreports@ofa.state.ny.us](mailto:caarsreports@ofa.state.ny.us) Comments must be labeled with AAA name, period covered, and contact person, if applicable.
- Contact Information:

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(518) 473-1947  
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By e-mail at: [caarsreports@ofa.state.ny.us](mailto:caarsreports@ofa.state.ny.us) or [clientdata@ofa.state.ny.us](mailto:clientdata@ofa.state.ny.us)

## Part I - General

### A. Period Covered:

Information requested is completed by system.

### B. Identification:

1. System will complete.
2. System will complete.
3. Enter name of person to be contacted for corrections (contact person).
4. Title of person (contact person) completing this report.
5. Area code, telephone number and e-mail address of contact person named above.
6. Area Agency on Aging director's review checkbox (*must be checked*).

### C. Staffing

**Area Agency Staffing:** Develop the staffing profile of your agency as of June 30, 2014 for filled positions only. Enter the total number of full time equivalents (FTEs) and the total number of minority FTEs. Line 5, Total AAA Staff includes both paid staff and volunteers. The numbers reported should be consistent with those reported for June 30, 2013. For personnel classifications definitions, refer to Section VII, Glossary of Terms.

**Note:** *Full time equivalents (FTEs) should be based on local definition of what constitutes a full time employee. As an additional point of clarification, information systems activities should be included under "administration."*

When entering data on the Volunteer line(s), please do not enter the total number of volunteers. Enter the number of FTEs that would result when volunteer hours are aggregated. An estimate may be made by supervisors familiar with volunteer work activity for the year. AAAs are not expected to implement additional work requirements or record keeping to estimate volunteer FTEs. For Subcontractor volunteers, if possible provide your best estimate of the FTEs used by the subcontractor in providing the contracted services.

### D. Provider Profile (Submit with January 1<sup>st</sup> - March 31<sup>st</sup> quarter.)

- a. Total number of Subcontractors providing services under a formal contractual agreement with the AAA.
- b. Total number of Subcontractors providing services to clients who live in rural areas.
- c. Total number of Minority Subcontractors providing services.

### E. Focal Points/Senior Centers\* (Submit with January 1<sup>st</sup> - March 31<sup>st</sup> quarter)

- a. On line 1, enter number of senior centers in the planning and service area.
- b. Of the total on line 1, enter on line 2 how many received Title III funds during the fiscal year.
- c. Of the total on line 1, enter on line 3 how many are designated as Focal Points. \*\*
- d. On line 4, enter the total number of Focal Points operating in the planning and service area.

\*Name & address of Centers/Focal Points are included in the Plan Roster.

\*\*Focal Points: A place or mobile unit in a community or neighborhood designated by the area agency for the collocation and coordination of services.

## **Part II - Program Information (Complete Each Quarter)**

### **A. EISEP Other Services (April 1 to date)**

Please breakdown the total Other Services shown under the EISEP column on page 3, line 21 using the service categories provided. Complete the requested information for each service category in which the AAA provided services or goods during the period being reported. Include the number of persons served, the units provided and expenditures for the goods and/or services.

**1. Home Modification(s)** is a change to a particular location that fosters independence, safety or allows the person to carry out their daily tasks more easily (includes both or either materials and/or labor) – examples of this include but are not limited to installation of grab bar, widening door frame, building a ramp, lowering a counter, raising an electrical socket, installing a lighted door bell, replacing doorknobs with levers, accessible bath tub;

**Unit** – each modification includes all the materials and labor for each modification if the AAA provides both aspects of the modification, if the AAA only provides one component still count each component – materials for one modification or labor for one modification.

**2. Home Maintenance/Repair** intended to keep the person's home habitable and in good working order (includes both or either materials and/or labor) – examples of this include but are not limited to installing storm windows/screens, snow removal, lawn mowing, replace faucet, secure a loosened hand railing, and replace a step to the porch.

**Unit** – each maintenance or repair includes all the materials and labor for each maintenance job or repair if the AAA provides both aspects of the modification. If the AAA only provides one component, count each component – materials for each maintenance/repair job or labor for each maintenance/repair job.

**3. Assistive Devices/Equipment**, also referred to as assistive technology, that is intended to increase, maintain or improve functional capabilities of a person with limitations and thereby fosters a person's independence, safety and quality of life (includes the item and its installation, if required, and if the AAA includes both aspects) – examples of this include but is not limited to tub seat, lift vests, modified telephone (e.g., headset, large buttons, speakerphone), medication dispenser, chair lift, and/or stair glide.

**Unit** – each item, including installation, if required, and provided by the AAA.

**4. Household Appliance** is a household item that is needed to maintain the person in his/her home safely or will foster the person's independence and ability to carry out daily tasks more easily (include item and installation if required and provided by the AAA) – examples of this include but is not limited to stackable washer and dryer, air conditioner, microwave oven, toaster oven.

**5. Miscellaneous Personal Items** includes adaptive clothing, protective undergarments (for incontinence), adult diapers, cooking utensils, bedding, and/or adaptive silverware.

**Unit/Item** – each category/grouping provided to a client (e.g., adaptive silverware is one unit).

**6. Other** – anything that does not fit into one of the above categories and was included under "other services".

## B. Cumulative Amount of Cost Sharing Accrued from EISEP/CSE Clients

1. - 2. (Before any transfers) enter the total amount of cost sharing collected or expected to be collected for services April 1 to date, regardless of when the cost share is actually received (i.e., on an accrual basis).
3. Enter the amount, if any, of EISEP cost sharing transferred to CSE.  
Note: In subsequent quarters it will be necessary to adjust amounts in a, b, or c, for any accrued cost sharing previously reported which the AAA was not able to collect.

## C. Non Registered Services (Cluster 3)

For cluster 3 (non-registered) services, **enter the estimated unduplicated count of persons served to date.** Estimates should reflect a reasonable estimate of actual persons served. **Service recipients reported should be age 60+.** Exceptions to this exist for I & A and caregivers services funded by Title III-E and NYConnects. Question a. 12, Total Non-Registered Persons Served on page 2 of the CAARS quarterly must **only include persons age 60+.** Note this is an estimate and does not require demographic information to be collected.

**D. Title VII Expenditures:** Indicate **Federal funds only** spent this quarter on the accrual basis. Round expenditures to the nearest dollar. Remember to also include this amount on Page 3 Expenditures line 20 in the Other column. The amount reported on Page 3, line 20 in the Other column may exceed Title VII expenditures due to funding from other sources but it may not be less than Title VII expenditure.

**E. State Transportation Information:** Enter the units of transportations service, the total expenditures and program income provided this quarter under the State Transportation Program. (Refer to 06-PI-14 for additional information.)

**F. Long Term Home Health Care Meals:** Enter the number of home delivered meals sold to the Medicaid Long Term Home Health Care program during the quarter. Please include the funds expended on these meals on page 3, Part III, "Other" column, line 4. These meals cannot earn NSIP funding from NYSOFA. **Note the clients and services files submitted should reflect the meal counts reported here.**

## G. Title V Expenditures:

- All data requested is for the quarter being reported.
- Do not include programs administered through National Sponsors for employment programs, e.g., N.C.O.A., Green Thumb, etc.
- Round all expenditures up to the nearest dollar and report whole dollars only. Non-Federal Matching Funds one cent or greater must be rounded up to the next dollar.
- Column A. Total accrued expenditures for the quarter being reported. The federal funds may not exceed 90% (rounded up) of the total expenditures.
- Column B, C, and D reflect appropriate breakdowns of the accrued expenditures reported in Column A.

### **Part III - Program, Services and Expenditure Breakdown - Federal\State Programs:**

- The order of services is the same as the Service Delivery Objectives and Resource Allocation Plan page of the current Four Year and Annual Implementation Plans.
- Complete the lines for all services provided by the area agency and its subcontractors during the quarter.
- Expenditures for comprehensive assessments and reassessments conducted for non-case managed home delivered meals (HDMs) recipients and assessments for short term HDM recipients (Refer to 98-PI-25 for further information) may be reported on the case management line under SNAP on Page 3 as well as other programs as appropriate.

#### **Amount of Funds Spent on an Accrual Basis This Quarter**

- This column is divided into twelve sub-columns representing various funding sources provided by the area agency.
- Title VII data is included in the Other column, line 20 and on page 2, Part II. E.
- Shaded areas show where funds may not be used. See Technical Assistance Memo 82-TAM-III-B-6 (C-6) dated August 12, 1982 for further information on the use of III-C contributions to pay for the cost of supportive and access services.
- Expenditure data is reported on the accrual basis. **That is, expenditures are recorded when incurred and for the period for which benefit is received regardless of when the bill is received and/or payment is made.** When actual expenditures are not known in time to meet reporting deadlines, the area agency must provide estimated data on its Quarterly report. When estimates are needed for subcontractor expenses, the subcontractor should provide the estimates to the area agency.
- For Definitions of Services Units of Service see Standard Definitions for Service and Units of Service, 2014.
- All expenditure data must be rounded and reported to the nearest full dollar.
- For each funding source, the Total (line 23) must equal the sum of funding (lines 24, 25, 26 and 27), except for the "Other" column. It must also equal the sum of lines 1-22.
- Title III-E column(s)
  - All Funds - includes data for all expenditures for services provided under this program for all recipients.
  - Grandparents Only - Enter only Title III E Grandparent services expenditures.
- On line 25 enter the total NSIP/Commodity Food expenditures utilized for that program.
- The minimum matching requirements for Titles III-B, III-C-1, III-C-2, III-D and III-E must be satisfied each quarter. Use the following method to calculate the minimum required Non-Federal share:

*Take the amount of the Area Plan Administration costs (line 22) and multiply by 25% and round up to the nearest dollar. From the Total amount (line 23), subtract the total Area Plan Administration costs (line 22); also subtract Program Income (line 24), if any, since income can be used only to expand services. The resulting figure is the portion that must be matched on a 90%/10% basis and round up to the nearest dollar. Multiply this amount by 10% and round up to the nearest dollar and then add the result to the figure calculated from 25% of administrative costs. This gives you the minimum required Non-Federal Share for the Title III programs. See Worksheet, Section IV of these instructions, to determine minimum match requirements. Your Agency may provide more than the minimum required local match. In this case, refer to the approved budgets for the appropriate matching percentages. For Title III-D, this calculation is simplified because the funds cannot be used for Area Plan Administration.*

- The minimum matching requirement for Title III-E must be satisfied each quarter. Take Total amount (line 23) subtract Program Income (line 24) and multiply the result by 25%. Round this amount up to the next dollar to get the minimum required local share.
- For Title III Programs, page 2, do not report any Program Income amounts on line 27a - Non-Federal Share (From Program Income). The Administration on Aging (AoA) has determined this to be ineligible as a source of match.
- Also, the amount reported on lines 24 and 27a. should equal the actual amount of program income collected during the reporting quarter. For the Community Services for the Elderly and Expanded In-home Services for the Elderly Programs, the breakdown of the Total Costs (line 23) on lines 24, 25 and 26 should be based on the following:
  - CSE/EISEP Planning/Implementation Costs (line 22) are 100% State Aid funded.
  - The sum of lines 24 and 27a. should equal the total amount of CSE/CSI/EISEP program income (contributions and accrued cost sharing) expended during the quarter. Please note, program income used as match under line 26a is limited to contributions only; CSE and EISEP cost sharing income may not be used as match. Accrued cost sharing under EISEP that is transferred to CSE should be reported in the CSE column on Line 24. Note that in subsequent quarters it will be necessary to adjust Line 27 for any accrued cost sharing previously reported that the AAA was not able to collect.
  - The Net Services Costs (line 23 minus line 22 minus line 24) are funded at 75% / 25%.
  - When calculating minimum required local match amounts, **always** round up to the next dollar. That is, Non Federal/State Share one cent or greater must be rounded up to the next dollar. If Non Federal/State Share is increased (rounded up), the Federal/State dollars must be decreased (rounded down).

## Section II, General Requirements/Information for Client Specific Data

### A. DATA REQUIREMENTS

1. AAAs are required to transmit client data for any Cluster 1, Cluster 2, Cluster 3 and Caregiver Clients (Title III-E) active as of **April 1, 2009** or subsequently added as a new client. Each quarter AAAs should generate data using these same criteria. This will allow new information entered during the latest quarter and any changes to existing data entered during the latest quarter to be captured using the same process. The data contained in these files provides information NYSOFA uses to meet both Federal and State reporting requirements as well as to perform necessary monitoring and assessment activities. The data in these files replaces the client and unit information previously collected as part of the CAARS quarterly system.

2. The following files are required for submission and must use the listed file names:

Clients.txt	Basic client identifying data, Nutrition Profile & NSI, Informal Supports, Financial Information, and Benefits/Entitlements (1 record per client)
Services.txt	Monthly units of service delivered (1 record per month per service per fund per client)
ADLIADL.txt	Client ADL/IADL needs (1 record per client)
Caregivers.txt	Caregiver type and relationship (1 record per client)
Characteristics.txt	Client Characteristics (1 record per characteristic per client)
Healthevents.txt	Hospital, emergency, physician visits, etc. <b>(1 record per event per client)</b>
Careplans.txt	Care Plan Services (1 record per service per client)
Elderabuse.txt	A record is required for each report of abuse.

3. Data must be sent to NYSOFA quarterly following the CAARS submission schedule.

4. NYSOFA will not require or store client names or Social Security Numbers in its centralized database. Therefore, these specifications do not include these fields as part of the AAA data submission to NYSOFA.

5. Reporting requirements are tied to the NAPIS cluster designations for services. Clusters are defined as follows:

Cluster 1 services:	Personal Care Levels I & II, Home Health Aide, Home Delivered Meals, Adult Day Care Services and Case Management, Consumer Directed In-Home Services
Cluster 2 services:	Congregate Meals, Assisted Transportation\Escort, and Nutrition Counseling
Cluster 3 services:	Transportation, Legal Assistance, Nutrition Education, Information & Assistance, Outreach, In-Home Contact & Support, Sr. Center/Rec Education, Health Promotion, PERS, Caregiver Services, Other/Local
Caregiver/Grandparent	Counseling/Support Groups/Training, Respite, Supplemental, Information, Access Assistance

6. Some files and/or data elements will be required for all Cluster 1, Cluster 2 and Caregiver service recipients; other files and/or data elements will be requested for clients receiving specific services. A Summary Table is provided in Attachment C - Fields Required by Cluster, showing which files are needed for each cluster. For example, data on ADL and IADL limitations will be required for Cluster 1 clients, but not for other clients.
7. Within specific files, some data elements will be required for all clients in the file and other data elements will be required only for those clients receiving services. For example, date of birth is required for all clients in the CLIENTS file. However, type of housing is required only for clients receiving Cluster 1 services.
8. Information on the number of participants at high nutritional risk is collected for all clients receiving Home Delivered Meals, Congregate Meals, Nutrition Counseling and Case Management using the NSI screen during the registration process or thereafter.
9. For both files and data elements, the following designations are used in Attachment A, File Specifications to note whether the information is required:
  - R Required for either NAPIS reporting or NYSOFA management/advocacy
  - M Information valuable to NYSOFA for ongoing monitoring, management and advocacy activities. If the data is available, NYSOFA would like to receive it from all AAAs from **April 1, 2009** forward. NYSOFA may require this information at a future date.
10. NYSOFA continues to review its longer term data needs and may require additional data by client in the future in such areas as:
  - Client Care Plan Outcome Statements
  - Compliance with the Government Performance Results Act (GPRA)
  - Medications taken by client
  - Presenting problems
  - Nutrition related profile information such as use of nutritional supplements and ability to open containers
  - Frequency and occurrence of significant client events such as reassessments,
  - Historical/prior information to allow analysis of changes over time in such areas as:
    - Client characteristics
    - IADL/ADL needs
    - Nutritional status
    - Financial information
    - Benefits/Entitlements information

## B. Technical Considerations

1. AAAs will be required to transmit cumulative client data for any Cluster 1, Cluster 2 and Caregiver /Grandparent clients active as of **April 2009** or subsequently added as a new client. Each quarter AAAs should generate data using these same criteria. This will allow both new information and any changes entered during the latest quarter to be captured using the same process. NYSOFA will delete the AAA information on its centralized database and replace it with the new data files.
2. Each record on the CLIENT file will be used to establish a client record in the consolidated database. Each client receiving Cluster 1 and/or Cluster 2 and/or Caregiver/Grandparent services must be included on this file. Non-registered clients receiving only Cluster 3 services may be included on this file if they are part of the database. Clients receiving non registered services who are not registered will be reflected in the client file using the appropriate 9999..... anonymous record key.

3. Each client must have an assigned Record Number/KEY which is unique. This Record Number/KEY must be used consistently in all tables to link all data for the same client. The scheme used for this number is up to the AAA to determine.
4. Where data is coded, AAA data must be translated into the equivalent codes provided. For example, if a local data base contains a field 'marital status' with a code of 4 for 'widowed', it must be changed to a code of 2 to correspond to the appropriate coding scheme being used in NYSOFA's consolidated database.
5. Numeric fields should be right-justified and zero-filled. For example, a monthly income of \$455 should appear in the 5-character field as 00455.
6. All files are in standard ASCII (text) format with fixed length records.
7. Files are to be submitted using NYSOFA's FTP web site, <https://reporting.ofa.state.ny.us/>. This site uses the same username and password for access as you are currently using for the AAARIN website. Also, when going to this site you may be prompted to install a Java script. This is required as Java is used by the application. You may need IT support to do this install. Additionally you may see the prompt Continue to this website (not recommended). It is safe to go to this site. There is a Certificate Error but it is procedural and does not affect the safety of the site. Further instructions can be found on page 24 in this guide.
8. Data files no longer are to be submitted using a file compression utility such as WinZip. Only submit files in the required "text" format.
9. At this time it is not required that data be encrypted; however, AAAs wishing to do so should coordinate this effort with NYSOFA to insure that the data can be decrypted when received.
10. **All files must conform to the Attachment A File Specifications for field length, characters used and file length.**

### C. Quarterly Data Quality Review

To help with identifying critical data completeness issues, NYSOFA will develop a report to show the reporting status for missing service records, missing ADL/IADL Count, and missing Nutrition Risk Score. This report will be shared with the AAAs on a quarterly basis. The following are the criteria used to determine data completeness: See Att. N. for more information.

- **Missing Service Records: Two or more Cluster 1 services (Personal Care Services, Case Management, Home Delivered Meals, Adult Day Services) with more than 50% service records not reported as compared to the number of clients reported through the verification report.**
- **Missing Functional Status (ADL/IADL): More than 50% of Case Management missing functional status counts.**
- **Missing Nutrition Risk Score: More than 50% of Home Delivered Meals or Congregate Meals clients missing nutrition risk score.**

Note AAAs not meeting these criteria will result in a letter being sent to the AAA director, County's Chief Executive Officer or Chairperson of the Governing Board advising that NYSOFA will withhold funding reimbursements until required data are received or a work plan acceptable to NYSOFA to address the issues with reasonable timelines.

**Section III - Title III-E Service Matrix (Crosswalk)**

<b>TITLE III-E SERVICE COMPONENTS</b> with NAPIS Codes that <b>a caregiver receives</b> when receiving a Title III-E funded service.	<b>CORRESPONDING NYSOFA STANDARD SERVICES</b> that the <b>caregiver or care receiver is provided</b> in order to show the Title III-E component services and to provide a linkage to the CAARS expenditures.
Counseling, Support Groups & Training* (Code 902)	Caregiver Services (Code 527)
Respite (Code 903)	<b>CD In-home Services (206)</b> PC Level II (Code 202) PC Level I (Code 205) Home Health Aide (Code 201) Adult Day Services--social adult day or adult day health (Code 510) In-home Contact and Support--when in-home supervision and monitoring will be provided (Code 526) Other--for those services not separately defined, e.g., overnight respite, which may be provided at a nursing home, adult home, or other appropriate facility (Code 602)
Supplemental Services (Code 904)	Home Delivered Meals (Code 401) Congregate Meals (Code 402) Nutrition Counseling (Code 502) Assisted Trans./Escort (Code 504) Transportation (Code 101) Legal Assistance (Code 301) <b>Health Promotion (Code 512)</b> Nutrition Education (Code 501) Personal Emergency Response Systems (Code 509) Other--for those services not separately defined, e.g., home modifications, etc. (Code 603)
Assistance (Code 905)	Case Management (Code 505) Information and Assistance (Code 103)
Information (Code 906)	Outreach (Code 102)  Other Services, i.e., Public Information (Code 604)
<b>* Training events that do not require preregistration and are open to the public should be reported as Information.</b>	
The CLIENT TYPES/FUNDING SOURCES codes for Title III-E services are 16 – III–E Caregiver and 20 – III–E Grandparent.  Title III-E expenditures are reported on page 3 of the CAARS online form following the above crosswalk.  Title III-E Other has been separated so they are tagged to the specific services.	

## Section IV - Minimum Match Determination Worksheet

**Instructions to Determine Minimum Match Requirements** - The minimum match requirements must be reported **each quarter**. The following formula must be followed and is designed to assist your determination of the **MINIMUM** amount required for Non-Federal Share under Titles III-B, III-C-1, III-C-2, and III-D(\*):

(\*): Please note for III-D, Area Plan Administration is not an allowable expense and should not be included in the calculation.

Step 1) Line #22 Area Plan Admin.					
	x .25 (25%)	=			
			Figure 1		
Step 2) Line #23 Total					
Minus Line #22 Area Plan Admin.		-			
Minus Line #25 Program Income		-			
	Subtotal =				
	x .10 (10%)	=			
			Figure 2		
Step 3) Figure 1					
Figure 2	+				
	MINIMUM REQUIRED MATCH	=			
Step 4) Round this amount up, even if it is only one cent over the dollar. The Minimum Required Match must equal the Total of Lines 27a.-27b. Your reported match may be higher.					

For CSE and EISEP the formula to determine **MINIMUM** Non-State Share is:

Step 1) Line #23 Total					
Minus Line #22 Plan/Impl.		-			
Minus Line #24 Program Inc.		-			
	Subtotal =				
	x .25 (25%)				
	MINIMUM REQUIRED MATCH	=			
Step 2) Same as Step 4 in Title III formula.					

## Section V, Reporting Tips

### General Notes

If you use purchased software, **always be sure you are using the most recent version** of it and any additional tools that may be provided. In addition if your vendor provides intake forms such as those that are designed to meet the requirements of the NYS Compass form, make sure you are using the most recent version of those forms.

### Information and Assistance

The reporting of persons served and services provided under Information and Assistance is certainly different than other services. Under I & A, a person may call and simply request information as to where a service is provided or where to go to find adult day services. In that case the person need not be counted and the anonymous code 9999999993 can be used; the unit of service is one hour so in this case .25 is counted. The same person may call a different time and ask more detailed information about Adult Day Service. During that call the worker asks more information about the caller and the reason for the call. Using information received from the caller, the worker describes in detail the service and sets up a referral to a case manager. In this case the individual and the unit which may extend beyond an hour may be reported.

### Client's Age

If an older person declares they are age 60 or older but does not provide a date of birth, you may enter a date 60 years back.

### Attachment A, Client Data Specifications

The file specifications outline the format to be used for each field. Failure to conform to the required format will result in errors and data not being processed. One example of this is the services file, which requires the count of units provided to be limited to ten spaces, 0000000.00. If this format is not followed we are unable to process that data. Additionally each of the files lists the county code as the first two spaces. AAAs are required to show only their county code. Incorrect County codes cannot be processed. Also the file names used must match the names used in the file specifications that are clients.txt, adliadl.txt, services.txt, healthevents.txt, characteristics.txt, careplan.txt, caregiver.txt and elderabuse.txt.

Note when entering Overall cost share, this is to be entered as a percent and should not exceed 100 %.

### 2014 Revisions:

#### **a. Client File**

For clients who are **Only** receiving a home delivered meal a date field has been added for the Six Month Contact. Refer to 97-PI-20, Subject: Program and Policy Changes Related to Implementation of MDS: (A) Home Delivered Meals; (B) EISEP and CSE EISEP-Like Services; and (C) All Six Community-Based Long Term Care Services dated July 10, 1997 and Attachment M - Areas to Be Covered During the Six-Month Contact for Non-Case Managed Home Delivered Meals Clients.

Under Financial Information the requirement has been changed to request the total monthly income for both the individual being assessed and the household income be reported for cluster 1 clients. The poverty status, being at 100% and 150% is required for both clusters 1 & 2.

Under Informal Supports for both the primary and secondary a field has been added for where the informal support has been identified as being a defined care giver, specific services can be checked if they will have the dual purpose of providing respite to the care giver.

A question has been added for local use if additional information is requested on care givers services.

The section, Client Receiving Eligible Meals Who Are Otherwise Non-Eligible has been reworded to be Client Receiving Eligible Meals. This has been done to broaden the questions use. Two categories have been added:

- Clients Receiving HDM for 10 consecutive days or less – this allows meals provided under circumstances to be reported for NSIP reimbursement without an assessment being done. For example a person who will only need meals for two weeks after being discharged from a hospital.
- Title III-E Caregivers Age 60+ receiving HDM who have not been assessed – this allows meals provided to a care giver who is 60 and older who has not been assessed to receive an NSIP eligible meal. The provision of this meal would be in the best interest of the care receiver.

### **g. Elder Abuse File**

A category of elder abuse has been added for None Reported

## **Attachment B - CLIENT FILE CODES**

### **B. STATUS / SUBSTATUS Codes**

Status and sub status codes are used to show clients who are active and receiving services or who have become inactive or terminated.

A client in the program who is receiving services should be tagged as being an active client (1) and have a sub status code of either 20 = Case Managed or 35= NONCASE Managed. See Att. L for examples of Case Managed/Noncase Managed recipients.

One example of this would apply to SNAP clients as the time spent doing the required assessment can be reported as a case managed service. Again, unless the case management service meets the Standard Definition of Service for Case Management, the client is not a case managed client so the client would be tagged as a Noncase Managed client.

A client who receives short term home delivered meals for example a person released from the hospital who receives a discharge plan that calls for a home delivered meal for two weeks. The plan is that the person will return to their daily routine after that time and no longer need the meal or the required assessment. The client in this example would not be a case managed client and would be tagged as a Noncase Managed client.

An additional example would be where an AAA provides a “shelf ready” emergency meal. If the person receiving the meal is not a registered home delivered meal client but would otherwise be program eligible, the meal would be counted as a NSIP eligible and the clients in this example would not be a case managed client and would be tagged as a Noncase Managed clients.

Another example is where an EISEP case manager may do an assessment for a potential client but for some reason that client does not become case managed. The AAA is allowed to count the time spent in doing the assessment as units of case management.

It is important to **correctly** utilize the case managed (20) and noncase managed (35) codes. Starting in SFY 2014-15, NYSOFA system will filter out noncase managed clients when we conduct NAPIS Data Review (Case Management). We understand that some clients receiving case management units may not have complete assessment data. Excluding these cases in the NAPIS Data Review (Case Management table) may help to reduce missing rate.

This is also helpful for the ASRs' assessment date review. For example, clients receiving EISEP case managed units but not becoming 'case managed' will be filter out from the EISEP Assessment Date report.

We hope that this change is a way to reduce staff time in investigating why some 'case management' clients do not have complete assessment data and/or do not have reassessment (every year).

The following is a brief synopsis of what is required for case management.

For a client to be reported as a case management client, he/she must be receiving or expected to receive all the components of Case Management as found in the standard definition. Case management consists of assessment and reassessment, care planning, arranging for services, follow up and monitoring and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor. Standard Definitions (11-PI-03).

If a client has become inactive or terminated, please select from one of the sub status codes that best describes the reason why. You may need to contact your software vendor to learn how these selections are to be implemented.

## D – SERVICES

### Coding for use in identifying nonregistered participants in client and service

Nonregistered clients receiving only cluster 3 services are on page 2 of the online CAARS reporting web page and in the electronic client files.

For the client based reporting using the client.txt/ services.txt files, recipients of nonregistered services who receive a Cluster 1 or Cluster 2 service can still be entered into the system using their unique identifying record key. AAAs will also have the option of using one of the 10 digit anonymous record keys provided in ATTACHMENT B, CLIENT FILE CODES. These codes need to be associated with the appropriate service to meet reporting requirements.

• Elder Abuse	Each contact	9999999980 as the record number/key
• III-E Assistance	Each event/activity	9999999982 as the record number/key
• Other Services General (601)	Each event/activity	9999999983 as the record number/key
• Other Services III-E Information (604)	Each event/activity	9999999984 as the record number/key
• In-Home Contact & Support	Each contact	9999999985 as the record number/key
• Sr. Center Recreation/Education	One group session	9999999986 as the record number/key
• Health Promotion	Each Participant	9999999987 as the record number/key
• Personal Emergency Response (PERS)	One unit	9999999988 as the record number/key
• Caregiver Services	Each Participant	9999999989 as the record number/key
• USDA eligible seniors, spouses, disabled persons living in Senior Housing	Each meal	9999999990 as the record number/key
• Guests/staff under 60 & other ineligible	Each meal	9999999991 as the record number/key
• USDA eligible volunteers	Each meal	9999999992 as the record number/key
• Information & Assistance	<b>One hour</b>	9999999993 as the record number/key
• Food handlers	Each meal	9999999994 as the record number/key
• Transportation	One Way Trip	9999999995 as the record number/key

- |                              |                  |                                     |
|------------------------------|------------------|-------------------------------------|
| • Legal                      | One hour         | 9999999996 as the record number/key |
| • Outreach (Including III-E) | Each contact     | 9999999997 as the record number/key |
| • Nutrition Education        | Each Participant | 9999999998 as the record number/key |

## **Examples:**

HIICAP provided Information & Assistance, Outreach and Other reported in CAARS on the appropriate service line with funds entered under the “Other” column. For Client data HIICAP funded units of Information & Assistance would be reported using the service code of 103, funding type code of 21 and would use Record Key 9999999993, Outreach would be reported using the service code of 102, funding type code of 21 and would use Record Key 9999999997 and Other would be reported using the service code of 601, funding type code of 21 and would use Record Key 9999999983.

NYConnects provided Information & Assistance would use the service code of 103, funding type code of 24 and would use Record Key 9999999993.

Long Term Home Health Care Program Meals which are not eligible for NSIP funding would be coded as 403 for an ineligible congregate meal or 404 for an ineligible home delivered meal, a funding type code of 05 and would use Record Key 9999999991.

State Transportation Program units would be reported using a code as 101 with a funding type code of 05 and may also use Record Key 9999999995.

### Congregate Meals:

Service codes are available for ineligible meals so that 403 are for Ineligible Congregate and 404 are for Ineligible Home Delivered Meals. One use is to code meals that are ineligible and for consumers who are otherwise eligible. One example of seniors who are otherwise eligible is where a third party, such as a municipality pays a flat rate and seniors are **charged** for the meal. The seniors attending that center are 60+ and would be eligible but the meals are not USDA eligible because there is a charge.

If you serve a USDA eligible senior at say a picnic, and know the meal is eligible but do not have any identifying information about the senior except to know they’re eligible, or serve a spouse of an eligible senior or a disabled person living in Senior Housing, then you can use the client file record key, 9999999990 representing that person and that same record key in the services file with the service code of 402.

If while doing a visit to a meal site and have lunch, you should be coding 9999999991 in the client file as a Guest or Staff under 60 and appear in the services file with that code and with the service code of 402.

A food handler working in the kitchen should be coded 9999999994 in the client file, and appear in the services file with that code and the service code of 402.

Note: All systems should have these codes available. We have found these codes to be under used in reported data. These codes are necessary when reporting Cluster 3 service information, anonymous congregate meals and for reporting ineligible meals now reported in CAARS. Contact your vendor or developer to ensure that the software allows the user to enter this information.

## E. CLIENT TYPES/FUNDING SOURCES

In addition to the programs listed below, services provided may also be reported as being provided informally when necessary an informal support.

### Allowable Service Expenditures by Fund

The following table shows by service the allowable funds. Software settings should ensure that AAAs do not select incorrect funding type for services.

Services		Allowable Funds
PC Level II (H/PC)	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other , Vet, Infor
PC Level I (H/Chore)	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet, Infor
CD In-home Services	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet, Infor
Home Health Aide	One Hour	Title IIIB, Title IIIE, CSE, Other, Vet
Home Delivered Meals	One Meal	Title IIIC-2, Title IIIE, EISEP, CSE, WIN, Other, Infor
Adult Day Services	One Hour	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet
Case Management	One Hour	Title IIIB, Title IIID, Title IIIE, EISEP, CSE, WIN, Other, Vet
Congregate Meals	One Meal	Title IIIC-1, Title IIIE, EISEP, CSE, WIN, Other
Nutrition Counseling	One Hour	Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, EISEP, CSE, CSI, WIN, Other, Vet
Assisted Trans.	One Way	Title IIIB, Title IIIC-1, Title IIIE, EISEP, CSE, CSI, WIN, Other, Vet, Infor
Transportation	One Way	Title IIIB, Title IIIC-1, Title IIIE, EISEP, CSE, CSI, WIN, Other, Vet, Infor
Legal Assistance	One Hour	Title IIIB, Title IIIE, CSE, Other, Vet
Nutrition Education	Each Participant*	Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, CSE, CSI, WIN, Other, Vet
Info & Assistance	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIID, Title IIIE, Title V, CSE, CSI, WIN, HIICAP , LTCIEOP , POE , Other, HEAP, WRAP, MIPPA, Vet
Outreach	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIIE, CSE, CSI, WIN, HIICAP , LTCIEOP ,Other, Vet
In-Home Cont. & Sup.	Each Contact	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIIE, EISEP, CSE, WIN, Other, Vet, Infor
Sr. Center/Rec & Educ.	Group Session	Title IIIB, Title IIIC 1, Title IIID, CSE, CSI, WIN, Other, Vet
Health Promotion	Each Participant	Title IIIB, Title IIID, Title IIIE, EISEP, CSE, CSI, MIPPA , Other, Vet
Per. Emerg. Response	One Unit	Title IIIB, Title IIIE, EISEP, CSE, Other, Vet
Caregiver Services	Each Participant	Title IIIB, Title IIID, Title IIIE, CSE, CSI, Other, Vet, Infor
LTC Ombudsman		Title IIIB, Other
Other Services	As Applicable	Title IIIB, Title IIIC-1, Title IIIC-2, Title IIID, Title V, EISEP, CSE, CSI, WIN, HIICAP , LTCIEOP , POE , Other, HEAP, WRAP, MIPPA, Vet, Infor
Counseling, Support Groups & Training	As Applicable	Title IIIE (16/20)
Respite	As Applicable	Title IIIE (16/20)
Supplemental	As Applicable	Title IIIE (16/20)
Access Assistance	As Applicable	Title IIIE (16/20)
Information Services	As Applicable	Title IIIE (16/20)
Other Services Respite	As Applicable	Title IIIE (16/20)
Other Services Supplemental	As Applicable	Title IIIE (16/20)
Other Services Information	As Applicable	Title IIIE (16/20)

\*Refer to Standard Definitions of Service 2011 for unit count information on distributed materials and media usage.

## F. Nutrition Services Incentive Program (NSIP) Eligibility and Reporting

### NSIP Eligibility:

Claimed Meals – all meals claimed for NSIP reimbursement must meet the nutritional requirements of the program (1/3 Dietary Reference Intake (DRI)). This extends to program variations such as the Restaurant Voucher option. In addition, if participants have been charged a fee or made to pay for a meal(s), those meals may not be claimed for reimbursement.

### Congregate Meals

- People 60 years of age or older, and their spouses regardless of age.
- Volunteers who assist in the meal services during meal time.
- Disabled individuals under age 60 who reside at home with an eligible congregate participant.
- Individuals under age 60 with disabilities who reside in housing facilities occupied primarily by older individuals at which congregate meals are provided.

### Home Delivered Meals

- Any person age 60 or older is eligible to receive home delivered meals provided that such person:
  - (i) is incapacitated due to accident, illness or frailty;
  - (ii) lacks the support of family, friends or neighbors; and
  - (iii) is unable to prepare meals due to a lack or inadequacy of facilities, or an inability to shop, cook or prepare meals safely, or a lack of knowledge or skill.
- The spouse of such a person, regardless of age, may receive home delivered meals if, according to criteria determined by the area agency, receipt of such meals is in the best interest of the eligible elderly person.
- Nonelderly disabled persons living with an eligible person.
- Volunteers who assist in the meal services/deliver the home delivered meals can be provided a meal. The meal would be considered a NSIP eligible meal; the volunteer would not be considered a home delivered meals client.

### NSIP Meals under National Family Caregiver Support Program (NFCSP)

- A caregiver who is a spouse, regardless of age, may receive a Congregate Meal/ HDM and have that meal counted for NSIP under IIIC-1/ III-C2.
- A caregiver, who is not a spouse (but could be another family member) and is over 60, could receive a HDM, funded by Part E, Supplemental Services. **This meal would NOT be eligible for NSIP** (it does not meet the requirements for C-2 of the OAA and its regulations).
- A caregiver, who is not a spouse (but could be another family member) and is under 60, could receive a Congregate Meals /HDM funded by Part E, Supplemental Services. **This meal would NOT be eligible for NSIP.**
- Care receivers who receive a meal as a Supplemental service must also meet the definition of "Frail" in the Older Americans Act (see below).

Section 102: (A)(i) 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.

Source: Unofficial Compilation of the Older Americans Act as Amended in 2006

### **Reporting Eligible Meals:**

To Report Home Delivered Meals (**Service Code = 401**) for:

- People 60 years of age or older must have their service information reported using their own Record Key.
- Spouses of the older people (under age 60) use 9999999990 code to enter service information.
- Nonelderly disabled persons living with an eligible person, use 9999999990 code to enter service information.
- Eligible Volunteers, regardless of age, use 9999999992 code to enter service information.

To Report Congregate Meals (**Service Code = 402**) for:

- People 60 years of age or older must have their service information reported using their own Record Key.
- Spouses of the older people (under age 60) use 9999999990 code to enter service information.
- Disabled individuals (under age 60) use 9999999990 code to enter service information.
- Eligible Volunteers, regardless of age, use 9999999992 code to enter service information.

### **Additional reporting tips:**

If the spouses of the older people, nonelderly disabled persons living with an eligible person/or living in senior housing, and NSIP eligible volunteers have their own unique Record Key, NYSOFA system will filter out these cases when we conduct NAPIS Data Review (e.g., review missing rate for functional status, high nutrition risk, poverty status and/or basic demographic characteristics) and overdue assessment date review. Please provide this information by tagging these clients in your system. If you do not know where to enter this information to your system, please contact your software developer.

Starting in SFY 2014-15, we also need your help to identify HDM clients receiving meals for only a very short period of time (10 consecutive days or less) due to emergency situation. For the clients requiring immediate provision of services prior to assessments, NYSOFA Nutrition Standard allows and provides the flexibility to conduct assessments within ten days of starting service. Note: this rule only applies to the emergency situation; AAAs should not routinely enroll individuals prior to assessments.

For HDM clients receiving meals 10 consecutive days or less with their own unique Record Key, NYSOFA system will filter out these cases when we conduct NAPIS Data Review and overdue assessment date review.

This rule will also apply to - Title III-E Caregivers Age 60+ receiving HDM who have not been assessed. NYSOFA system will filter out these cases when we conduct NAPIS Data Review and overdue assessment date review.

## **Reporting Ineligible Meals:**

Home Delivered/Congregate Meals (**Service Code = 403/404**) for:

- People under 60 (noncaregivers) and not eligible for NSIP meals use 9999999991 to enter service information.
- Other NSIP ineligible meals (e.g., LTHHCP (29)).
- Use these service codes for meals that are ineligible and for consumers whose meals are ineligible but they are otherwise eligible.

## **Reporting Caregiver Meals:**

All caregivers who receive meals as supplemental services funded under IIIIE should have their own Record Key and use Service Code 904.

If a caregiver is program eligible or the spouse of care receiver and receives meals funded under IIIIE, the meal is NSIP eligible provided any other applicable program rules are met.

## **G. Reporting Websites**

The user name and password used to access the AAARIN can be used to access the following web sites. For those who do not have one and need it, a request can be made by the AAA Director through their ASR. User IDs and passwords are sent via US mail.

### **NYSOFA Budgeting and Reporting Systems**

The CAARS Data Entry page has been revised. Area Agency staff will no longer be choosing a county and logging in with that county's password. Instead, staff will use their individual NYSOFA IDs and passwords to log in. Additionally, while the CAARS and AIP forms themselves will remain the same, the "look and feel" of the system will be changing. These changes will make the system more user-friendly, accessible, and secure. The new link for this is:

<http://www.reporting.aginq.ny.gov>.

### **NYSOFA Data Exchange**

This site eliminates the need to use compressed (Zipped) files when submitting the associated client files to NYSOFA. Now the client data files can be submitted using a simple Windows click and drag method. This site will also be used when NYSOFA needs to transmit a file to an AAA that exceeds e-mail size limits. When copying a file from NYSOFA to your local computer you may experience "Transfer Failed" before it reaches 100%. There can be many reasons for this. Simply try it again, the software will continue the transfer at the point it failed. In the future, an e-mail will be sent to the AAA advising them that the approved AIP is in their county folder and available for download. The link for this site is: <https://reporting.ofa.state.ny.us/>.

### **NYSOFA Report Viewer**

NYSOFA has long had a policy of providing reports using the data submitted using the CAARS, AIP, and recently the client files. Currently these reports are created after the majority of reports have been received from the AAAs and made available as a PDF file on the AAARIN site under Reporting. In the past users were able to run units of service and expenditures reports from the CAARS Data Entry pages. Using this site allows authorized users to select a report, select their county and time period and run the report. These reports can be printed or exported to a PDF file or MS Excel format. The link for this site is:

<http://www.boedmz.ofa.state.ny.us/infoviewapp/logon.aspx>

## Section VI - County Codes

<b>County</b>	<b>County</b>	<b>County</b>
01 Albany	22 Jefferson	42 Schenectady
02 Allegany	23 Lewis	43 Schoharie
03 Broome	24 Livingston	44 Schuyler
04 Cattaraugus	25 Madison	45 Seneca
05 Cayuga	26 Monroe	46 Steuben
06 Chautauqua	27 Montgomery	47 Suffolk
07 Chemung	28 Nassau	48 Sullivan
08 Chenango	29 Niagara	49 Tioga
09 Clinton	30 Oneida	50 Tompkins
10 Columbia	31 Onondaga	51 Ulster
11 Cortland	32 Ontario	52 Warren/Hamilton
12 Delaware	33 Orange	53 Washington
13 Dutchess	34 Orleans	54 Wayne
14 Erie	35 Oswego	55 Westchester
15 Essex	36 Otsego	56 Wyoming
16 Franklin	37 Putnam	57 Yates
17 Fulton	38 Rensselaer	60 New York City
18 Genesee	39 Rockland	62 Seneca Nation
19 Greene	40 St. Lawrence	63 St Regis/Mohawk
21 Herkimer	41 Saratoga	

## Section VII - Glossary of Terms

**Accrual Basis** - Expenditures are recorded when incurred and for the period for which benefit is received regardless of when the bill is received and/or payment is made.

**Advocacy/Related Services** - The monitoring, evaluating, and commenting on policies, programs, hearings, levies and community actions which affect older people. This includes conducting public hearings on the needs of older people, the representation of the interests of older people to public officials, public and private agencies and organizations, and coordinating planning with other agencies and organizations to promote new or expanded benefits and opportunities for older people.

**Area Plan Administration** - Costs incurred by the area agency for administering the Area Plan. This includes planning activities as well as on-going administrative and oversight efforts.

**Caregiver** – A caregiver is a traditional or non-traditional family member, friend or neighbor who is helping another person they are concerned about with the everyday tasks of living. The caregiver and care receiver may live together, near each other or far away from one another. For further information refer to Attachment H.

**Case Managed Client** – is a person who has accepted their care plan and for EISEP clients, has signed the Financial Information & Client Agreement and who receives follow-up and monitoring which provides for contact every two months.

**Child** – An individual who is not more than 18 years of age (Including children with disabilities) and children with disabilities between the ages of 19 and 59. This term relates to a grandparent or other relative who is a caregiver of a child.

**Community Services for the Elderly/Expanded In-home Services for the Elderly Program Planning & Implementation** - Costs incurred by the area agency for Plan preparation and revision; evaluation of projects conducted under the Plan, execution of interagency agreements necessary to carry out the Plan; administrative actions to consolidate or combine services or relocate separate services into one location; ongoing management supervision of all activities conducted under the Plan including: accounting, budgeting, record keeping, staff salaries, fringe benefits, consultant services, space, equipment and supplies, utilities and other related costs approved by the NYSOFA Director.

**Congregate Meal** - A hot or other appropriate meal which meets nutritional requirements and is served in a group setting.

**Domestic Violence** - Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV), is broadly defined as a pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, or cohabitation. Domestic violence, so defined, has many forms, including physical aggression or assault (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

### **Elder Abuse\***

- **Physical abuse:** Non-accidental use of force that results in bodily injury, pain, or impairment. This includes, but is not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
- **Sexual abuse:** Non-consensual sexual contact of any kind. This includes, but is not limited to, forcing sexual contact with self or forcing sexual contact with a third person.

- **Emotional abuse:** Willful infliction of anguish, pain, or distress through verbal or non-verbal acts. This includes, but is not limited to, isolating or frightening an adult.
- **Financial exploitation:** Improper use of an adult's funds, property, or resources by another individual. This includes, but is not limited to, fraud, embezzlement, forgery, falsifying records, coerced property transfers, or denial of access to assets.
- **Intentional Neglect:** Failure to meet the needs of the dependent elderly person by, for example, willfully withholding food or medications or refusing to take the elder to seek medical care.
- **Unintentional Neglect:** Neglect that involves ignorance or from genuine inability to provide care.
- **Self Neglect:** This is the adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself.
- **Abandonment:** Desertion of a vulnerable elder by anyone who has assumed care or custody of that person.

\* Social Services Law. § 473 and NY Codes, Rules and Regulations, 18 NYCRR § 457.1.

**Eligible Meal** – Eligible meals are those served to persons age 60 and older, the spouse of someone age 60 regardless of age, and disabled persons under age 60 who reside in a housing facility occupied primarily by the elderly where congregate meals are served. This includes staff age 60 and older, and all volunteers. individuals with disabilities who reside at home with older individuals.

Note: participating area agencies on aging may establish procedures that allow nutrition project administrators the option to offer a meal, on the same basis as meals provided to participating older individuals, to individuals providing volunteer services during the meal hours, and to individuals with disabilities who reside at home with older individuals eligible under this chapter, Section. 339. NUTRITION. (H) of the OAA.

Note that staff and volunteers who are program eligible should be registered so that all appropriate information may be reported. For further information on this, please refer to 90-PI-26 Revised Nutrition Program Standards.

**Disabled** - Any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. This includes alcoholism and drug addiction. Note, all EISEP clients are considered to be frail/disabled.

**Focal Point** - A place or mobile unit in a community or neighborhood designated by the area agency for the collocation and coordination of services.

**Frail** - A person with one or more functional deficits in the following areas:

- Physical functions
- Mental functions
  - Activities of Daily Living [ADL] (eating, bed/chair transfer, dressing, bathing, toileting and continence).
  - Instrumental Activities of Daily Living [IADL] (meal preparation, housekeeping, shopping, medications, telephone, travel and money management).

**Grandparent or other older relative caregiver of a child** – A grandparent, step grandparent or other relative of a child by blood, marriage, or adoption who is 55 years of age or older and;

- (A) lives with the child;
- (B) 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
- (C) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.

for further information refer to Attachment H.

**High Nutritional Risk** – An individual who scores (6) or higher on the Nutrition Risk Checklist.

**Home Delivered Meal** - A hot or other appropriate meal, which meets nutritional requirements and is provided to an eligible person for home consumption.

**Impairment in Activities of Daily Living (ADL)** -The inability to perform one or more of the following seven activities of daily living without personal assistance, stand-by assistance, supervision or cues: Bathing, Personal Hygiene, Dressing, Mobility, Transfer, Toileting and Eating.

**Impairment in Instrumental Activities of Daily Living (IADL)** - The inability to perform one or more of the following eight instrumental activities of daily living without personal assistance, or stand-by assistance, supervision or cues: Housework/cleaning, Shopping, Laundry, Use transportation, Prepare & cook meals, Handle Personal business/finances, Use Telephone and Self-administration of medications.

**Ineligible Congregate** - Meals served to paid staff under age 60, guests under age 60 of provider and monitoring agencies. Include meals served to other people who do not meet the requirements for becoming a participant; i.e., who are not age 60 or older or who are not the spouse of a person 60 or older.

**Limited English Proficiency** - Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or "LEP."

**Low Income/Poverty** - An income level at or below 150% of the poverty threshold for Community Services for the Elderly Program, Expanded In-home Services for the Elderly Program recipients and Supplemental Nutrition Assistance Program recipients, and 100% of the poverty threshold for Title III recipients as established by the Bureau of the Census. The poverty level uses total household income and includes the number of persons in the family/household. The HHS Poverty Guidelines are published annually in the first quarter of the calendar year.

Note: Income Used to Compute Poverty Status (Money Income)

•Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources.

•Noncash benefits (such as food stamps and housing subsidies) do not count.

•Before taxes.

•Excludes capital gains or losses.

•If a person lives with a family, add up the income of all family members. (Nonrelatives, such as housemates, do not count.)

<http://www.census.gov/hhes/www/poverty/about/overview/measure.html>

**Minority Provider** – A provider of services to clients which meets any one of the following criteria: 1) A not-for-profit organization with a controlling board comprised at least 51% of individuals in the racial and ethnic categories listed below. 2) A private business concern that is at least 51 percent owned by individuals in the racial and ethnic categories listed below. 3) A publicly owned business having at least 51 percent of its stock owned by one or more individuals and having its management and daily business controlled by one or more individuals in the racial and ethnic categories listed below. The applicable racial and ethnic categories include: American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or Hispanic.

**Multi-Purpose Senior Center Facility** - means a community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals.

**Nonprofit** - as applied to any agency, institution, or organization means an agency, institution, or organization which is, or is owned and operated by, one or more corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

**Nutrition Services** - will be available to older individuals and to their spouses, and may be made available to individuals with disabilities who are not older individuals but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided, under this chapter, Section. 339. NUTRITION. (l) of the Older Americans Act of 1965 as Amended In 2006 (Public Law 109-365).

**Older Individual** - means an individual who is 60 years of age or older

**Race/Ethnicity Status** – The following reflects the requirements of the Office of Management and Budget (OMB) for obtaining information from individuals regarding race and ethnicity. It constitutes what OMB classifies as the “two-question format.” When questions on race and ethnicity are administered, respondents are to be asked about their ethnicity and race as two separate questions. Respondents should ideally be given the opportunity for self-identification, and are to be allowed to designate all categories that apply to them. Consistent with OMB requirements, the following are the race and ethnicity categories to be used for information collection purposes:

**Ethnicity -**

- Hispanic or Latino - A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- Not Hispanic or Latino – Self explanatory

**Race** – Those individuals belonging to one of the following groups: American Indian/Alaskan Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander.

- American Indian or Alaskan Native - A person having origins in any of the original peoples of North America (including Central America), and who maintains cultural identification through tribal affiliation or community recognition.
- Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian Subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam.
- Black or African American - A person having origins in any of the black racial groups of the original peoples of Africa.

- Native Hawaiian or Other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or the Pacific Islands.
- White – A person having origins in any of the peoples of Europe, the Middle East or North Africa
- White Hispanic - People who identify their origin as Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

### **Personnel Categories by Functional Responsibilities**

- Agency Executive/Management Staff - Personnel such as the area agency director or deputy directors of key divisions and other positions which provide overall leadership and direction to the agency.
- Other Paid Staff - Personnel who are considered professional staff who are not responsible for overall agency management or direction setting but carry out key responsibilities or tasks associated with the area agency in the areas listed below:
  - Planning - Includes needs assessment, plan development, budgeting/resource analysis, service inventories, standards development and policy analysis.
  - Development - Includes public education, resource development, training and education, research and development and legislative activities.
  - Administration - Includes bidding, contract negotiation, reporting, reimbursement, accounting, auditing, monitoring, information system activities and quality assurance.
  - Service Delivery - Includes those activities associated with the direct provision of a service which meets the needs of an individual older person and/or caregiver.
  - Access/Care Coordination – Includes outreach, screening, assessment, case management and I & A.
- Clerical/Support Staff - All paid personnel who provide support to management and professional staff.
- Volunteer - See below.

**Registered Client** – A registered client is an individual who received at least one unit of the following specified services within the reported fiscal year. The services include: congregate meals, nutrition counseling, assisted transportation, personal care level I, personal care level II, home delivered meals, adult day care, case management, consumer directed in-home.

**Rural** – For the purpose of reporting, a rural area is: any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.

**Rural Subcontractor** – Providers of services to clients who live in rural areas. Rural providers are not necessarily providers of service only to rural clients. They may also be providers of services to clients in urban areas.

**Terminated/Inactive** - clients have not used any aging network services for more than 12 consecutive months.

**Veteran** - A man or woman who served on active duty in the armed forces of the United States and who was discharged or released under conditions other than dishonorable.

**Volunteer** - A volunteer is a person who performs a service without financial compensation for an individual or community organization. A volunteer may also assist the area agency in carrying out its responsibilities either in direct service provision or any of its planning, development, administration, access/care coordination roles.

The time of the volunteer service is measurable in increments of 15 minutes, so as to be able to determine the FTEs.

**Supporting Document List**

86-PI-54	EISEP - County Home Care Plan for the Functionally Impaired Elderly
89-PI-03	Provision of Meals to Disabled Persons Residing with Elderly Participants
90-PI-26	Revised Nutrition Program Standards
90-PI-40	Revised Page 5 and 6 of the Nutrition Standards 90-PI-26
91-IM-72	Mandated Aging Services
91-IM-84	Personal Emergency Response Systems (PERS)
97-PI-01	Assessment Data Collection Requirements
97-PI-19	CAARS Reporting Forms & Instructions (Reporting HDM assessments as Case Management)
97-PI-20	Program and Policy Changes Related to Implementation of MDS (6 Month HDM Reassessment)
97-IM-24	Final - COMPASS
97-IM-24	Att. 1- COMPASS Intake Information
97-IM-24	Att. 2 - COMPASS Instructions
97-IM-32	Community Based Long Term Care Minimum Data Set -Questions and Answers #1
97-IM-36	Community Based Long Term Care Minimum Data Set -Questions and Answers #2
97-IM-54	Community Based Long Term Care Minimum Data Set -Questions and Answers #3
98-PI-25	Guidelines for Conducting Short Term Home Delivered Meal Assessments
97-TAM-06	Determining Meal Costs
99-PI-21	Revised Regulations for the Nutrition Program and the Expanded In-home
00-TAM-02	Services for the Elderly Program -- Final Rule Making
03-PI-05	NYSOFA Policy on Program Income
03-PI-10	FFY 2003 Title III Transfers, Carryover and Budget Modifications
06-PI-14	AAA Transportation Program
07-IM-03	Title III Intra-state Funding Formulas (IFFs)
09-PI-14	ARRA Section 1512 Reporting and Other Reporting Requirements
10-PI-05	Revised Maximum Housing Adjustment for 2010 Financial Levels for EISEP and CSE
10-PI-06	Preparing to Implement Regulatory Changes for EISEP or CSE-funded EISEP-like Ancillary Services
11-PI-02	2011 Poverty Income Guidelines
11-PI-03	Standard Definitions for Service and Units of Service
12-PI-07	Attachment C - Fields Required by Cluster
12-PI-07	Attachment J – Client Status
13-PI-07	Revised Minimum Data Set and 2013 COMPASS Forms and Instructions
13-PI-07 Att. 1	Reporting Guide CAARS and Client Data
13-PI-07 Att. 2	CAARS Quarterly Report Forms,
13-PI-07 Att. A	Attachment A - Client Data Specification
13-PI-07 Att. B	Attachment B – Coding Structure
13-PI-07 Att. 4	Attachment D - Instructions for Comprehensive Assessment for Aging Network
13-PI-07 Att. 3	Attachment E - COMPASS
13-PI-07 Att. L	Examples of Case Managed and Noncase Managed Clients
13-PI-07 Att. K	Attachment K - CAARS\Client Reports 2013
13-PI-07 Att. D	Sample Congregate Services Intake Form/Sample III-E Registration Form

# Area Agency Quarterly Report

Area Agency: \_\_\_\_\_

NYSOFA #358 Rev. (04/2014) New York State Office for the Aging

## Part I - Operations

### A. Period Covered -

Report is:  Original

Revision

Date Submitted:

Quarter Reported:

1st:

2nd:

3rd:

4th:

### B. Identification

1. Area Agency: \_\_\_\_\_

2. Code: \_\_\_\_\_

3. Completed by: \_\_\_\_\_

4. Title: \_\_\_\_\_

5. Area Code & Phone: \_\_\_\_\_

6. Email Address: \_\_\_\_\_

7. Director Review

### C. Staffing

(Submit with quarter ending June 30th)

AAA Staffing: Develop the following staffing profile of the AAA as of June 30<sup>th</sup> for filled positions only.

For personnel classifications definitions, refer to Section VII, Glossary of Terms.

AAA Personnel Categories	Full Time Equivalent(s)	
	No. of FTEs	No. of Minority FTEs
1. Exec./Man. Staff		
2. Other Paid Professional Staff (By Functional Responsibility)		
a) Planning		
b) Development		
c) Administration		
d) Service Delivery		
e) Access/Care Coord.		
f) Other		
3. Clerical/Support Staff		
4. AAA - Volunteers		
5. Subcontractor - Volunteers		
6. Total		

### D. Provider Profile:

(Submit with quarter ending March 31<sup>st</sup>)

a. Total Number of Subcontractors: \_\_\_\_\_

c. Total Number of Min. Subcontractors: \_\_\_\_\_

b. Total Number of Rural Subcontractors: \_\_\_\_\_

### E. Focal Points/Senior Centers:

(Submit with quarter ending March 31<sup>st</sup> only)

1. Total number of Senior Centers in planning & service area:	
2. How many centers received Title III funds during the past state fiscal year?	
3. How many centers are designated as focal points?	
4. Total number of focal points operating in the county during the past fiscal year:	

## Part II - Program Information

### A. EISEP Other Services (April 1 to date)

Please breakdown the total Other Services shown under the EISEP column on page 3 line 21. Complete the requested information for each service category in which the AAA provided services or goods during the period being reported. Include the number of persons served, the units/items provided and expenditures for the goods and/or services.

Goods and Services	Persons Served	Units	Expenditures
1. Home Modifications			
2. Home Maintenance\Repair			
3. Assistive Devices/Equipment			
4. Household Appliances			
5. Misc. Personal Items			
6. Other Describe			

Area Agency: \_\_\_\_\_ Report is: [ ] Original [ ] Revision Date Submitted:  
 Quarter Reported: [ ] 1st: [ ] 2nd: [ ] 3rd: [ ] 4th:

**Part II - Program Information Continued (Complete Each Quarter)**

**B. Cumulative amount of Cost Sharing funds accrued from EISEP/CSE clients**

April 1 to date:

1. CSE Cost Sharing \_\_\_\_\_ 2. EISEP Cost Sharing \_\_\_\_\_  
 3. EISEP Cost Sharing Transferred to CSE \_\_\_\_\_

**C. Non Registered Services**

a. For the following services excluding Title III E, enter the estimated unduplicated count of persons served to date

1. Transportation		7. Sr. Center Rec./Ed.	
2. Legal Services		8. Health Promotion	
3. Nutrition Education		9. PERS	
4. Information & Assistance		10. Caregiver Services	
5. Outreach		11. Other	
6. In-Home Contact & Support		<b>12. Total Non-Registered Persons Served</b>	

b. For the following Title III E funded services, enter the estimated audience size

1. Information		2. Assistance	
----------------	--	---------------	--

**D. Title VII Expenditures (Indicate Federal funds only spent this quarter on the accrual basis.)**

(Round expenditures to the nearest dollar.)

Amount of Title VII funds spent on LTCOP Ombudsman activities this quarter: \_\_\_\_\_

(Do not include State LTCOP expenditures here.)

**E. State Transportation Information**

Enter the units of transportation service, State Funds, Program Income and Local Funds expended this quarter under the State Transportation program (Total funds will be calculated). Report expenditures in whole dollars only. (Refer to 06-PI-14 for additional information.)

A. Units Provided	B. Total Expend.	C. State Funds Expended	D. Program Income	E. Local Funds Expended

**F. Long Term Home Health Care Program Meals:**

Enter the number of home delivered meals sold to the Medicaid Long Term Home Health Care program during the quarter: \_\_\_\_\_

Please include the funds expended on these meals on page 3, Part III, "Other" column, line 4. These meals can not earn NSIP funding from NYSOFA.

**G. Title V Expenditures (Do not include programs administered through national sponsors)**

Indicate funds spent this quarter on the accrual basis under the AAA's directly operated/subcontracted NYSOFA funded Title V Program. **Report expenditures in whole dollars only.**

Budget Category	A. Total	B. Administration	C. Enrollee Wages & Fringe Benefits	D. Other Enrollee Costs
1. Total Expenditures	0			
2. Federal Share Expended	0			
3. Non-Federal Matching Funds Expended	0			

Area Agency: \_\_\_\_\_ Report is:  Original  Revision Date Submitted: \_\_\_\_\_  
 Quarter Report  1st:  2nd:  3rd:  4th:

**Part III - Program Services Expenditure Breakdown - Federal/State Programs**

Amount of Funds Spent on an ACCRUAL Basis this Quarter (Whole Dollars Only)

Service Categories	Grand Total	Title III-B <sup>1</sup>	III-C-1 <sup>2,3</sup>	III-C-2 <sup>2,3</sup>	III-D	III-E <sup>5</sup> (All Funds)	III-E <sup>9</sup> (Grand-parent Only)	EISEP <sup>4,5</sup>	CSE	CSI	WIN <sup>6</sup>	Other <sup>6</sup>
1 a. PC Level II (H/PC)												
b. PC Level I (H/Chore)												
2 CD In-home Services												
3 Home Health Aide												
4 Home Delivered Meals												
5 Adult Day Services												
6 Case Management												
7 Congregate Meals												
8 Nutrition Counseling												
9 Assisted Trans./Escort												
10 Transportation												
11 Legal Assistance												
12 Nutrition Education												
13 Info & Assistance												
14 Outreach												
15 In-Home Cont. & Sup. <sup>2</sup>												
16 Sr. Center/Rec & Educ.												
17 Health Promotion												
18 Per. Emerg. Response												
19 Caregiver Services												
20 LTC Ombudsman <sup>1</sup>												
21 Other Services <sup>7</sup>												
22 Area Plan Admin/Plan Implmentation/Admin												
23 TOTAL	0	0	0	0	0	0	0	0	0	0	0	0
24 Program Income												
25 NSIP/Commodity Food												
26 Federal Share												
27 Non Federal Share												
a. from Program Income												
b. Other Sources												

1. IIIB column, line 20 does not include Title VII. Include Title VII in "Other" column and show on page 2, Part II, E.
2. Only III-C contributions may be used to pay for the cost of supportive and access services.
3. Title IIIC-1 & IIIC-2 column, line 15 can only be used for Shopping Assistance.
4. EISEP column, line 5, is for Non-Institutional Respite only.
5. WIN column, line 15, Shopping Assistance only. EISEP column, line 15, is for Supervision Level-Non Institutional Respite only.
6. Other column includes Foster Grandparents, HEAP, WRAP, Title V, Title VII, State LTCOP, CRC, Grants-in Aid, RSVP, HIICAP, Title XIX/XX, other locally funded programs etc.
7. EISEP column, line 21 includes all allowable ancillary services not listed on Lines 4,7,8,9,10,17 & 18.
8. Include all Title III E expenditures including Grandparent services. Other Services includes all other services.
9. Enter only Title III E Grandparent services expenditures.

## **MINIMUM DATA SET**

**(April 2014)**

Listed Below Are The Minimum/Basic Data Elements To Be Collected For The Following Services:

Personal Care Levels 1 & 2, Case Management, Home Health Aide Services, Home Delivered Meals, Consumer Directed In-Home and Social Adult Day Care

### **INTAKE INFORMATION**

Intake Worker's Name: Date of Referral: Referral Source:

Presenting Problem and/or Client's Concerns:

Does the client know the referral is being made? If not, why?

### **CASE IDENTIFICATION**

Assessor Name:

Client Case Number: Agency Name:

Reason for Completion: Assessment, Reassessment, Event Based.

### **CLIENT INFORMATION**

Client Name:

Social Security Number:

Client's Address with Zip Code and Telephone Number

Marital Status: Married, Widowed, Divorced, Separated, Single

Sex: Female, Male

Transgender: Male to Female, Female to Male

Birth Date:                      Age:

Race\Ethnicity: American Indian/Native Alaskan, Asian, Black not Hispanic, Native Hawaiian/Other Pacific Islander, White (Alone) Hispanic, Other Race, 2 or More Races and White, Not Hispanic, Hispanic

Sexual Orientation: Heterosexual or Straight, Homosexual or Gay, Lesbian, Bisexual, Other

Creed: Christianity, Islam, Hinduism, Buddhism, Judaism, Other

National Origin:

Language: Primary Language, Speaks, Reads, Understands English, Spanish, Chinese, Russian, Italian, French\Haitian Creole, Korean, Other

Living Arrangement: Alone, With Spouse, With Spouse & Others, With Relatives, With Non-Relatives, Domestic Partner, Others

### **EMERGENCY CONTACT**

Name, Address, Phone (home/work), Relationship: Specify if more than one Emergency Contact.

### **INFORMAL SUPPORT STATUS**

Is there a member of the client's family, a friend or neighbor who helps with care? If yes, indicate Name, Address, Phone, and Relationship. Specify if more than one Informal Caregiver.

How often does -this person help the client? Be as specific as possible.

Specify if more than one Informal Caregiver is providing help. Describe help the informal Caregiver provides: Tasks, Supervision, Social/Emotional Support, Transportation, Other (specify).

Does the client appear to have a good relationship with his/her informal caregivers?

Note any factors that might limit caregiver involvement: Job, Finances, Family Responsibilities, Physical Burden, Emotional Burden, Health Problems, Reliability, other (specify).

To what extent would client accept help from family in order to remain at home and/or independent- Definitely yes but only short term, Possibly but uncertain, Never, Other (specify).

Evaluation of informal support system: Adequate, Could expand if, needed, Adequate could not expand, Inadequate/Limited, Temporarily Unavailable, Other (specify).

Is caregiver relief needed? If yes, explain.

When is relief - for the caregiver needed: Morning, Afternoon, Evening, Overnight, Weekend, Other (specify).

Can other informal support(s) provide temporary care to relieve caregiver? If yes, explain.

Does the client have any community/neighborhood/religious affiliations that could provide assistance? If yes, explain.

Would the person providing “informal supports” be considered by definition a care giver?

### **SERVICES CLIENT IS CURRENTLY RECEIVING**

What Services Does the Client Currently Receive: None utilized, Adult Day Health Care, Caregiver Support, Case Management, Community-based Food Program, consumer directed in-home services, Congregate Meals, Equipment/Supplies, Escort, Friendly Visitor/Telephone Reassurance, health promotion, Home Delivered Meals, Home Health Aide, Health Insurance Counseling, Homemaker/Personal Care Services, Hospice, Housing Assistance, Legal Services, PERS, Mental Health Services, Nutrition Counseling, Occupational Therapy, Outreach, Physical Therapy, Protective Services, Respite, Respiratory Therapy, Senior Center, Senior Companions, Services for the Blind, Shopping, Skilled Nursing, Social Adult Day Care, Speech Therapy, Transportation, other (specify).

Provider Name, Service, Address, Telephone, Contact Person

### **IADL STATUS/UNMET NEED**

Status must be noted: Totally Able, Requires intermittent supervision and/or minimal assistance, Requires continual help with all or most of this task and Person does not participate; another person performs all aspects of this task.

<b>Activity</b>	<b>Met</b>	<b>Status</b>	<b>Comments</b>
Housework/cleaning	Y/N		
Shopping, Laundry	Y/N		
Use transportation	Y/N		
Prepare & cook meals	Y/N		
Self-admin of medications	Y/N		
Handle Personal business/finances	Y/N		
Use Telephone	Y/N		

### **ADL STATUS/UNMET NEED**

Status must be noted: Totally Able, Needs Some Assistance, Needs Maximum Assistance, and Unwilling to Perform.

<b>Activity</b>	<b>Met</b>	<b>Status</b>	<b>Comments</b>
Personal Hygiene	Y/N		
Dressing	Y/N		
Mobility	Y/N		
Transfer	Y/N		
Toileting	Y/N		
Bathing	Y/N		
Eating	Y/N		

### **COGNITIVE STATUS**

Psycho/Social Condition: Alert, Cooperative, Dementia, Depressed, Diagnosed Mental Health Problem, Disruptive Socially, Evidence of Substance Abuse, Hallucinations, Hoarding, Impaired Decision Making, Memory Deficit, Physical Aggression, Problem Behavior Reported, History of Mental Health Treatment, Evidence of Substance Abuse Problems, Verbal Disruption, Worried or Anxious, Suicidal Thoughts, Sleeping Problems, Appears Lonely, Other (specify).

Does it appear that a Mental Health Evaluation is needed?

### **HEALTH STATUS**

Primary Physician/Clinic/Hospital: Name, Address and Phone Date of last visit to Primary Medical Provider:

Does the client have a Chronic Illness and/or Self-Declared Disability: Alcoholism, Alzheimer, Anemia, Anorexia, Arthritis, Cancer, Chronic Constipation, Chronic Diarrhea, Colitis, Colostomy, Congestive Heart Failure, Dehydration, Dental Problems, Diabetes, Digestive Problems, Diverticulitis, Gall Bladder Disease, Hearing Impairment, Heart Disease, Hiatal Hernia, High Blood Pressure, Hypoglycemia, Liver Disease, Low Blood Pressure, Osteoporosis, Parkinson's, Recent Fractures, Renal Disease, Respiratory Problems, Smelling Impairment,

Speech Problems, Stroke, Swallowing Difficulties, Taste Impairment, Ulcer, Urinary Tract Infection, Visual Impairment, Other (specify).

Does the client have an assistive device: Cane, Dentures, Glasses, Hearing Aid, Walker, Wheelchair, other (specify).

If yes, does the client/caregiver need training on use?

Has the client been hospitalized within the last 6 months?

If yes, indicate reason for admission and hospital discharge date.

Has the client been brought to the emergency room within the last 6 months?

If yes, indicate reason for most recent ER visit and date.

Has a PRI and/or DMS-1 been completed in the past 6 months?

If yes, indicate date of most recent completion, by whom and score.

#### **PRESCRIBED AND OVER-THE-COUNTER MEDICATIONS CURRENTLY TAKEN**

Name of Medication, Dose/Frequency and Reason Taken.

Does the client state any problems with medications - Adverse

Reactions/Allergies, Cost of Medication, Obtaining Medications, Other (specify).

#### **HOUSING STATUS**

Type of Housing: Single Family Unit or Multi-unit Dwelling

Does the Client: Rent, Own, Other (specify)

Home Safety Checklist: Smoke/CO detectors are not present/working

Bad odors, Accumulated garbage, Floors and stairways dirty and cluttered, doorway widths are inadequate, Loose scatter rugs present in one or more rooms, No rubber mat or non-slip decals in the tub or shower, No grab bar over the tub or shower, Traffic lane from the bedroom to the bathroom is not clear of obstacles, Telephone and appliance cords are strung across areas where people walk, No lamp or light switch within easy reach of the bed, No lights in the bathroom or in the hallway, Stairs are not well lighted, No handrails on the stairways, Stairways are not in good condition, No locks on doors or not working, Other (specify).

Is Neighborhood Safety an issue?

#### **NUTRITION**

Reported Height: Feet /Inches. Reported Weight: Pounds. Body Mass Index:

Are the client's refrigerator/freezer and cooking facilities adequate?

Is the client able to open containers/cartons and to cut-up food?

Does the client use nutritional supplements?

Does the client have a physician diagnosed food allergy?

Does the client have a physician prescribed modified/therapeutic diet?

### **Nutritional Risk Status (NSI)**

Client has illness/condition that changes kind/amount of food eaten,  
Eats fewer than 2 meals/day, Eats few fruits or vegetables, or milk products, Has 3+ drinks of beer/wine/liquor almost every day,  
Has tooth/mouth problems making it hard to eat, Does not always have enough money to buy food needed, Eats alone most of the time, Takes 3+ prescribed/over-the-counter drugs/day, Lost or gained 10 pounds in last 6 months, Not always able to physically shop, cook and/or feed self.

Score by adding the numbers of those factors that were answered Y.

A score of 6 or more indicates "High" nutritional risk, 3-5 indicates "Moderate" nutritional risk and 2 or less indicates "Low" nutritional risk.

### **MONTHLY INCOME**

Monthly Income: SS (net), SSI, Pension/Retirement Income, Interest, Dividends, Salary/Wages, Other (specify).

### **ENTITLEMENTS**

Benefit Status Code must be noted: Has the Benefit/Entitlement, Does not have the Benefit/Entitlement, or May be Eligible and is willing to pursue the Benefit/Entitlement.

EPIC, Food Stamps(SNAP), Health Insurance, HEAP, IT-214, Lifeline/PERS, Long Term Care Insurance, Medicaid, Medicare, Medicare Part D, Medigap Insurance/HMO, Private Health Insurance, Public Assistance, QMB, Railroad Retirement, Real Property Tax Exemption (STAR), Reverse Mortgage, Section 8 Housing, SLIMB, Social Security, SSD, SSI, VA Benefits, Veteran Tax Exemption, WRAP

Does the client need information and/or counseling on benefits and entitlement programs?

## **CARE PLAN**

Is the client self-directing/able to direct home care staff?

Indicate the client's preferences regarding provision of services.

Goals:

Care Plan Objectives:

Proposed Time Frame to Achieve Stated Goals and Objectives:

Provider name, provider ID, formal/informal, service type

Start Date, End Date

Frequency: Number of Hours/Day

Frequency Period: Daily, Weekly, Bi-weekly, Monthly, Bi-monthly, Yearly, Other (specify).

Referrals made for service:

Information/Special Instructions

Type of Diet: Regular, Special Diet: Vegetarian, Ethnic, Religious (indicate type), Other (specify)

Modified/Therapeutic: Texture Modified, Calorie Controlled Diet, Sodium Restricted, Fat Restricted, High Calorie, Renal, Other (specify)

Has the client been placed on a waiting list for any service need?

If yes, specify date. Specify service

Plan has been discussed and accepted by client and/or informal supports.

Plan Approved by:

Signature and Title, Date, Phone

Service Termination Date:

Client Outcome Statements: (completed upon service termination) Plan Terminated by:

Signature and Title, Date, Phone

## ATTACHMENT A - CLIENT DATA SPECIFICATIONS

### SUMMARY TABLE

April 1, 2014

TABLE #	FILE NAME	DESCRIPTION	FORMAT	File Length	TABLE REQUIRED FOR:			
					CLUSTER 1	CLUSTER 2	CLUSTER 3	CARE GIVERS
1	CLIENTS.TXT	Basic client identifying data, Nutrition	1 record per client	224	YES	YES	YES *	YES
2	SERVICES.TXT	Monthly units of service delivered	1 record per month/quarter per service per fund per client	33	YES	YES	YES *	YES
3	ADLIADL.TXT	Client ADL/IADL needs	1 record per ADL/IADL per client	74	YES			
4	CHARACTERISTICS.TXT	Client Characteristics	1 record per characteristic per client	15	YES			
5	HEALTHEVENTS.TXT	Health Events	1 record per event per client	24	YES			
6	CAREPLANS.TXT	Care Plan Services	1 record per service per client	31	YES			
7	CAREGIVERS.TXT	Caregiver types & relationships	1 record per service per relationship	14	YES			YES
8	ELDERABUSE.TXT	Elder Abuse type & referrals	1 record per abuse	22	YES			
CLUSTER 1:		Personal Care Level 2 (H/PC), Personal Care Level 1 (H/Chore) , Case Management, Consumer Directed In-Home, Home Health Aide, Adult Day Care Services and Home Delivered Meals						
CLUSTER 2:		Congregate Meals, Assisted Transport, Nutrition Counseling						
CLUSTER 3:		Transportation, Legal Services, Nutrition Education, Information & Assistance, Outreach, In-Home Contact & Support, Sr. Center Recreation/Education, Health Promotion, PERS, Caregiver Services, and Other						
CAREGIVERS:		Access Assistance, Counseling/Support Groups/Training, Information Services, Supplemental Services, Respite Care						

\* Information collected by these files allows the AAA to report units of service provided to recipients for other services.

# CLIENT DATA SPECIFICATIONS - April 2014

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End	
1	2	3	CG	Field Name	Length	Pos.	Codes or See Att. B
R	R	R	R	County Code	2	1	2 See Att. B Sec. A
R	R	R	R	Record Number/KEY*	10	3	12 Locally Assigned
M				Last 4 Digits Social Security Number	4	13	16
R	R	M	R	Zip Code	5	17	21
R	R	M	R	Rural/Urban Designation	1	22	22 R or U
R	R	M	R	Date of Birth (mm/dd/yyyy)	10	23	32
R	R	M	R	Race Code	1	33	33 0=Unknown/Missing 1=Amer Ind/Alaskan Native 2=Asian 3=Black or African American 4=White (Alone) Hispanic 5=White not Hispanic 6=Native Hawaiian/Other Pacific Islander 7=Other Race 8=2 or More Races
R	R	M	R	Ethnic Code	1	34	34 0=Unknown/Missing 1= Hispanic or Latino 2=Not Hispanic or Latino
R	R	M	R	Limited English Proficiency	1	35	35 Y or T or 1; N or F or 2; blank = Unknown
R	R	M	R	Sex	1	36	36 M or 1; F or 2
R				Creed Code	1	37	37 1=Christianity 2=Islam 3=Hinduism 4=Buddhism 5=Judaism 6=Did Not Answer 7=Other
R				National Origin	3	38	40 See Att. B Sec. H
R				Sexual Orientation	1	41	41 1=Heterosexual or Straight

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER      GENERAL CLIENT INFORMATION  
 1      2      3      CG Field Name

R                      Transgender - Gender Identity or Expression

Length	Start Pos.	End Pos.	Codes or See Att. B
			2=Homosexual or Gay
			3=Lesbian
			4=Bisexual
			5=Not Sure
			6=Did Not Answer
			7=Other
1	42	42	1=Male to Female
			2=Female to Male
			3=Transgender, did not identify as male or female
			4=No
			5=Did not answer

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End		
1	2	3	CG	Field Name	Length	Pos.	Pos.	Codes or See Att. B
R	R	M		Veteran Status	1	43	43	Y or T or 1; N or F or 2; blank = Unknown
R	R	M		Living Status	1	44	44	1=Alone 2=With Spouse Only 3=With relatives (Excludes Spouse) 4=With non-relatives 5=With Spouse and others 6=Others
R	R	M		Number in Household	2	45	46	
R	R	M		Marital Status	1	47	47	1=Married 2=Widowed 3=Domestic Partner or Significant Other 4=Divorced 5=Single/Never Married 6=Separated
R	R	M		Frail/Disabled Indicator	1	48	48	Y or T or 1; N or F or 2; blank = Unknown
R	R	M		Activation/Registration Date(mm/dd/yyyy)**	10	49	58	
R	R	R	R	Status Code	1	59	59	1=Active; 2=Inactive or Terminated
R	R	R	R	Sub-status Code	2	60	61	See Att. B Sec. B
R	R	R	R	Date of Current Status (mm/dd/yyyy)***	10	62	71	
R				Assessment Date (mm/dd/yyyy)	10	72	81	
R				HDM Recipient 6 Month Contact Date (mm/dd/yyyy)	10	82	91	
M				Type of Housing	3	92	94	001 or 108 = Single Family 102 or 107 = Multi-Family
M				Housing Ownership	1	95	95	1=Rent; 2=Own; 3=Other
M				Disabled Veteran Status	1	96	96	Y or T or 1; N or F or 2; blank = Unknown
<b>Financial Information:</b>								
R	M	M		Total Monthly Individual Income	5	97	101	Dollars only See Note B
R	M	M		Total Monthly Household Income	5	102	106	Dollars only See Note B
R	R	M		Poverty Status				
				Below 100% Poverty Level	1	107	107	Y or T or 1; N or F or 2; blank = Unknown See Note B
				Below 150% Poverty Level	1	108	108	Y or T or 1; N or F or 2; blank = Unknown See Note B

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION		Start	End		
1	2	3	CG	Field Name	Length	Pos.	Pos.	Codes or See Att. B
				<b><u>Cost Share Status:</u></b>				
R				Overall cost share % (000 thru 100)	3	109	111	See Note C
M				Total Monthly Housing Expenses	5	112	116	Dollars only See Note C
				<b><u>Nutritional Risk Status:</u></b>				
R	R			Client has illness/condition that changes kind/amount of food eaten	1	117	117	Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats fewer than 2 meals/day	1	118	118	Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats few fruits or vegetables, or milk products.	1	119	119	Y or T or 1; N or F or 2; blank = Unknown
				BLANK	1	120	120	
				BLANK	1	121	121	
R	R			Has 3+ drinks of beer/wine/liquor almost every day	1	122	122	Y or T or 1; N or F or 2; blank = Unknown
R	R			Has tooth/mouth problems making it hard to eat	1	123	123	Y or T or 1; N or F or 2; blank = Unknown
R	R			Does not always have enough money to buy food needed	1	124	124	Y or T or 1; N or F or 2; blank = Unknown
R	R			Eats alone most of the time	1	125	125	Y or T or 1; N or F or 2; blank = Unknown
R	R			Takes 3+ prescribed/over-the-counter drugs/day	1	126	126	Y or T or 1; N or F or 2; blank = Unknown
R	R			Lost or gained 10 pounds in last 6 months	1	127	127	Y or T or 1; N or F or 2; blank = Unknown
R	R			Not always able to physically shop, cook and/or feed self	1	128	128	Y or T or 1; N or F or 2; blank = Unknown
R				Body Mass Index (format is 99.9) OR	4	129	132	See Note E
R				Height (inches) AND	3	133	135	See Note E
R				Weight (lbs)	3	136	138	See Note E
				<b><u>Alcohol Screening Test:</u></b>				
R				Have you ever felt you should cut down on your drinking?	1	139	139	Y or T or 1; N or F or 2; blank = Unknown
R				Have people annoyed you by criticizing your drinking?	1	140	140	Y or T or 1; N or F or 2; blank = Unknown
R				Have you ever felt bad or guilty about your drinking?	1	141	141	Y or T or 1; N or F or 2; blank = Unknown
R				Have you ever had a drink first thing in the morning?	1	142	142	Y or T or 1; N or F or 2; blank = Unknown

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER	GENERAL CLIENT INFORMATION	Start	End	
1 2 3	CG Field Name	Length	Pos.	Pos. Codes or See Att. B
	<b><u>Informal Supports - Up to two Supports</u></b>			
	For Primary Informal Support, if one exists:			
R	a. Relationship of Informal Support	2	143	144 See Att. B Sec. C
M	b. Factors that might limit caregiver involvement:			
M	Job	1	145	145 Y or T or 1; N or F or 2; blank = Unknown
M	Finances	1	146	146 Y or T or 1; N or F or 2; blank = Unknown
M	Family Responsibilities	1	147	147 Y or T or 1; N or F or 2; blank = Unknown
M	Physical Burden	1	148	148 Y or T or 1; N or F or 2; blank = Unknown
M	Emotional Burden	1	149	149 Y or T or 1; N or F or 2; blank = Unknown
M	Health Problems	1	150	150 Y or T or 1; N or F or 2; blank = Unknown
M	Reliability	1	151	151 Y or T or 1; N or F or 2; blank = Unknown
M	Other	1	152	152 Y or T or 1; N or F or 2; blank = Unknown
M	c. Is Caregiver relief needed?	1	153	153 Y or T or 1; N or F or 2; blank = Unknown
M	If yes, when?	2	154	155 11-Morning 12-Afternoon 13-Evening 14-Overnight 15-Weekend 16-Other
R	d. Would this person be considered the caregiver?	1	156	156 Y or T or 1; N or F or 2; blank = Unknown
M	e. Services Provided as Respite to the Caregiver			
M	Adult Day Services	1	157	157 Y or T or 1; N or F or 2; blank = Unknown
M	Personal Care Level 1	1	158	158 Y or T or 1; N or F or 2; blank = Unknown
M	Personal Care Level 2	1	159	159 Y or T or 1; N or F or 2; blank = Unknown
M	In Home Contact & Support (Paid Supervision)	1	160	160 Y or T or 1; N or F or 2; blank = Unknown
M	f. Would the caregiver like to receive information about other caregiver services?	1	161	161 Y or T or 1; N or F or 2; blank = Unknown
	For Second Informal Support, if one exists:			
M	a. Relationship of Informal Support	2	162	163 See Att. B Sec. C
M	b. Factors that might limit caregiver involvement:			
M	Job	1	164	164 Y or T or 1; N or F or 2; blank = Unknown
M	Finances	1	165	165 Y or T or 1; N or F or 2; blank = Unknown
M	Family Responsibilities	1	166	166 Y or T or 1; N or F or 2; blank = Unknown
M	Physical Burden	1	167	167 Y or T or 1; N or F or 2; blank = Unknown
M	Emotional Burden	1	168	168 Y or T or 1; N or F or 2; blank = Unknown
M	Health Problems	1	169	169 Y or T or 1; N or F or 2; blank = Unknown

See Note F

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION	Length	Start Pos.	End Pos.	Codes or See Att. B
1	2	3	CG Field Name				
M			Reliability	1	170	170	Y or T or 1; N or F or 2; blank = Unknown
M			Other	1	171	171	Y or T or 1; N or F or 2; blank = Unknown
M			c. Is Caregiver relief needed?	1	172	172	Y or T or 1; N or F or 2; blank = Unknown
M			If yes, when?	2	173	174	11-Morning 12-Afternoon 13-Evening 14-Overnight 15-Weekend 16-Other
M			d. Would this person be considered the caregiver?	1	175	175	Y or T or 1; N or F or 2; blank = Unknown
M			e. Services Provided as Respite to the Caregiver				
M			Adult Day Services	1	176	176	Y or T or 1; N or F or 2; blank = Unknown
M			Personal Care Level 1	1	177	177	Y or T or 1; N or F or 2; blank = Unknown
M			Personal Care Level 2	1	178	178	Y or T or 1; N or F or 2; blank = Unknown
M			In Home Contact & Support (Paid Supervision)	1	179	179	Y or T or 1; N or F or 2; blank = Unknown
M			f. Would the caregiver like to receive information about other caregiver services?	1	180	180	Y or T or 1; N or F or 2; blank = Unknown
M			Overall Evaluation of Informal Support System	1	181	181	1-Adequate, Can Expand if needed 2-Adequate, Could not expand

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION	Start	End	
1	2	3	CG Field Name	Length	Pos.	Pos. Codes or See Att. B
			<b><u>Client Receive/Have Following Benefits/Entitlements?</u></b>			
M			EPIC	1	182	182 Y or T or 1; N or F or 2; blank = Unknown
M			Food Stamps (SNAP)	1	183	183 Y or T or 1; N or F or 2; blank = Unknown
M			Health Insurance	1	184	184 Y or T or 1; N or F or 2; blank = Unknown
M			HEAP	1	185	185 Y or T or 1; N or F or 2; blank = Unknown
M			IT-214	1	186	186 Y or T or 1; N or F or 2; blank = Unknown
M			Lifeline/PERS	1	187	187 Y or T or 1; N or F or 2; blank = Unknown
M			Long Term Care Insurance	1	188	188 Y or T or 1; N or F or 2; blank = Unknown
M			Medicaid	1	189	189 Y or T or 1; N or F or 2; blank = Unknown
M			Medicare	1	190	190 Y or T or 1; N or F or 2; blank = Unknown
M			Medicare Part D	1	191	191 Y or T or 1; N or F or 2; blank = Unknown
M			Medigap Insurance/HMO	1	192	192 Y or T or 1; N or F or 2; blank = Unknown
M			Private Health Insurance	1	193	193 Y or T or 1; N or F or 2; blank = Unknown
M			Public Assistance	1	194	194 Y or T or 1; N or F or 2; blank = Unknown
M			QMB	1	195	195 Y or T or 1; N or F or 2; blank = Unknown
M			Railroad Retirement	1	196	196 Y or T or 1; N or F or 2; blank = Unknown
M			Real Property Tax Exemption (STAR)	1	197	197 Y or T or 1; N or F or 2; blank = Unknown
M			Reverse Mortgage	1	198	198 Y or T or 1; N or F or 2; blank = Unknown
M			Section 8 Housing	1	199	199 Y or T or 1; N or F or 2; blank = Unknown
M			SLIMB	1	200	200 Y or T or 1; N or F or 2; blank = Unknown
M			Social Security	1	201	201 Y or T or 1; N or F or 2; blank = Unknown
M			SSD	1	202	202 Y or T or 1; N or F or 2; blank = Unknown
M			SSI	1	203	203 Y or T or 1; N or F or 2; blank = Unknown
M			VA Benefits	1	204	204 Y or T or 1; N or F or 2; blank = Unknown
M			Veteran Tax Exemption	1	205	205 Y or T or 1; N or F or 2; blank = Unknown
M			WRAP	1	206	206 Y or T or 1; N or F or 2; blank = Unknown

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER			GENERAL CLIENT INFORMATION	Start	End		
1	2	3	CG Field Name	Length	Pos.	Pos.	Codes or See Att. B
			<u>Does Client Participate in the following Program(s)?:</u>				
R	R		Community Living Program (CLP)	1	207	207	Y or T or 1; N or F or 2; blank = Unknown
R	R		Chronic Disease Self Management Program (CDSMP)	1	208	208	Y or T or 1; N or F or 2; blank = Unknown
R	R		Integrated Systems Grant Part A (SI)	1	209	209	Y or T or 1; N or F or 2; blank = Unknown
R	R		Other Programs as Defined by NYSOFA	1	210	210	Y or T or 1; N or F or 2; blank = Unknown

**Client Receiving Eligible Meals**

R	R		Under 60 Spouses of eligible seniors	1	211	211	Y or T or 1; N or F or 2; blank = Unknown
R	R		Disabled Persons living in senior housing	1	212	212	Y or T or 1; N or F or 2; blank = Unknown
R	R		USDA eligible volunteers under 60	1	213	213	Y or T or 1; N or F or 2; blank = Unknown
R	R		Disabled Persons living at home w/eligible person	1	214	214	Y or T or 1; N or F or 2; blank = Unknown
R			Clients Receiving HDM for 10 consecutive days or less	1	215	215	Y or T or 1; N or F or 2; blank = Unknown
R			Title III-E Caregivers Age 60> receiving HDM who have not been assessed	1	216	216	Y or T or 1; N or F or 2; blank = Unknown

**Unique Client Identifier**

R	R	R	R	First letter of First Name	1	217	217
R	R	R	R	First three letters of Last Name	3	218	220
R	R	R	R	Last 4 digits of phone number	4	221	224

See Note G

Total 224

\* Client's Record Number/KEY must remain the same each submission.

\*\* Activation/Registration Date - This is the date that the AAA begins interacting with the client, either through conducting an assessment or registering him/her for a service or providing a service. This date corresponds to when the client becomes "Active." It is not for a specific service.

\*\*\* Date of Current Status - This is the date of the client's most current status. If the client is active, it would be same date as the activation/registration date. If the client is terminated, it would be the date terminated. If s/he were reactivated, it would be the date the client was reactivated.

Table #: 1  
 File Content CLIENT DEMOGRAPHICS AND OTHER DATA  
 Format: One record per client

File Name: CLIENTS.TXT  
 STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2  
 & CAREGIVER CLIENTS

SERVICE CLUSTER      GENERAL CLIENT INFORMATION  
 1      2      3      CG Field Name

Start      End  
 Length   Pos.   Pos.   Codes or See Att. B

**NOTES**

- A      Provide both the client's Zip Code and Urban/Rural Indicator
- B      Provide EITHER Monthly Income OR Annual Income OR Poverty Status for both 100% and 150% of the poverty level.  
 Note, when including monthly/annual income & poverty levels, the correct poverty levels are checked.
- C      Required only for clients receiving EISEP or CSE services for which there is cost sharing. Leave blank otherwise.
- D      Required for clients receiving Case Management, Home Delivered Meals, Nutrition Counseling and Congregate Meals.  
 See Data Requirements item #8 in the Reporting Guide Consolidated Area Agency Reporting System (CAARS)  
 and Client Data Systems.
- E      Provide EITHER Body Mass Index OR both Height and Weight
- F      Provide for UP TO two informal supports, regardless of ADL or IADL
- G      This field will be used in conjunction with date of birth and gender to identify duplication between counties.

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 2

File Name: SERVICES.TXT

File Conter ACTUAL UNITS OF SERVICES PROVIDED

STATUS: REQUIRED FOR CLUSTER 1, CLUSTER 2, OTHER & CAREGIVER CLIENTS

Format: One record per service delivered per fund per client per quarter

SERVICE CLUSTER				Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
1	2	3	CG					
R	R	R	R	County Code	2	1	2	See Att. B Sec. A
R	R	R	R	Record Number/KEY*	10	3	12	Locally assigned
R	R	R	R	Period of Service (yyyymm)	6	13	18	Month & Year of service delivery
R	R	R	R	Service Code	3	19	21	See Att. B Sec. D
R	R	R	R	Funding Source	2	22	23	See Att. B Sec. E
R	R	R	R	Number of units provided	10	24	33	<b>Format: 7 places,decimal point, 2 decimals numbers(9999999.99)</b>
				Total	33			

\* **Client's Record Number/KEY must remain the same each submission.**

EXAMPLES for South County (county code 75):

1 John Jones (Client ID # 088) received 21 home delivered meals from County MOW paid for under SNAP, and 14 1/4 hours of Housekeeping/Chore from Catholic Family Services through EISEP funding during April - June, 2000

2 Mary Smith (Client ID #245) received 12 congregate meals from the South County Meals Program through Title III funding and 10 units of transportation from the ABC Bus Service funded through CSE during April-June, 2000

Data records to be submitted:

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 3  
 File Content: ADL/IADL Status of Clients  
 Format: One record per client

File Name: ADLIADL.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
County Code	2	1	2	See Att. B Sec. A
Record Number/KEY	10	3	12	Locally assigned
<b>IADL Type</b>				
<hr/>				
01=Housework/cleaning IADL Status	1	13	13	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	14	14	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	15	15	Y or T or 1; N or F or 2; blank = Unknown
b. Met with Informal Supports?	1	16	16	Y or T or 1; N or F or 2; blank = Unknown
02=Shopping IADL Status	1	17	17	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	18	18	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	19	19	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	20	20	Y or T or 1; N or F or 2; blank = Unknown
03=Laundry IADL Status	1	21	21	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	22	22	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	23	23	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	24	24	Y or T or 1; N or F or 2; blank = Unknown

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 3  
 File Content: ADL/IADL Status of Clients  
 Format: One record per client

File Name: ADLIADL.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
04=Use transportation IADL Status	1	25	25	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	26	26	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	27	27	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	28	28	Y or T or 1; N or F or 2; blank = Unknown
05=Prepare & cook meals IADL Status	1	29	29	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	30	30	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	31	31	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	32	32	Y or T or 1; N or F or 2; blank = Unknown
07=Handle Personal business/finances IADL Status	1	33	33	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)? If yes:	1	34	34	Y or T or 1; N or F or 2; blank = Unknown
a. Met with Formal Supports?	1	35	35	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	36	36	Y or T or 1; N or F or 2; blank = Unknown
08=Use Telephone IADL Status	1	37	37	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	38	38	Y or T or 1; N or F or 2; blank = Unknown

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 3  
 File Content: ADL/IADL Status of Clients  
 Format: One record per client

File Name: ADLIADL.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
If yes:				
a. Met with Formal Supports?	1	39	39	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	40	40	Y or T or 1; N or F or 2; blank = Unknown
16=Self-admin of medications				
IADL Status	1	41	41	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	42	42	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	43	43	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	44	44	Y or T or 1; N or F or 2; blank = Unknown
<b>ADL Type</b>				
09=Bathing				
ADL Status	1	45	45	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	46	46	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	47	47	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	48	48	Y or T or 1; N or F or 2; blank = Unknown
10=Personal Hygiene				
ADL Status	1	49	49	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	50	50	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	51	51	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	52	52	Y or T or 1; N or F or 2; blank = Unknown

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 3  
 File Content: ADL/IADL Status of Clients  
 Format: One record per client

File Name: ADLIADL.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
11=Dressing				
ADL Status	1	53	53	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	54	54	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	55	55	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	56	56	Y or T or 1; N or F or 2; blank = Unknown
12=Mobility				
ADL Status	1	57	57	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	58	58	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	59	59	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	60	60	Y or T or 1; N or F or 2; blank = Unknown
13=Transfer				
ADL Status	1	61	61	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	62	62	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	63	63	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	64	64	Y or T or 1; N or F or 2; blank = Unknown
14=Toileting				
ADL Status	1	65	65	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	66	66	Y or T or 1; N or F or 2; blank = Unknown

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 3  
 File Content: ADL/IADL Status of Clients  
 Format: One record per client

File Name: ADLIADL.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

Field Name	Length	Start Pos.	End Pos.	Codes or See Att. B
If yes:				
a. Met with Formal Supports?	1	67	67	Y or T or 1; N or F or 2; blank = Unknown
b. Met with InFormal Supports?	1	68	68	Y or T or 1; N or F or 2; blank = Unknown
15=Eating				
ADL Status	1	69	69	1=Totally Able 2=Requires intermittent supervision and/or minimal assistance 3=Requires continual help with all or most of this task 4=Person does not participate; another person performs all aspects of this task
Is Need Met Currently (at time of Assessment)?	1	70	70	Y or T or 1; N or F or 2; blank = Unknown
If yes:				
a. Met with Formal Supports?	1	71	71	Y or T or 1; N or F or 2; blank = Unknown
b. Met with Informal Supports?	1	72	72	Y or T or 1; N or F or 2; blank = Unknown
<b>Total Number of ADL**</b>	1	73	73	
<b>Total Number of IADL**</b>	1	74	74	

Total 74  
 \* Client's Record Number/KEY must remain the same each submission.

\*\*The client must have a status of 2, 3, 4 to be counted.

IADL	ADL
01=Housework/cleaning	09=Bathing
02=Shopping	10=Personal Hygiene
03=Laundry	11=Dressing
04=Use transportation	12=Mobility
05=Prepare & cook meals	13=Transfer
07=Handle Personal business/finances	14=Toileting
08=Use Telephone	15=Eating
16=Self-admin of medications	

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 4

File Conter CLIENT CHARACTERISTICS

Format: One record per characteristic per client

File Name: CHARACTERISTICS.TXT

STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Characteristic Code	3	13	15	See Att. B Sec. F
	Total	15			

\* **Client's Record Number/KEY must remain the same each submission.**

EXAMPLES for South County (county code 75):

- 1 John Jones (Client ID # 088) uses a walker and has a hearing aid because of his serious hearing impairment; he also has high blood pressure, is significantly dehydrated and frequently suffers from depression.

Data records to be submitted for this client:

**countycode clientID characteristic code**

```
75 0000000088 002
75 0000000088 004
75 0000000088 099
75 0000000088 167
75 0000000088 199
75 0000000088 177
```

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 5  
 File Content: HEALTH EVENTS  
 Format: One record per event per client

File Name: HEALTHEVENTS.TXT  
 STATUS: REQUIRED FOR **CLUSTER 1 CLIENTS ONLY**

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Health event category	2	13	14	For Health Event Category Use:
R	Date of event (mm/dd/yyyy)	10	15	24	01=Hospital visit
					02=Emergency Room
					03=PRI
					04=DMS-1
					05=Physician Visit
					06=Clinic
					09=Other
					00=No Event
	Total	24			

\* Client's Record Number/KEY must remain the same each submission.

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 6

File Conter CARE PLAN SERVICES\*\*

Format: One record per service per client

File Name: CAREPLANS.TXT

STATUS: REQUIRED FOR CLUSTER 1 CLIENTS ONLY

		Length	Start Pos.	End Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally assigned
R	Service code	3	13	15	See Att. B Sec. D
R	Number of Units of Service (>0)	3	16	18	
R	Frequency Period	1	19	19	W or 2 = Weekly; M or 3 = Monthly O or 4 = Services only delivered as needed
	Has client been placed on waiting list for this service?	1	20	20	Y or T or 1; N or F or 2; blank = Unknown
R	Care Plan Acceptance Date (mm/dd/yyyy)**	10	21	30	
R	Client is Self directing/able to direct	1	31	31	Y or T or 1; N or F or 2; blank = Unknown
	Total	31			

\* Client's Record Number/KEY must remain the same each submission.

\*\* Use most current care plan. Note only one care plan per client covering all services. Care plans created for individual services do not get reported.

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 7 File Name: Caregivers.txt  
 File Content: CAREGIVERS FOR ELDERLY AND GRANDPARENT  
 Format: One record per relationship

SERVICE CLUSTER	GENERAL CLIENT INFORMATION		Start	End	
		Length	Pos.	Pos.	
R	County Code	2	1	2	See Att. B Sec. A
R	Record Number/KEY*	10	3	12	Locally Assigned
R	Type	1	13	13	C=Caregiver G=Grandparent
R	Relationship	1	14	14	For <b>C</b> aregiver use: 0=Unknown\Missing 1=Husband 2=Wife 3=Son/Son-in-law 4=Daughter/Daughter-in-law 5=Other Relative 6=Non-Relative
					For <b>G</b> randparent use: 0=Unknown\Missing 1=Grandparents 2=Other Elderly Relative 3=Other Elderly Non-Relative
	Total	14			

\* Client's Record Number/KEY must remain the same each submission.

## CLIENT DATA SPECIFICATIONS - April 2014

Table #: 8

File Conter ELDER ABUSE CONTACTS

Format: Multiple categories per client

File Name: ELDERABUSE.TXT

STATUS: A record is required for each report of abuse.

If the client exists within the system, all fields are required

If the client does not exist, the use the anonymous key of 999999980 or include in NYConnects report.

SERVICE CLUSTER				Field Name	Length	Start Pos.	End Pos.	
1	2	3	CG					
R				County Code	2	1	2	See Att. B Sec. A
R				Record Number/KEY*	10	3	12	Locally assigned
R				Contact Month (yyyymm)	6	13	18	
R				Elder Abuse Category	2	19	20	01=Physical Abuse 02=Sexual Abuse 03=Emotional Abuse 04=Financial Exploitation 05=Active and Passive Neglect 06=Self Neglect 07=Domestic Violence 08=None Reported 00=Other (e.g. Abandonment)
R	R	R	R	Referred to	2	21	22	01=Adult Protective Services 02=Police Agency 03=Domestic Violence Service Provider 04=AAA 05=Other 06=Not Referred
				Total	22			

\* Client's Record Number/KEY must remain the same each submission.

Case Management Minimum Example

January*	1.5	0.5
February		0.5
March	0.25	0.5
April		0.5
May	0.25	0.5
June		0.5
July	0.25	0.5
August		0.5
September	0.25	0.5
October		0.5
November	0.25	0.5
December		0.5
	2.75	6

\*Initial Assessment

## ATTACHMENT B - CODING STRUCTURE

April 2014

FOR USE BY AAAs IN CODING ELECTRONIC CLIENT FILES

### A. COUNTY CODES

Albany	01	Onondaga	31
Allegany	02	Ontario	32
Broome	03	Orange	33
Cattaraugus	04	Orleans	34
Cayuga	05	Oswego	35
Chautauqua	06	Otsego	36
Chemung	07	Putnam	37
Chenango	08	Rensselaer	38
Clinton	09	Rockland	39
Columbia	10	St. Lawrence	40
Cortland	11	Saratoga	41
Delaware	12	Schenectady	42
Dutchess	13	Schoharie	43
Erie	14	Schuyler	44
Essex	15	Seneca	45
Franklin	16	Steuben	46
Fulton	17	Suffolk	47
Genesee	18	Sullivan	48
Greene	19	Tioga	49
Herkimer	21	Tompkins	50
Jefferson	22	Ulster	51
Lewis	23	Warren/Hamilton	52
Livingston	24	Washington	53
Madison	25	Wayne	54
Monroe	26	Westchester	55
Montgomery	27	Wyoming	56
Nassau	28	Yates	57
Niagara	29	NYC	60
Oneida	30	Seneca Nation of Indians	62
		St. Regis-Mohawk	63

## B. STATUS / SUB-STATUS

**Status:** 1- Active  
2- Inactive or Terminated

**Sub-status:**

**if Status =1**, use Sub-status Code 20 or 35

20 = Case Managed

35= Non Case Managed

**if Status =2**, use the following Sub-status Codes

For clients changing status from active to terminated/inactive.\*

Use the following sub-status codes to record primary reason for terminating services or becoming inactive.

01 - None (Reason Unknown)

02 - Nursing Facility

08 - Assisting Living

05 - Moved

06 - Died

07 - Other (Reason not listed)

14 - Client refused service, assessment or reassessment (Includes 15 - Refused assessment and 16 - Refused reassessment).

17 - Medicaid Home Care eligible

23 - Unable to serve due to appropriateness issue (client changes in behavior, mental, cognitive, or physical status - no longer appropriate for receiving aging network services, but still live in community).

24 - Unable to serve due to accessibility issue - Note: accessibility issues include for example, workers or services are not able to reach the client or the client is not able to access the services, e.g., no transportation. (This category includes: 12 - No response, 18 - Not in service area, 19 - No contact, 21-worker safety, and 22-transportation unavailable).

25 - Unable to serve due to eligibility issue (This category includes: 11 - age, and 34 - other eligibility issues).

33 - Client no longer needs service - Client improved and or goals have been met.

36 - Services are substituted by other helping resources (formal/informal) in the community and not due to appropriate, accessibility, or eligibility issue.

Following codes have been eliminated; 03 - Non-Payment, 04 - Service Complete, 31 - Requested by Client, 32 – Refused to apply for Medicaid.

\* Terminated/Inactive: clients have not used any aging network services for more than 12 consecutive months.

## C. RELATIONSHIP

53 - Agency	24 - Mother-in-law
52 - Agent	41 - Neighbor
05 - Aunt	49 - Nephew
03 - Brother	48 - Niece
60 - Brother-in-law	72 - None Exists
62 - CHHA	55 - Officials
14 - Cousin	13 - Other
50 - Daughter-in-law	54 - Owner
08 - Daughter	56 - Relative
45 - Doctor	67 - Religious Org.
69 - Domestic Partner	40 - Self
71 - Family	04 - Sister
02 - Father	61 - Sister-in-law
23 - Father-in-law	68 - Social Service Agency
43 - Friend	47 - Social Worker
19 - Granddaughter	07 - Son
09 - Grandfather	16 - Stepdaughter
10 - Grandmother	17 - Stepfather
20 - Grandson	18 - Stepmother
65 - Hospital	15 - Stepson
12 - Husband	44 - Super
51 - Son-in-law	06 - Uncle
42 - Landlord	46 - Visiting Nurse
66 - Medicaid	11 - Wife
01 - Mother	

## D – SERVICES

Code	Service	Code	Service
905	Access Assistance <sup>5</sup>	906	Information Services
510	Adult Day Services	301	Legal Services
504	Assisted Transport	502	Nutrition Counseling
527	Caregiver Services	501	Nutrition Education
505	Case Management	601	Other Services General
206	Consumer Directed In-Home Services	602	Other Services IIIE Respite
403	Congregate Ineligible Meals <sup>6</sup>	603	Other Services IIIE Supplemental
402	Congregate Meals	604	Other Services IIIE Information
902	Counseling/Support Groups/Training <sup>5</sup>	102	Outreach
512	Health Promotion Services	509	PERS
401	Home Delivered Meals	205	Personal Care Level I <sup>3</sup>
404	Home Delivered Ineligible Meals <sup>6</sup>	202	Personal Care Level II <sup>4</sup>
201	Home Health Aide	903	Respite Care <sup>5</sup>
526	In-Home Contact & Support <sup>1</sup>	519	Senior Center Rec. & Ed
103	Information & Assistance <sup>2</sup>	904	Supplemental Services <sup>5</sup>
		101	Transportation

- 1 Includes Friendly Visiting, Shopping Assistance, Supervision Level NIR, and Telephone Reassurance
- 2 Includes Case Assistance, Counseling, Health Insurance Counseling, and Housing Assistance
- 3 Personal Care Level I = Housekeeping/Chore
- 4 Personal Care Level II = Homemaking/Personal Care
- 5 Title III-E Caregiver Services (Caregivers serving the elderly/Grandparents serving children) only
- 6 Use to code meals that are ineligible and for consumers who are otherwise eligible

## E. CLIENT TYPES/FUNDING SOURCES

05 - OTHER	13 - III-C-1	18 - Title V	23 - WRAP	32 - MIPPA
07 - WIN (SNAP)	14 - III-C-2	19 - TITLE III-B	24 - NYConnects*	33- Informal***
09 - EISEP	15 - III-D	20 - III-E Grandparent	29 - LTHHCP	
10 - CSE	16 - III-E Caregiver	21 - HIICAP	30 - Medicaid**	
12 - CSI	17 - HEAP	22 - LTCIEOP	31 - Veterans Program	

\* Previously labeled PoE

\*\* Medicaid-funded, non-LTHHCP “Medicaid Service Coordination” (MSC) program.

\*\*\* Informal is used when necessary, to record those services delivered as an informal support.

## F. CHARACTERISTICS INFORMATION (*Where there is none please use 000*)

### **Assistive Devices (1)**

965	Accessible vehicle	004	Hearing Aid
966	Bed rail	008	Other
001	Cane	002	Walker
003	Dentures	005	Wheelchair
006	Eyeglasses		

### **Chronic Illness (2)**

159	Alcoholism	200	High Cholesterol
010	Alzheimer's	180	Hyperglycemia
160	Anemia	943	Hypoglycemia
174	Anorexia	406	Incontinence
096	Arthritis	958	Legally blind
098	Cancer	168	Liver disease
969	Cellulitis	181	Low blood pressure
161	Chronic constipation	169	Osteoporosis
175	Chronic diarrhea	402	Other
953	Chronic obstructive pulmonary disease (COPD)	959	Oxygen dependent
954	Chronic pain	960	Paralysis
162	Colitis	102	Parkinson's
176	Colostomy	961	Pernicious anemia
163	Congest heart failure	170	Recent fractures
955	Decubitus ulcers	182	Renal disease
956	Developmental Disabilities	103	Respiratory problems
101	Diabetes	962	Shingles
957	Dialysis	183	Smelling impairment
178	Diverticulitis	171	Speech problems
201	Frequent Falls	963	Traumatic brain injury
165	Gall bladder disease	104	Stroke
099	Hearing impairment	964	Tremors
166	Heart disease	173	Ulcer
179	Hiatal hernia	185	Urinary Tract infection
167	High blood pressure	097	Visual impairment

### **Cognitive Status (3)**

020	Alert	026	Memory deficit
190	Appears lonely	271	Other
021	Cooperative	023	Physical aggression
270	Dementia	028	Problem behavior reported
199	Depressed	967	Self-neglect
030	Diagnosed mental health problem	187	Sleeping problems
024	Disruptive socially	968	Suicidal behavior
029	Evidence of substance abuse	189	Suicidal thoughts
025	Hallucinations	022	Verbal disruption
188	History of mental health treatment	186	Worried or Anxious
027	Impaired decision making	944	Hoarding

### **Nutrition Problems (4)**

014	Appetite	015	Digestive Problems
016	Chewing/Swallowing	403	Other
177	Dehydration	184	Taste Impairment
017	Dental Problems		

### **Primary Language (5)**

946	Chinese	951	Other
949	French/Haitian Creole	947	Russian
948	Italian	945	Spanish
950	Korean		

**G. CODING FOR USE IN IDENTIFYING NON-REGISTERED PARTICIPANTS IN CLIENT AND SERVICE FILES**

In the record number/key field which is 10 characters long:

• Elder Abuse	Each contact	9999999980 as the record number/key
• III-E Assistance	Each event/activity	9999999982 as the record number/key
• Other Services General (601)	Each event/activity	9999999983 as the record number/key
• Other Services III-E Information (604)	Each event/activity	9999999984 as the record number/key
• In-Home Contact & Support	Each contact	9999999985 as the record number/key
• Sr. Center Recreation/Education	One group session	9999999986 as the record number/key
• Health Promotion	Each Participant	9999999987 as the record number/key
• Personal Emergency Response (PERS)	One unit	9999999988 as the record number/key
• Caregiver Services	Each Participant	9999999989 as the record number/key
• USDA eligible seniors, spouses, disabled persons living in Senior Housing	Each meal	9999999990 as the record number/key
• Guests/staff under 60 & other ineligible	Each meal	9999999991 as the record number/key
• USDA eligible volunteers	Each meal	9999999992 as the record number/key
• Information & Assistance	One hour	9999999993 as the record number/key
• Food handlers	Each meal	9999999994 as the record number/key
• Transportation	One Way Trip	9999999995 as the record number/key
• Legal	One hour	9999999996 as the record number/key
• Outreach (Including III-E)	Each contact	9999999997 as the record number/key
• Nutrition Education	Each Participant	9999999998 as the record number/key

9999999999 code reserved for NY Connects data use.

\*Use for Other Services: 601 and 604.

To illustrate the coding above, it may be helpful to look at an example of a July picnic funded by CSE in County 75 that included 16 senior guests. The **client record** would have the county code (75) and special record key (9999999990) and nothing else. The **service record** would show:

**Service Record**

County code	75
Record number/key	9999999990
Period of service	200207
Service code	402
Funding source	10
Number of units	0000016.00

**Client Record**

County code	75
Record number/key	9999999990

## H. CODING FOR USE IN IDENTIFYING NATION OF ORIGIN

**Add**... A) General Client Information may be incorrect. Concerning the "Nation of Origin" section: the choices should include United States and Puerto Rico, because the choice "American" could mean, South America or North America, they are considered American also.

001	Afghan	034	Cameroonian	066	Gambian
002	Albanian	035	Canadian	067	Georgian
003	Algerian	036	Cape Verdean	068	German
004	American (USA)	037	Central African	069	Ghanaian
005	Andorran	038	Chadian	070	Greek
006	Angolan	039	Chilean	071	Grenadian
007	Antiguans	040	Chinese	072	Guatemalan
008	Argentinean	041	Colombian	073	Guinea-Bissauan
009	Armenian	042	Comoran	074	Guinean
010	Australian	043	Congolese	075	Guyanese
011	Austrian	044	Costa Rican	076	Haitian
012	Azerbaijani	045	Croatian	077	Herzegovinian
013	Bahamian	046	Cuban	078	Honduran
014	Bahraini	047	Cypriot	079	Hungarian
015	Bangladeshi	048	Czech	080	I-Kiribati
016	Barbadian	049	Danish	081	Icelander
017	Barbudans	050	Djibouti	082	Indian
018	Batswana	051	Dominican	083	Indonesian
019	Belarusian	052	Dutch	084	Iranian
20	Belgian	053	East Timorese	085	Iraqi
021	Belizean	054	Ecuadorean	086	Irish
022	Beninese	055	Egyptian	087	Israeli
023	Bhutanese	056	Emirian	088	Italian
024	Bolivian	057	Equatorial Guinean	089	Ivorian
025	Bosnian	058	Eritrean	090	Jamaican
026	Brazilian	059	Estonian	091	Japanese
027	British	060	Ethiopian	092	Jordanian
028	Bruneian	061	Fijian	093	Kazakhstani
029	Bulgarian	062	Filipino	094	Kenyan
030	Burkinabe	063	Finnish	095	Kittian and Nevisian
031	Burmese	064	French	096	Kuwaiti
032	Burundian	065	Gabonese	097	Kyrgyz
033	Cambodian	066	Gambian	098	Laotian

099	Latvian	132	North Korean	165	South Korean
100	Lebanese	133	Northern Irish	166	Spanish
101	Liberian	134	Norwegian	167	Sri Lankan
102	Libyan	135	Omani	168	Sudanese
103	Liechtensteiner	136	Pakistani	169	Surinamer
104	Lithuanian	137	Palauan	170	Swazi
105	Luxembourger	138	Panamanian	171	Swedish
106	Macedonian	139	Papua New Guinean	172	Swiss
107	Malagasy	140	Paraguayan	173	Syrian
108	Malawian	141	Peruvian	174	Taiwanese
109	Malaysian	142	Polish	175	Tajik
110	Maldivan	143	Portuguese	176	Tanzanian
111	Malian	144	Qatari	177	Thai
112	Maltese	145	Romanian	178	Togolese
113	Marshallese	146	Russian	179	Tongan
114	Mauritanian	147	Rwandan	180	Trinidadian or Tobagonian
115	Mauritian	148	Saint Lucian	181	Tunisian
116	Mexican	149	Salvadoran	182	Turkish
117	Micronesian	150	Samoan	183	Tuvaluan
118	Moldovan	151	San Marinese	184	Ugandan
119	Monacan	152	Sao Tomean	185	Ukrainian
120	Mongolian	153	Saudi	186	Uruguayan
121	Moroccan	154	Scottish	187	Uzbekistani
122	Mosotho	155	Senegalese	188	Venezuelan
123	Motswana	156	Serbian	189	Vietnamese
124	Mozambican	157	Seychellois	190	Welsh
125	Namibian	158	Sierra Leonean	191	Yemenite
126	Nauruan	159	Singaporean	192	Zambian
127	Nepalese	160	Slovakian	193	Zimbabwean
128	New Zealander	161	Slovenian	<b>200</b>	<b>Reported Multiple</b>
129	Nicaraguan	162	Solomon Islander		
130	Nigerian	163	Somali		
131	Nigerien	164	South African		

**NOTES:**

For data elements, the following designations are used in the file specifications to note whether the information is required:

- R Required for either NAPIS reporting or NYSOFA management/advocacy.  
 M Information is used for NYSOFA monitoring, management and advocacy activities.

<b>Code</b>	<b>Program</b>	<b>Abbrev.</b>
05	All Other Programs Administered by the AAA	OTHER
07	Wellness In Nutrition (SNAP)	WIN
09	Expanded In-home Services for the Elderly Program	EISEP
10	Community Services for the Elderly Program	CSE
12	Congregate Services Initiative	CSI
13	Title III-C-1 of the Older Americans Act of 1965 as Amended	III-C-1
14	Title III-C-2 of the Older Americans Act of 1965 as Amended	III-C-2
15	Title III-D of the Older Americans Act of 1965 as Amended	III-D
16	Title III-E of the Older Americans Act of 1965 as Amended	III-E Caregiver
17	Home Energy Assistance Program	HEAP
18	Title V of the Older Americans Act of 1965 as Amended	V
19	Title III-B of the Older Americans Act of 1965 as Amended	III-B
20	Title III-E of the Older Americans Act of 1965 as Amended	III-E Grandparent
21	Health Insurance Information Counseling Program	HIICAP
22	Long Term Care Insurance Education and Outreach Program	LTCIEOP
23	Weatherization Referral and Packaging	WRAP
24	NY Connects (Point of Entry)	POE
27	American Recovery and Reinvestment Act	ARRA
29	Long Term Home Health Care Program	LTHHCP
30	Provides financial assistance for medical expenses of individual needy citizens	Medicaid
31	Veterans Directed Services Program	Veterans
32	Medicare Improvements for Patients and Providers Act	MIPPA
33	Services delivered through an informal support process	Informal

## Attachment C - Fields Required by Cluster - April 2014

The fields listed represent the fields required for submission in the eight required files; **Clients.txt, services.txt, adliadl.txt, characteristic.txt, careplans.txt, healthevents.txt, caregivers.txt and elderabuse.** They are a subset of the fields required by the Minimum Data Set (MDS).

<b>CLUSTER 1:</b>	Personal Care Level 2, Personal Care Level 1, Case Management, Home Health Aide, Adult Day Care Services, Home Delivered Meals and Consumer Directed In-home Services
<b>CLUSTER 2:</b>	Congregate Meals, Assisted Transport/Escort, Nutrition Counseling
<b>CLUSTER 3:</b>	Transportation, Legal Services, Nutrition Education, Information & Assistance, Outreach, In-Home Contact & Support, Sr. Center Recreation /Education, Health Promotion, PERS, Caregiver Services, and Other
<b>CAREGIVER:</b>	Group 1: Counseling/Support Groups/Training, Supplemental Services, Respite Care Group 2: Access Assistance, Information Services

### Clients.txt - Required Fields

#### For Cluster 1 Clients

County Code  
Record Number/KEY\*  
Zip Code  
Rural/Urban Designation  
Date of Birth (mm/dd/yyyy)  
Race Code  
Ethnic Code  
Limited English Proficiency  
Sex  
Creed Code  
National Origin  
Sexual Orientation  
Transgender - Gender Identity or Expression  
Veteran Status  
Living Status  
Number in Household  
Marital Status  
Frail/Disabled Indicator  
Activation/Registration Date(mm/dd/yyyy)\*\*

#### For Cluster 2\* Clients

County Code  
Record Number/KEY\*  
Zip Code  
Rural/Urban Designation  
Date of Birth (mm/dd/yyyy)  
Race Code  
Ethnic Code  
Limited English Proficiency  
Sex  
Veteran Status  
Living Status  
Number in Household  
Marital Status  
Frail/Disabled Indicator  
Activation/Registration Date(mm/dd/yyyy)  
Status Code  
Sub-status Code  
Date of Current Status (mm/dd/yyyy)  
Total Monthly Income OR

Status Code  
Sub-status Code  
Date of Current Status (mm/dd/yyyy)\*\*\*  
Assessment Date (mm/dd/yyyy)  
HDM Recipient 6 Month Contact Date (mm/dd/yyyy)  
Total Monthly Individual Income  
Total Monthly Household Income  
Poverty Status  
Overall cost share % (000 thru 100)  
Client has illness/condition that changes kind/amount of food eaten  
Eats fewer than 2 meals/day  
Eats few fruits or vegetables, or milk products.  
Has 3+ drinks of beer/wine/liquor almost every day  
Has tooth/mouth problems making it hard to eat  
Does not always have enough money to buy food needed  
Eats alone most of the time  
Takes 3+ prescribed/over-the-counter drugs/day  
Lost or gained 10 pounds in last 6 months  
Not always able to physically shop, cook and/or feed self  
Body Mass Index (format is 99.9) OR  
Height (inches) AND  
Weight (lbs)  
Have you ever felt you should cut down on your drinking?  
Have people annoyed you by criticizing your drinking?  
Have you ever felt bad or guilty about your drinking?  
Have you ever had a drink first thing in the morning  
a. Relationship of Informal Support  
d. Would this person be considered the caregiver  
Community Living Program (CLP)  
Chronic Disease Self Management Program (CDSMP)  
Integrated Systems Grant Part A (SI)  
Other Programs as Defined by NYSOFA  
Under 60 Spouses of eligible seniors  
Disabled Persons living in senior housing  
USDA eligible volunteers under 60  
Disabled Persons living at home w/eligible person  
Clients Receiving HDM for 10 consecutive days or less  
Title III-E Caregivers Age 60> receiving HDM who have not been assessed  
First letter of First Name

Total Annual Income  
Poverty Status; Below 100% Poverty Level & Below 150% Poverty Level  
Client has illness/condition that changes kind/amount of food eaten  
Eats fewer than 2 meals/day  
Eats few fruits or vegetables, or milk products.  
Has 3+ drinks of beer/wine/liquor almost every day  
Has tooth/mouth problems making it hard to eat  
Does not always have enough money to buy food needed  
Eats alone most of the time  
Takes 3+ prescribed/over-the-counter drugs/day  
Lost or gained 10 pounds in last 6 months  
Not always able to physically shop, cook and/or feed self

*\*Nutrition Risk information is only collected for clients receiving a congregate meal or nutrition counseling.*

#### For Caregivers (Included in clients.txt file)

County Code  
Record Number/KEY\*  
Zip Code  
Rural/Urban Designation  
Date of Birth (mm/dd/yyyy)  
Race Code  
Ethnic Code  
Limited English Proficiency  
Sex  
Status Code  
Sub-status Code  
Date of Current Status (mm/dd/yyyy)  
First letter of First Name  
First three letters of Last Name  
Last 4 digits of phone number

#### Healthevents.txt - Required Fields Required for Cluster 1 Only (All Fields)

County Code  
Record Number/KEY\*

First three letters of Last Name  
Last 4 digits of phone number

**For Cluster 3 Clients**

County Code  
Record Number/KEY\*  
Status Code  
Sub-status Code  
Date of Current Status (mm/dd/yyyy)

**Services.txt Required - Fields**  
**Required for all Clusters; 1, 2, 3, CG**

County Code  
Record Number/KEY\*  
Period of Service (yyyymm)  
Service Code  
Funding Source  
Number of units provided

**ADLIADL.txt - Required Fields**  
**Required for Cluster 1 Only (All Fields)**

County Code  
Record Number/KEY\*  
ADL or IADL Type  
ADL/IADL Status  
Is Need Met Currently (at time of Assessment)?  
If yes:  
    a. Met with Formal Supports?  
    b. Met with Informal Supports?  
Total Number of ADLs  
Total Number of IADs

**Characteristics.txt - Required Fields**  
**Required for Cluster 1 Only (All Fields)**

Health event category  
Date of event (mm/dd/yyyy)

**Careplans.txt - Required Fields**  
**Required for Cluster 1 Only (All Fields)**

County Code  
Record Number/KEY\*  
Service code  
Number of Units of Service  
Frequency Period  
Has client been placed on waiting list for this service?  
Care Plan Acceptance Date (mm/dd/yyyy)\*\*  
Client is Self directing/able to direct

**Caregivers.txt - Required Fields**

**Required for CG Group 1\* Services Only**

County Code  
Record Number/KEY\*  
Type  
Relationship

*\* Counseling/Support Groups/Training, Supplemental Services,  
Respite Care*

**Comprehensive Assessment for  
Aging Network Community-Based  
Long Term Care Services**

**COMPASS**



**Instructions**

**April 2014**

**New York State Office for the Aging**

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# INSTRUCTIONS

## Comprehensive Assessment for Aging Network Community-Based Long Term Care Services

### INTRODUCTION

The Comprehensive Assessment for Aging Network Community-Based Long Term Care Services (COMPASS) is designed to be a useful client assessment instrument that will inform and guide comprehensive care planning. It provides the basis to determine the need for AAA-funded services, as well as referrals to other programs and providers when appropriate. The COMPASS is intended to reflect the critical role informal caregivers play in the client's plan of care and to gather information to develop a care plan that focuses on goals and objectives to address identified problems or needs.

This version of the COMPASS contains the Minimum Data Set (MDS) that all assessment instruments for aging-funded community-based long term care are required to include as of April 1, 2014.

***The person being assessed has certain rights in regards to the assessment process. It is important that the assessor and the person know these rights. The assessor has the responsibility to inform the person of their rights.*** The person being assessed must be told:

- Why the assessment is being conducted;
- Why the information is being requested;
- How the information will be used; and
- That he/she has a right to refuse to provide information.

If a person refuses to provide some information in response to a question asked by the assessor, he/she must be told:

- It may be possible to provide services to him/her based on the information that is provided, but
- Failure to provide all the information requested could result in the person not receiving the services he/she wants or those services most appropriate to meet his/her needs.

If the inability to provide services to a person is due to the person failing to provide adequate information, the person should be notified of that fact.

***All information gathered during the assessment process, including that contained in the assessment document, is confidential.*** This information should be shared with others only as needed. The person must be informed that information will be shared with others as necessary to implement the care plan and to comply with program requirements, including but not limited to monitoring, research and evaluation.

## GENERAL CONCEPTS

**USE THESE INSTRUCTIONS** --- Read these instructions before completing the COMPASS. Keep them with the COMPASS as assessments are completed. ***Frequent reference to these instructions will aid in accurately completing the COMPASS.***

**USE ONLY THE DEFINITIONS WITHIN THESE INSTRUCTIONS** --- Different types of assessment instruments are used for specific reasons and programs. Consequently, they often require different definitions. ***In all cases, use the definitions supplied on the COMPASS, in these instructions, the Reporting Guide, Consolidated Area Agency Reporting System (CAARS) and Client Data Systems or by this office as part of the Standard Service Definitions. Do not use definitions used on other assessment forms.*** Our ability to achieve consistency in assessment from assessor to assessor depends on a common understanding of all the terms.

**HOW TO ANSWER QUESTIONS** --- completing questions having ranges of responses will be easier by beginning with the first descriptor if the person is relatively independent, and the last if the person tends to be heavily dependent. ***Descriptors that are obviously not applicable to the person should be eliminated immediately.*** Attention can then be focused on the remaining descriptors to determine which best describes the individual.

**USE YOUR BEST JUDGMENT** --- At times it may be difficult to choose between two responses to describe a person. ***Do not leave the question blank, but use your best judgment to select the most appropriate response. It may be possible to use other available information to provide a response.***

**EXAMPLES** --- ***Examples given in these instructions are just that -- examples.*** They suggest types of conditions that pertain but are not to be taken as the only ones that apply.

**MEASURE THE PERSON'S STATUS** --- ***a person's functional status fluctuates from day to day and even within the day.*** To determine at what level a person will be assessed, use the following four CRITERIA:

- **TIME PERIOD** --- Use the person's average status over the past ***four weeks*** (unless a question specifically uses a different time period). If the assessor's information about the person covers less than four weeks, use that lesser time period in assessment of the person for the COMPASS.
- **60% RULE** --- Measure what the person generally does. Generally means ***what the person did 60% or more of the time*** during the past four weeks or appropriate time period. If the person's care plan is or will be governed by a behavior that took place less than 60% of the time, base the assessment on this behavior since it is influencing the plan of care.
- **CHANGE OF CONDITION RULE** --- If the person has improved or deteriorated during the past 28 days and is expected to remain at the new level or continue to

change in the same direction, ***record on the assessment instrument the response that best reflects the person's new functional status.***

- **MEASURE WHAT THE PERSON ACTUALLY DOES** --- Measure the person's actual performance, not what the person might be able to do. This applies even when someone else performs a task that the person can do.
- **OBSERVED VS. RECORDED** --- If a medical or other record for the person is not consistent with the person's actual functional status or the care being provided, ***use the actual rather than recorded.***
- **SHARE WITH THE PERSON BEING ASSESSED** –
  - That you want to ask some questions about themselves, because you don't want to sit there and make assumptions about them; you want to get to know them accurately. And a lot of people have identities that people can't necessarily see.
    - Also, that you don't want to make assumptions about the kind of relationships they have, or how they see themselves. You want them to let you know, so that you can really get to know them and understand what's going on in their life.
  - Tell them that everyone is asked the same questions, so no one is being singled out. Note too that medical and health information must remain private and is federally protected against intrusion and unlawful sharing under State and Federal law. [If possible, you can provide materials on the federal Privacy Rule and how medical and health information is kept private. For more information, visit [www.hhs.gov/ocr/privacy/](http://www.hhs.gov/ocr/privacy/)]
  - Let them know that the information collected is shared only on a need to know basis. This will include the people involved in developing, overseeing or monitoring the assessment and care plan process (e.g, case manager, supervisor). If someone else needs to see your information, you will be notified. You can also say that some data is anonymously reported to the state but will not include your name or address or other information that would identify the client as an individual (e.g. number of units of service or total number of clients by age).
  - Make it clear that the person being assessed is the primary focus of the assessment. Make every effort to understand and act on his/her point of view. At times, these instructions emphasize the involvement of appropriate family members and other informal caregivers whenever possible. However, this involvement should occur only with the consent of the person being assessed. Also, if there are differing and competing wishes, those of the older person who is being assessed should come first whenever possible.

**SOURCES OF INFORMATION** --- the information requested may be available from the person, informal supports, and/or available agency records (those of the completing agency and others). However, the person her/himself should be the first and primary source of information unless the person is unable to provide information.

## **NEED TO MAKE A REFERRAL TO A HEALTH OR MENTAL HEALTH PROFESSIONAL**

-- See Appendix "Indicators for Referral", at the end of the Instructions. The assessment interview provides the assessor with an opportunity to observe and learn many things about the person. Some of these may be beyond the scope, training and/or purview of the assessor and some may require follow-up. The Appendix provides guidance in evaluating some of these conditions, in determining when to consider them to be emergencies, and in deciding on appropriate follow-up. Become familiar with the material in this appendix so that it is available during the assessment and care planning processes.

### **INTAKE INFORMATION**

***This is a stand-alone section that is completed only at the time of the initial contact.***

- A. Person's Name:** Self-explanatory.
- B. Address:** Specify the person's current address. If this is temporary indicate this. Also, if any further contact will be at a different location this should be noted and the additional information provided.
- C. Phone # and E-mail:** Enter all phone numbers at which person can be reached. If this is temporary indicate this. If further contact will be at a location with a different phone number this should be noted and the additional information provided. If none, write "none." Enter the client's e-mail address if one's available and used.
- D. Date of Referral:** Enter the date that the referral came in to your office using two digits each for the month, and day and four for the year. For example, April 15, 1997 would be entered as 04/15/1997.
- E. Referral Source:** Identify the person by name who made the referral and the agency he/she is affiliated with, if there is one (for example: Mary Smith, receptionist at Doctor Jones' office); or the connection the referrer has to the person (for example: Edith Noble, next door neighbor). Also include a phone number in case it is necessary to follow up with the person who made the referral.  
  
If it is a self-referral, this would be so noted.
- F. Presenting Problem/Person's Concern(s):** Summarize the statements made by the referral source that explains why the referral is being made.
- G. Does The Person Know That A Referral Has Been Made?** Find out if the person is aware of the referral being made on his/her behalf and if not, why not, as this information has implications for how the assessor may approach the person in order to continue with the assessment process.
- H. Intake Worker's Name and E-mail:** Self-explanatory.

## CASE IDENTIFICATION

**Client Case #:** This is the unique identifying number generally completed by the software system being used to meet the 10 digit numeric client record/number key requirement.

**Assessment Date:** Enter the date that the assessment is being conducted using two digits each for the month and day and four for the year. For example, April 15, 2012 would be entered as 04/15/2012.

**Assessor Name:** Self-explanatory.

**Assessment Agency:** Self-explanatory.

**Reason for COMPASS Completion:** Check the one item which best explains the reason for the assessment. "Initial" refers to the first assessment done for a person who has not previously been assessed for any of the community based long term care services covered by this assessment/reassessment process. "Reassessment" is an assessment done after the initial assessment or a subsequent reassessment, according to the required timeframes or because of a change in the person's situation that indicates the need to conduct a complete event-based reassessment.

**Next Assessment Date:** Enter the projected date for the next assessment using two digits each for the month and day and four for the year. For example, April 15, 2013 would be entered as 04/15/2013.

### I. CLIENT INFORMATION

**A. Person's Name:** Self-explanatory.

**B. Address:** Specify the person's address, *where services will be provided*. Be sure to include the zip code.

If the mailing address is different from the person's home address, this should be noted and the mailing address included in the case file.

**C. E-mail:** Enter the client's e-mail address if one's available and used.

**D. Telephone No.:** Enter all phone numbers including cell at which person can be reached. If none, write "none."

**E. Social Security No.:** Use only the number assigned by the federal Social Security Administration to the person, not one assigned to the person's spouse. If the person has no Social Security Number, write in "none." If a person refuses to give you this information write "refused" and continue on with the assessment. You can ask if they will provide the last four digits of the social security number. This is being used for research purposes with grants provided by our Federal funding agencies.

- F. Marital Status:** Check the appropriate answer.  
*Note to interviewer: “Domestic partner” is a legal relationship recognition status available to some same-sex and opposite-sex couples in some states and cities. Some couples also may define themselves as “domestic partners” or “significant others” even if they have no legal relationship to each other. It is important to recognize that for some, the most important person in their lives is someone to whom they have no legally recognized relationship. If a client checks this category, you should consider asking the client who is the domestic partner/significant other so as to better inform your care plan for the individual. Please note that Domestic Partnership is not the same as a legally recognized marriage in New York State.*
- G. Sex:** Self-explanatory. Check the appropriate answer.  
*Note to interviewer: If a client asks what you mean, you can clarify and say “when you were born, did the doctors say you were a boy or a girl?”*
- H. Transgender - Gender Identity or Expression**  
  
*Note to interviewer: This question may draw some questions from your client. If the client asks what you mean, you may provide further guidance by saying, “Your gender is the way you experience yourself – for many people that’s either male or female, and for some people it might be something else.”*
- I. Birth Date:** Enter the date that the person was born using two digits each for month and day and four for the year. For example, November 4, 1923 would be entered as 11/04/1923.  
  
**Age:** Self-explanatory
- J. Race/Ethnicity:** Self-explanatory.
- K. Sexual Orientation ---** *Note to interviewer: If a client asks why you need to know that, you might say:*  
  
*These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.*
- L. Creed:** Enter the person's creed, a formal statement of religious belief; a confession of faith or a system of belief, principles using one of the available responses including did not answer or other.
- M. National Origin:** Enter the person’s national origin which includes the birthplace of the individual or their ancestors as self-identified by the client.

- N. Primary Language:** Answer all parts of this question by checking the appropriate boxes. Specify the primary language. **Note that this question is designed to allow for different languages to be entered for the three language skills.**
- O.** Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are considered to be limited English proficient, or "LEP." This can affect their ability to receive needed services and require the provision of interpretation services.
- P. Living Arrangement:** Identify who the person lives with. This information should be collected for the residence where the person will be receiving formal services.
- Q. Has the person experienced any of the listed forms of abuse within the last six months** and were they referred to one of the listed agencies. If the issues are ongoing review what steps can be taken to provide assistance.

These types of abuse are defined as:

### **Domestic Violence**

Domestic violence, also known as domestic abuse, spousal abuse, battering, family violence, and intimate partner violence (IPV), is broadly defined as a pattern of abusive behaviors by one or both partners in an intimate relationship such as marriage, dating, family, or cohabitation. Domestic violence, so defined, has many forms, including physical aggression or assault (hitting, kicking, biting, shoving, restraining, slapping, throwing objects), or threats thereof; sexual abuse; emotional abuse; controlling or domineering; intimidation; stalking; passive/covert abuse (e.g., neglect); and economic deprivation.

### **Elder Abuse\***

- **Physical abuse:** Non-accidental use of force that results in bodily injury, pain, or impairment. This includes, but is not limited to, being slapped, burned, cut, bruised or improperly physically restrained.
- **Sexual abuse:** Non-consensual sexual contact of any kind. This includes, but is not limited to, forcing sexual contact with self or forcing sexual contact with a third person.
- **Emotional abuse:** Willful infliction of anguish, pain, or distress through verbal or non-verbal acts. This includes, but is not limited to, isolating or frightening an adult.
- **Financial exploitation:** Improper use of an adult's funds, property, or resources by another individual. This includes, but is not limited

to, fraud, embezzlement, forgery, falsifying records, coerced property transfers, or denial of access to assets.

- **Intentional Neglect:** Failure to meet the needs of the dependent elderly person by, for example, willfully withholding food or medications or refusing to take the elder to seek medical care.
- **Unintentional Neglect:** Neglect that involves ignorance or from genuine inability to provide care.
- **Self-Neglect:** This is the adult's inability, due to physical and/or mental impairments, to perform tasks essential to caring for oneself.
- **Abandonment:** Desertion of a vulnerable elder by anyone who has assumed care or custody of that person.

\* Social Services Law. § 473 and NY Codes, Rules and Regulations, 18 NYCRR § 457.1.

**R. Emergency Contact Person:** Enter the name, address, relationship to the person, phone number(s) at home and work of the primary individual the person wishes to be contacted in case of an emergency. There is room to provide this information for a secondary emergency contact person, if two individuals have been identified. If none, print "none."

**S.** Use these definitions for determining frail and disabled status:

a. Frail - A person with one or more functional deficits in the following areas:

- Physical functions
- Mental functions
- Activities of Daily Living [ADL] (eating, bed/chair transfer, dressing, bathing, toileting and continence).
- Instrumental Activities of Daily Living [IADL] (meal preparation, housekeeping, shopping, medications, telephone, travel and money management).

b. Disabled - Any person who has a physical or mental impairment which substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such impairment. This includes alcoholism and drug addiction. Note, all EISEP clients are considered to be frail/disabled.

## II. HOUSING STATUS

**A. Type of Housing:** Check the type of housing that applies.

**Single Family Home:** a detached living unit housing one household. Trailers/mobile homes, elder or echo cottages and accessory apartments are considered single-family homes.

**Multi-unit Housing:** more than one living unit such as two, three or four family dwellings, duplexes, triplexes, condominiums, cooperatives, or multi-unit apartment buildings/complexes.

If other, specify.

*The assessor should describe under the Comments any special living conditions associated with the person's type of housing that affects the person's informal support system. For example, an elder cottage may be located on property containing the home of a family member, which would have a direct impact on the person's supportive environment.*

- B. Person Owns, Rents, Other:** Check the appropriate answer. If other, specify. For example, a person may live with a family member or friend, but pay no rent.
- C. Home Safety Checklist:** Check each condition that applies. The checklist will help the assessor identify situations that may cause problems to the person's or providers' health and safety or the person's capacity to stay at home.

The following guidelines should be used to evaluate the conditions that are included in this section:

**Accumulated Garbage:** Assessor should check both inside and outside to determine if there is an unusual amount of accumulated garbage which may affect the person's general health and safety.

**Bad Odors:** These are odors which appear unusual such as strong smell of urine, rotting garbage, animal waste.

**Carbon Monoxide (CO)/Detectors Not Present/Not Working:** Check/Recommend installation.

**Doorway Widths Are Inadequate:** When applicable to the person's situation, doorways should be wide enough to accommodate a wheelchair or other special equipment, such as a walker.

**Floors and Stairways Dirty and Cluttered:** Self- explanatory.

**Loose Scatter Rugs Present in One or More Rooms:** Self-explanatory.

**No Lights in the Bathroom or in the Hallway:** Self- explanatory.

**No Handrails on the Stairway:** Check the condition of the handrails.

**No Lamp or Light Switch Within Easy Reach of Bed:** Fixtures should be at a height that is comfortable and possible for the person to reach. For example, if a person is in a wheelchair, fixtures might have to be lowered or if a person is bedridden and cannot reach a wall switch, a new arrangement such as extension cords or new lights may be needed.

**No Locks on Doors or Not Working:** Self-explanatory.

**No Grab Bar in Tub or Shower:** Self-explanatory.

**No Rubber Mat or Non-Slip Decals in the Tub or Shower:** Self-explanatory.

**Smoke Detectors Not Present/Not Working:** Check Battery/ Recommend installation.

**Stairs Not Lit:** Check for inadequate lighting.

**Stairways Not in Good Condition:** Check for dirt, clutter and condition of stair treads. Stairs should be firm and strong.

**Telephone and Appliance Cords Strung Across Areas Where People Walk:** Self-explanatory.

**Traffic Lane from the Bedroom to the Bathroom Is not Clear of Obstacles:** Self-explanatory.

**Other:** Specify any other home environment condition that might be problematic to the person's health or safety. For example, exposed or hazardous wiring, pest or vermin infestation.

Under Comments include all changes that must be made to accommodate person's current condition. For example, a commode installed and bath arrangement made downstairs if the only house bathroom is upstairs and the person cannot climb stairs; the installation of a bed downstairs; or bed with rails because the person needs such protection at night. Include any other factors which might affect the care plan, such as availability of space for a sleep-in care giver.

- D. Neighborhood Safety:** Check yes or no. Check yes if environmental conditions outside the person's residence affect the safety of the person or of informal or formal caregivers. For example, high crime rate in the neighborhood, and describe under the Comments.

### III. HEALTH STATUS

As you go through the Health Status section, keep in mind that a referral may be necessary for the person based on information provided to the assessor. Referral information is located in the Care Plan section; you should note the possible need for a referral in the comments portion at the end of this section.

**A. Primary Physician, Clinic, HMO, Hospital:**  
Name/Address/Phone

**Complete the Appropriate Line:**

- Physician if person has an individual private practitioner as primary medical provider;
- Clinic/HMO if a clinic or HMO;
- Hospital if the person uses the emergency room as his/her primary medical provider.
- Other: specify health practitioners other than the primary provider regularly involved in the person's care, including specialists.

Print name, address, and phone number of health practitioner who monitors person's health and provides health care services. If applicable, specify the type of primary care provider and title (e.g., doctor of medicine - M.D.; physician assistant - P.A.; nurse practitioner - N.P., etc.)

A person may not have a physician, clinic or HMO who serves as primary provider. ***Under no circumstances may an assessor force a person to choose a particular provider, or force a person to seek a provider.*** A person without a primary medical provider should be assisted in finding one, and encouraged to do so. Depending on instructions from the local AAA, assistance in finding a primary medical provider may be the responsibility of the assessor or another staff person.

***Services cannot be withheld if the person refuses to seek a primary medical provider, except if you determine that services cannot safely be provided.***

- B. Date of last visit to Primary Medical Provider:** Note the month and year of most recent visit to primary medical provider. Specify whom the person saw on most recent visit, reason for contact, and specify location of visit in the comments portion of this section, if applicable.
- C. Does the person have a self-declared chronic illness and/or disability?** Check all that apply from the list provided. If the person indicates a condition not listed, check 'other' and specify. Under the Comments, include diagnoses and impairments that may affect the Care Plan. Definitions for items in the list are included at the end of the instructions for item III.C.

To answer this item, use all available sources: the person her/himself and, with the person's consent, informal caregivers, the person's physician if necessary, and informed formal service providers. The purposes of recording this information are to have available data which assist in:

- Making a Care Plan which is appropriately responsive to the person's needs;
- Enabling the assessor or other designated person to participate in the coordination of other services if necessary; and
- Identifying indicators for referral for medical assessment and/or treatment if needed.

The assessor should ask the person to describe known health conditions, and to state whether the condition has been diagnosed by a health professional and a course of treatment prescribed. Note if the person seems to have a good awareness of his/her health condition. Note especially if your observation suggests the possibility of other health conditions not named by the person.

Some persons may not have a well-organized perception of their health condition. In those cases, you may have to undertake a more focused interview with the person or by interviewing others.

***Any of the health conditions may require action by the case manager, including discussing with the person what current treatment or remedy is being used or considered. Some conditions should be brought to the attention of a Nutrition Program for the Elderly as they may indicate need for assessment by a nutritionist or dietitian. These conditions are:***

- alcoholism
- cancer
- dental problems
- diabetes
- digestive problems
- heart disease
- high blood pressure
- hypoglycemia
- smelling impairment
- swallowing difficulties
- taste impairment

## Health Status Checklist Definitions

The purpose of these definitions is to help the assessor understand and clarify the meaning of conditions that may affect the client. If the person has a condition, indicates the possible presence of a condition, or the assessor observes the possible presence of a condition, the definitions should help the assessor clarify the condition and consider whether follow-up should be pursued.

**Alcoholism:** A disorder manifested by complete absorption with and loss of control over consumption of alcohol and characterized by chronicity, intoxication, and tendency toward relapse. Excessive drinking causes physical disability, leading to impaired emotional, occupational, and social adjustments.

Symptoms and Signs: There may be motor instability; reduced mental function; increased pulse rate; decreased blood pressure; dilated pupils; flushing of skin; drowsiness or stupor.

**Alzheimer's Disease:** A severe neurological disorder marked by progressive dementia and cerebral cortical atrophy. The disease has a relentless and irreversible course but may take from a few months to four or five years to go to the stage of complete helplessness.

**Arthritis:** Inflammation of a joint, usually accompanied by pain and, frequently, changes in structure.

**Cancer:** Any of various malignant tumors or neoplasms that manifest invasiveness and a tendency to spread (metastasize) to new sites. It spreads directly into surrounding tissues and also may be disseminated through the lymphatic and circulatory system.

**Constipation:** Difficult defecation; infrequent defecation with unduly hard and dry fecal material; sluggish action of the bowels.

**Colitis:** Inflammation of the mucus membrane of the colon.

**Colostomy:** Incision of the colon for the purpose of making a more or less permanent duct (fistula) between the bowel and the abdominal wall. The location is usually indicated as groin area (inguinal colostomy) or back and sides between lowest ribs and pelvis (lumbar colostomy), etc.

**Congestive Heart Failure:** Condition, characterized by weakness, breathlessness, abdominal discomfort, edema in lower portions of body, resulting from venous stasis and reduced outflow of blood.

**Dehydration:** Occurs when output of water exceeds water intake. May result from deprivation of water, excessive loss of water, reduction in total quantity of electrolytes, or injection of hypertonic solutions.

**Dental Problems:** Pertaining to the teeth.

**Diabetes:** A disorder characterized by an abnormally high concentration of glucose in the blood (hyperglycemia) and excretion of abnormal quantities of sugar in the urine (glycosuria).

Diabetes mellitus is a disease of pancreatic origin, characterized by insulin deficiency, subsequent inability to use carbohydrates, excess sugar in the blood and urine, excessive thirst, hunger and urination, weakness, emaciation, imperfect combustion of fats resulting in abnormal increase in acidity in body's fluids (acidosis), and, without injection of insulin, eventual coma and death.

**Diarrhea:** Frequent passage of watery bowel movements. It is a frequent symptom of gastrointestinal disturbances and is primarily the result of increased wave-like muscle contractions that propel contained matter along tubular organs (peristalsis).

**Digestive Problems:** Problems with digestion, the process by which food is broken down mechanically and chemically in the digestive tract and converted into absorbable forms.

**Diverticulitis:** Inflammation of a diverticulum or of diverticula in the intestinal tract, especially in the colon, causing stagnation of feces in little distended sacs of the colon.

**Fractures (Recent):** A sudden breaking of a bone, or a broken bone. A recent fracture is one that has occurred within the past two years or so.

**Frequent Falls:** Has the person experienced 2 or more falls during the prior one year period?

**Gall Bladder Disease:** Any pathological disorder affecting the gall bladder and/or bile ducts.

**Hearing Impairment:** Difficulty perceiving sound.

**Heart Disease:** Any pathological disorder of the heart.

**Hiatal Hernia:** Protrusion of the stomach upward into the mediastinal cavity, through the esophageal hiatus of the diaphragm.

**High Blood Pressure:** A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

**High Cholesterol:** Having levels of LDL (low-density lipoprotein cholesterol, also called "bad" cholesterol) in excess of 160.

**Hypoglycemia:** Deficiency of sugar in the blood. A condition in which glucose is abnormally low.

**Liver Disease:** Any of several ailments affecting the liver. The liver receives blood from the portal vein and thus is the first organ to receive blood from the intestines where the blood has absorbed the final products of digestion and decomposition products.

**Low Blood Pressure:** A diagnostic judgment or opinion which must be considered with respect to the person's age, body build, previous blood pressure, and state of mental and physical health at the time the blood pressure is obtained.

**Osteoporosis:** Increased porosity (small openings) of bone, leads to frequent fractures, falls, humpback, and/or loss of height. This frequently occurs in women due to a calcium deficiency.

**Parkinson's:** A chronic disease affecting the central nervous system characterized by a fine slowly-spreading tremor, muscular weakness and rigidity.

**Renal Disease:** Disease of the kidney.

**Respiratory Problems:** Trouble with breathing.

**Smelling Impairment:** A decrease in the person's sense of smell. Smell and taste are closely aligned, and impairment in smell may affect ability to determine flavors, etc.

**Speech Problems:** Trouble with oral expressions of one's thought.

**Stroke:** Sudden onset of paralysis resulting from injury to brain or spinal cord.

**Swallowing Difficulties:** Difficulties in passing food from the mouth through the throat and esophagus into the stomach.

**Taste Impairment:** Difficulty determining the flavor of a substance in the mouth.

**Ulcer:** An open sore or lesion of the skin or mucous membrane of the body.

**Urinary Tract Infection:** An infection in the organs and ducts participating in secretion and elimination of urine.

**Visual Impairment:** Of or relating to difficulty viewing external objects.

Source: Taber's Cyclopedic Medical Dictionary (1979: F.A. Davis Company, Philadelphia) with modifications

- D. Does the person have an assistive device?** Check yes or no. If yes, check all that apply. If the person has dentures, check whether they are full or partial.

Other should be checked if assistive devices not listed are used. Examples include prosthesis, flashing lights for telephone or doorbell, telephone for persons with hearing impairments, and "grabber" to reach items on floor or overhead. Specify the device and its use where appropriate (e.g., limb which is replaced).

- E. Does the person need assistive device?** On the basis of your observations, the person's comments, or statements from the informal or formal caregivers, identify any assistive device(s) or additional assistive device(s) the person may need.

Check yes or no. If yes, specify the type of device the person needs.

- F. Does person and/or caregiver need training on use?** Check yes or no. If yes, describe the training needs or instructions required by the person and/or the informal caregiver. Specify if the person, the person and the primary caregiver, or just the primary caregiver need training on use.

- G. Has the person been hospitalized within the last 6 months?** Check yes or no. If yes, specify month/year of most recent visit. Specify the reason for stay in hospital and note month and year of discharge date.

*Consider this information when developing the care plan. Service need may be affected by medical condition and should be noted. Potential referral may be necessary, depending on indicators, such as the person being frequently hospitalized.*

- H. Has the person been taken to the emergency room within the last 6 months?** Check yes or no. If yes, specify month/year of most recent emergency room visit. Describe the reason for most recent ER visit and whether this led to a hospital admission.

- I. Has PRI and/or DMS-1 been completed in the past 6 months?** Check yes or no. Specify month and year of most recent assessment completed. It is possible that the person will be unfamiliar with specific names of assessment processes and instruments. The person may, however, know that a nurse or other professional has been to see her/him recently, and that she or he has been asked questions about her or his health, etc. An informal caregiver may also be helpful with this information. Find out the name of the individual and/or agency that may have performed an

assessment, for further inquiry as to the specific instrument and the details such as completion date and score.

*This information is valuable for several reasons. It provides additional information and insight about the person and his/her circumstances. It indicates the involvement of other professionals who you may need or want to contact at some point. It provides information that may be useful or needed in the future. Lastly, it helps the assessor in building a more complete client record.*

The Patient Review Instrument (PRI) is generally performed by a nurse and is completed for purposes of nursing home placement in New York State.

A Long Term Care Placement Form (more commonly referred to as the DMS-1) is generally completed by a nurse or doctor and may have been completed for purposes of the Long Term Home Health Care Program or Program for All-Inclusive Care for the Elderly (PACE, a demonstration program operational in some locations in New York.)

Comments: The assessor should use the comments portion of this section to note any additional information about health status not covered in the items in this section, and information based on the items that the assessor would like to specify. This is especially important as items relate to the care plan.

#### **J. Alcohol Screening Test - The CAGE Questionnaire**

The CAGE test is a straightforward alcohol screening test, used by many professionals in the alcohol addiction field that simplifies the process of identifying those with alcohol issues.

It is a VERY SIMPLE 4 question self-test where you have the person answer yes or no to the questions.

It is important that they note that when answering the questions they take into account their behavior and feelings over their whole lifetime NOT just now.

Let them know that just because they may have answered yes to 2 or more questions **does not mean they are alcoholic.**

What it does mean is that their drinking should be investigated further

##### **What do the Answers mean?**

###### ***Answering yes to 1 question.***

*Then the probability of an alcohol problem is about 25%*

###### ***Answering yes to 2 questions.***

*Then the probability of having an alcohol problem is about 50%*

**Answering yes to 3 questions.**

*Then the probability of having an alcohol problem is about 75%*

**Answering yes to 4 questions.**

*Then the probability of having an alcohol problem is about 95%*

*You can advise them that:*

If you have answered yes to any of the questions in the CAGE questionnaire, or they are worried about alcohol consumption, it is strongly advisable to consult an alcohol specialist.

Usually this means making an appointment with an **alcohol/addiction counselor** and so that they can discuss their alcohol consumption with him/her.

If they feel more comfortable with their **family doctor** then they should go to them by all means. Most doctors have a good knowledge of alcoholism and its signs. If they think there is a problem they can refer to a counselor/treatment center. Medicare also now pays for screening and behavioral counseling in primary care to reduce alcohol misuse. There are no copayments, coinsurance or deductibles.

***THE ASSESSOR SHOULD NOTE THE POSSIBLE NEED FOR A REFERRAL IN THIS PART OF THIS SECTION. THIS WILL BE USEFUL FOR CARE PLANNING PURPOSES.***

#### **IV: NUTRITION**

Data taken in this section, together with other information on the COMPASS, will identify the need for Home Delivered Meal service and/or potential interventions by a registered dietitian.

Eligibility and/or need for Home Delivered Meal service is based on information gathered from the following sections: Health Status, Nutrition, IADLs, ADLs and Informal Support Status. This cumulative information will help the assessor in developing the person's care plan.

To be eligible for Home Delivered Meal service, the person must meet all three of the following criteria:

- Person is incapacitated due to accident, illness, or frailty; and
- Person lacks the support of family, friends, or neighbors; and
- Person is unable to prepare meals because of lack/inadequacy of facilities, inability to shop and cook for self, inability to prepare meals or lack of knowledge or skill.

*Referral to a registered dietitian: Factors that should be considered include person's Body Mass Index (BMI), Nutritional Risk Score, Modified/Therapeutic Diet needs, Nutritional Supplements, and Health status.*

**A&B Height and Weight:** Enter person's height and weight. Assessor should note the source used to document the person's height and weight. For example, the person may have been weighed measured by a health professional during his/her last doctor's visit. ***Height and weight are simple but important ways of monitoring nutritional status.***

**C. Body Mass Index (BMI):** The BMI can be used to assess quickly whether the person is over or underweight. Healthy older adults should have a BMI between 22 AND 27. A BMI outside of this range may indicate the need for a referral to a dietician.

BMI is calculated from the person's height (converted to inches) and weight by using the following formula: weight in pounds x 703; divide this number by height in inches; then divide this number by height in inches again. For example: Person is 5 ft. 4 inches and weighs 140 pounds.  $140 \times 703 = 98,700$ ;  $98,700 \div 64 \text{ inches} = 1542$ ;  $1542 \div 64 \text{ inches} = 24$  (BMI). The BMI is within normal range.

Assessor may also use the Nomogram chart (shown below) to calculate the person's Body Mass Index as follows:

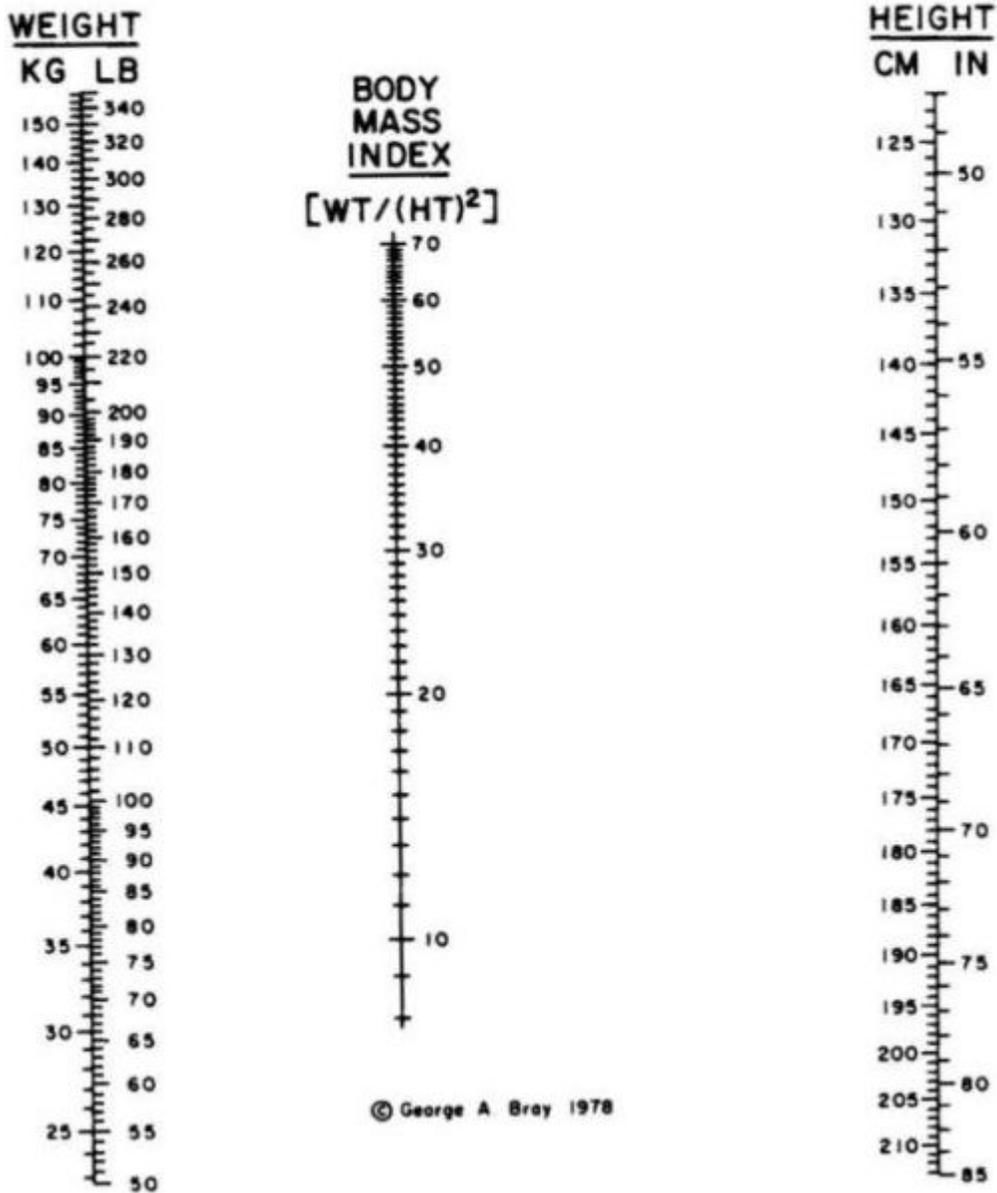
- Record the person's height (convert into inches) and weight on the appropriate scale.
- Use a straight edge to connect the two points and circle the spot where this straight line crosses the center line.
- This is the person's Body Mass Index.

**D. Are the Person's Refrigerator/Freezer & Cooking Facilities Adequate?** Check yes or no. Facilities are not adequate if the person cannot safely store, cook, heat/reheat food or meals.

**E. Is the Person Able to Open Containers/Cartons & Cut Up Food?** Check yes or no. If person is unable to perform these functions, check "no". The assessor should include specific information about person's physical disability (such as arthritis, paralysis) or other reason(s) which limit the person's ability and the person's need for adaptive utensils or food containers.

**F. Does the Person Have a Physician Prescribed Modified/-Therapeutic Diet?** Check yes or no. ***Check yes only if diet has been prescribed by a physician.*** If possible, the assessor should determine if the person has a copy of his/her prescribed diet.

## NOMOGRAM FOR BODY MASS INDEX



A modified/therapeutic diet is designed to meet the requirements of a given situation. It may be modified in individual nutrients, caloric value, consistency, flavor, content of specific foods or a combination of these factors.

***If yes, check which type of modified/therapeutic diet the person's physician has prescribed.*** Types of modified/therapeutic diets include the following:

**Texture Modified:** A diet designed to minimize the amount of chewing or aid in swallowing. It may be used for dental problems, postoperative patients of head, neck, and mouth surgery, and stroke. For example: chopped diet.

**Sodium Restricted:** The goal of sodium (Na, salt) restriction is to control hypertension, promote the loss of excess fluids and/or manage impaired liver function, cardiovascular disease and renal disease. Foods containing large amounts of natural sodium or commercially processed foods to which sodium has been added are restricted in amount (e.g., salted snack foods, sauerkraut, seasoning salts.) For example: No Added Salt diet, 2 gm. Sodium.

**High Calorie, High Protein:** A diet designed to meet the need for increased nutrition during certain illnesses such as cancer and HIV. Nutritional supplements may be included as part of an overall nutritional care plan.

**Calorie Controlled Diet:** The goal is to aid in the management of Diabetes and/or in weight control. In cases of Diabetes, daily dietary intake is controlled carefully for calories, protein, carbohydrates, and fat. Diet may require simple menu substitutions such as in desserts high in concentrated sugar: cakes, cookies, pies, canned fruit in heavy syrup. For example: 1200 ADA calorie diet, or 1200 calorie weight reducing diet.

**Fat Restricted:** A diet designed to limit fat intake and/or reduce fat in the blood (serum lipid levels). These lipids include cholesterol and triglycerides. A fat controlled diet is used in the management of conditions where fat is not tolerated (hyperlipo-proteinemias or for biliary tract, pancreas, and malabsorptive syndromes). For example: 40 gm Fat.

**Renal:** A diet designed to maintain optimal nutritional status in persons with impaired renal function who may be on hemodialysis. Protein, sodium, potassium, phosphorus, and fluid are controlled.

**Other:** If the person has a physician-prescribed diet that is not included in the list of Modified/Therapeutic Diets, assessor should check other and specify.

***If no, ask if the person follows a regular diet or a special diet.*** A regular diet is designed to maintain a healthy person in a nutritional status sufficient to meet the needs of a particular stage of a life cycle. It satisfies the requirements of the recommended dietary allowances. A special diet includes or substitutes foods to meet a particular need or choice. Check all diets which apply. Types of Special Diets include the following:

**Ethnic/Religious:** A regular or modified diet that also considers preferences of a nationality, race, ethnic group and/or religious community. If a client has an ethnic/religious diet specify. For example: Kosher/Jewish.

**Vegetarian:** There are three major classifications within the term vegetarian diet: plant foods with dairy products and eggs (lacto-ovovegetarian), plant foods with dairy products (lactovegetarian), and plant foods only (vegan).

- G. Does the Person Have a Physician-Diagnosed Food Allergy?** Check yes or no. Check yes *only if allergy has been diagnosed by physician*. Allergies produce definable physiological reactions, including but not limited to indigestion, diarrhea, hives, intestinal cramps, and choking. **Do not enter food dislikes**. If yes, describe which food produces an allergic reaction.
- H. Does the Person Use Nutritional Supplements?** Check yes or no. If person uses food or beverage supplements, including vitamin/mineral supplements, answer yes. If yes, specify who prescribed and describe the type of supplement(s) person is currently taking.
- I. Nutritional Risk Status (NSI):** The purpose of questions in this section is to determine the person's Nutritional Risk Status based on the person's responses.

***The person's nutritional risk score will help the assessor make appropriate referrals to a registered dietitian.***

Check all appropriate risk indicators that apply and circle corresponding numbers at the right. All "yes" answers have a score assigned. The NSI score is obtained by adding the number of those factors that were answered yes. Check the appropriate level of nutritional risk.

**Score of 6 or more** indicates "high" nutritional risk: Refer to registered dietitian.

**Score of 3-5** indicates "moderate" nutritional risk.

**Score of 2 or less** indicates "low" nutritional risk.

- 1. Person Has Illness or Condition that Changes the Kind and/or Amount of Food Eaten:** Any disease, illness or chronic condition may affect the way a person eats. Also confusion, memory loss, loneliness, or depression can cause changes in a person's appetite and/or digestion. Energy level may have an effect. The assessor may want to cross reference the person's response to this question with Section III. Health Status, Item C and Section V. Psycho-Social Status, Item A.
- 2. Eats Fewer than Two Meals/Day:** Self-explanatory.
- 3. Eats Fewer than Two Daily Servings of the Following Food Groups:** A serving from each food group constitutes the following:

**Fruits:** One half cup cooked, fresh or juice; or portion as normally served.

**Vegetables:** One half cup cooked or fresh; or portion as normally served.

**Milk Products:** One cup of milk or yogurt, one ounce of cheese, one half cup of ice cream or cottage cheese.

If person answers yes to any of these, circle the 2 points. For example, if a person eats fewer than two daily servings from fruits, vegetables, and milk products, you would **add only 2 points**. If the person eats fewer than two daily servings from the fruit group, but indicates he/she is eating more than two daily servings from vegetable or milk group, you would still **add only 2 points**.

4. **Has Three or More Drinks of Beer, Liquor or Wine Almost Every Day:** Self-explanatory.
5. **Has Tooth or Mouth Problems that Make It Hard to Eat:** Refers to problems person may have with loose, missing, or rotten teeth, poor gums, or dentures which don't fit well or cause mouth sores making it hard to eat.
6. **Does Not Always Have Enough Money to Buy Food that Is Needed:** Self-explanatory.
7. **Eats Alone Most of the Time:** Self-explanatory.
8. **Takes Three or More Prescribed or Over-the-Counter Drugs a Day:** *This question should be asked and cross-referenced with Section VIII-Medications currently taken.*
9. **Without Wanting To, Lost or Gained 10 Pounds in the Past Six Months:** Self-explanatory.
10. **Not Always Physically Able to Shop, Cook and/or Feed Self:** Self-explanatory.

**Comments:** Specify any special considerations which have been noted in the Nutrition Section or elsewhere on the COMPASS and that have an impact on the person's nutritional needs or indicates the need for a referral to a dietitian. These include:

- Health related factors (Section III, item C): The assessor should be aware that the majority of health conditions listed there have implications for nutrition intervention.
- Impaired in IADLs (Section VII): Shopping (item B); Prepare and Cook meals (item E)
- Impaired in ADLs (Section VIII): Mobility (item D); Eating (item G).
- Informal Support Status (Section X).

## V. PSYCHO-SOCIAL STATUS

For each of the questions, assess the presence of the behavior as exhibited by the person, or reported by his/her formal and/or informal caregivers.

Your capacity to provide details in response to these questions will depend not only on your interviewing skills but also the amount of experience you have with the person and his/her formal and/or informal caregivers. When the behavior or condition exists, describe to the extent possible in the space provided. The person's psycho-social status must be considered during the development of the Care Plan. Insofar as you can, any comments you make concerning a problem behavior should include the following factors:

Frequency: How often does this behavior occur? Describe the behavior as occurring monthly if it happens one to three times every four weeks; weekly if it happens at least weekly but not daily; and daily if it happens every day.

Predictability: Is the behavior predictable or unpredictable? For predictable behavior, the caregiver can discern when a person will exhibit the behavioral problem and plan appropriate responses in advance. The behavioral problem may occur during ADL routines (e.g., bathing), specific treatments (e.g., ambulation exercises) or for a logical reason, such as being wrongly criticized, bumped into, etc. The behavior is unpredictable when the caregiver cannot foretell when or under what circumstances the person will exhibit the behavioral problem since there is no evident pattern.

Origin of Condition: When measuring the person's condition, do not consider the origin of this disability, i.e., physical, mental and/or social problems. The concern for measurement is what the person's condition is. Origin of condition is not relevant to the assessment:

### A. **Does the Person Appear, Demonstrate and/or Report, Any of the Following? Check all that apply.**

#### **Checklist Definitions**

**Alert**: The person is mentally responsive and perceptive. Able to appropriately communicate and provide feedback.

**Cooperative**: The person willingly works with others that are acting on his/her behalf.

**Dementia**: The person demonstrates distorted comprehension and expression. Exhibits inaccurate or unwise decision making and unsafe self-direction.

**Depressed**: The person appears melancholy and/or withdrawn. Expresses feelings of sadness and/or guilt. For example, the person often refuses to participate in social activities.

**Disruptive Socially:** Through verbal and/or physical actions, the person interferes with others. This interference requires immediate attention to control the situation. Without intervention, the disruption would persist or a problem would occur.

**Hallucinations:** The person demonstrates false or distorted perception of objects or events with a compelling sense of their reality. For example, the person may claim to see people or objects that are not there.

**Hoarding:** Pathological or compulsive hoarding is a specific type of behavior characterized by:

- acquiring and failing to throw out a large number of items that would appear to have little or no value to others (e.g., papers, notes, flyers, newspapers, clothes)
- severe cluttering of the person's home so that it is no longer able to function as a viable living space
- significant distress or impairment of work or social life

**Impaired Decision-Making:** The person makes decisions which put themselves and/or others at risk of illness, injury, and/or death. The person creates financial risk due to inappropriate expenditures. This is not due to lack of knowledge.

**Lonely:** The person expresses feelings of loneliness. States for example, that he/she does not see his/her family and friends enough and/or indicates that he/she misses contact with other people.

**Memory Deficit:** The person demonstrates forgetful behavior which is dangerous to self or others. For example, fails to shut off burners on stove, fails to put out cigarettes, does not watch food that is cooking and/or burns food, etc.

**Physical Aggression:** The person is assaultive or combative to self or others with intent for injury. For example, the person hits self, throws objects, punches or hits others, and/or makes dangerous maneuvers with wheelchair.

**Self-Neglect:** is a behavioral condition in which an individual neglects to attend to their basic needs, such as personal hygiene, appropriate clothing, feeding, or tending appropriately to any medical conditions they have. Extreme self-neglect can be known as Diogenes syndrome.

**Sleeping Problems:** The person exhibits increased activity, restlessness, anxiety, fear, and/or tension that occurs during the night.

**Suicidal Thoughts:** The person expresses feelings of despondency, self-destruction or suicide. For example, the person states he/she would like to end it all.

**Suicidal Behavior:** The term is understood to mean both suicidal equivalents not recognized as such (accidents, repeated risk-taking) and repeated suicide attempts whose chronic and unsuccessful nature certainly constitutes a real risk, but which are also acts of essentially relational significance.

**Verbal Disruption:** The person routinely yells, baits, and/or threatens other individuals.

**Worried or Anxious:** The person appears uneasy, distressed and/or troubled. Demonstrates apprehension, fear, nervousness and/or agitation.

**Other (specify):** Do not include behaviors or conditions otherwise noted in this section or elsewhere on the COMPASS. Indicate behaviors not included on the list that may affect the safety of the person and/or caregivers. In the space provided, enter the problem behavior.

- B. Evidence of Substance Abuse Problems:** Check yes or no. If the person demonstrates behaviors such as abuse of drugs and/or alcohol (there are clear patterns, levels and strength of the evidence that indicate such abuse), check yes and describe in the space provided.
- C: Problem Behavior Reported:** Check yes or no. Although not demonstrated during your observations and/or through your interactions directly with the person, check yes, if the person's formal and/or informal caregivers report problem behavior. This situation will require further investigation and assessment to verify. Describe in the space provided.
- D. Diagnosed Mental Health Problem:** Check yes or no. If the person has a professionally diagnosed mental health problem and/or an active treatment plan, check yes and describe in the space provided.
- E. History of Mental Health Treatment:** Check yes or no. If the person has a history of receiving professional services or any other type service for a mental health condition, but not now receiving such services, check yes and describe in the space provided.
- F. Does It Appear That A Mental Health Evaluation Is Needed?** Check yes or no. On the basis of a past mental health assessment and the observation of current behavior problems, the person should be referred to treatment services. The services can be provided in any appropriate setting. ***Note Section E, Problems to be referred, in the Care Plan Section, XIII.*** Also see Appendix, Indicators for Referral.

## VI. PRESCRIBED AND OVER THE COUNTER MEDICATIONS CURRENTLY TAKEN

In care planning, medication use patterns may need to be addressed. You should assess potential problems in drug use, such as history of non-compliance or abuse of specific medications or with all medications. Observe indicators for possible problem behaviors, such as use of outdated medications, similar medications from several physicians, and use of medications (over-the-counter and prescription) which may be antagonistic or which may exaggerate each other's effects. For example, use of aspirin and blood thinners (anti-coagulants).

### A. Medications: Name, Dose, Frequency, Reason Taken

Determine medications used and purposes as stated by the person or by another informed source. A useful technique in the home is to ask to see containers of all medications used. If assessor believes there is a problem, you should check with person's pharmacist or physician (if person has one).

**Name:** List all medications that are prescribed and/or purchased over-the-counter. Medications include laxatives, antacids, heart medication, etc.

**Dose/Frequency:** For each medication listed, identify the amount/quantity to be taken at each time (e.g., three teaspoons, 1 250 mg tablet). Also state the frequency which is the number of times the medication is to be taken per day, week or as needed.

**Reason Taken:** State the reason for taking the medication as expressed by the person. Record the person's statement of the reason for taking the medication. To the extent possible, you should attempt to have an explanation provided to the person when she/he cannot remember the reason for the medication, or if the reason does not match your personal understanding of the purpose of the medication. It is important to note if the person is not taking medications properly (knowingly or unknowingly.)

**B. Primary Pharmacy and Phone Number:** Specify the name and phone number of the primary pharmacy used by the person for prescriptions and other drug/personal items. This should be asked of the person and may be confirmed by the labels on the prescription medication.

### C. Does the Person State Any Problems With Medication(s)?

#### **Adverse Reactions/Allergies/Sensitivities:**

Check yes or no. If yes, describe any demonstrable physiological reactions produced by any substance. Include substances that cause an allergy (allergens) such as medications and/or environmental factors. Food allergies should **not** be included here, as they are recorded in Section VI., Nutrition.

## Cost of Medication

Check yes or no. If yes, describe any problem the person states that he/she has with cost of medication. This is important for potential referral.

## Obtaining Medications

Check yes or no. If yes, briefly explain whether person can get own medications (refill prescriptions), whether it can be done by an informal caregiver, whether pharmacy can deliver, or whether a formal service is needed to obtain medications. This may be important for care planning.

**Other:** Self-explanatory.

## VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLS)

Use the following qualifiers in answering each IADL question:

**Time period: Past four weeks.**

**Frequency:** Assess how the person completed each IADL 60% or more of time it was performed (***IADL status may fluctuate during the day or over the past four weeks***).

**Changed Condition Rule:** When a person's capacity to perform IADLs with or without an adaptive/assistive device has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the IADL according to its status during the past seven days.

**Changes in Functional Capacity:** Consider whether the degree to which the person can no longer perform the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with shopping because he/she is recovering from an operation or broken limb, but the level of assistance would diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the IADL, or how much the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

**Is Need Met: At the time of the assessment are the needs for these activities being met?**

**Activity Status: What Can the Person Do?** The IADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. They involve handling equipment, tools or systems outside the body. Consider the person's abilities such as bending, stretching, lifting, pulling, walking a specific distance, etc. By breaking tasks into simple steps, the assessor will be able to determine what aspects of each task are most challenging. For each IADL

question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the IADL in the box provided.

**Check if Assistance Is/Will be Provided by Informal and/or Formal Supports:**

If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver, such as in the administration of medications, or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. State the name of the informal caregiver and the specific days/hours the assistance is required. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

**Comments:** Describe any specific limitations or needs there might be for each activity, parts of tasks to be done and responsibilities of informal and formal services, and/or other factors that may be important for developing and/or implementing the Care Plan. For example, in the activity of shopping, you have the opportunity to indicate to what degree the person needs assistance. In the example of telephone, you can assess whether the person needs some type of assistive device, perhaps even the telephone itself, to satisfy the IADL need. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

**Definitions of Activities**

**A. Housework/Cleaning:** To be able to dust, sweep, wash dishes, vacuum, move small pieces of furniture to clean, rinse out bath - to handle the normal range of housekeeping chores.

**Status #1:** Able to perform almost all household tasks - light and heavy work. Person is totally able.

**Status #2:** Able to perform light housework (e.g., dusting, dishes, trash disposal). Cannot do most heavy housework (e.g., vacuuming, washing floors, cleaning kitchen). Person needs some assistance.

**Status #3:** Unable to do any housework. Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

**B. Shopping:** To select, order, or purchase items in a store (groceries, clothes, drugs, etc.) and to carry them home or be able to have them sent.

**Status #1:** Able to go by self to shop, including carrying packages. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- Able to go by self to shop or order items, but needs someone to carry packages.
- Able to do by self only light shopping and carry small packages, but needs someone to do occasional major shopping.
- Unable to go shopping alone, but can go with someone to assist.

**Status #3:** Needs someone to do all shopping and errands. Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

**C. Laundry:** To carry laundry to and from washing machine, to get to laundry facilities, to use washer and dryer, to wash small items by hand.

**Status #1:** Able to take care of all laundry and can get to laundry facilities. Person is totally able.

**Status #2:** Able to do light laundry, such as minor hand wash or light washer loads. Needs help with heavy laundry such as getting to laundry facility, carrying large loads of laundry, or supervision. Person needs some assistance.

**Status #3:** Unable to do any laundry physically or needs continual supervision and assistance (if confused or judgment impaired). Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

**D. Transportation:** Ability to use transportation such as a car, van, taxi, or public transportation to go to a place farther than person can walk. For example, to go to a medical appointment. To do this, it implies that the person has the cognitive and physical ability to travel.

**Status #1:** Able to drive a car or arrange and use a van, taxi or public transportation. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- Can arrange necessary transportation, but needs help in and out of vehicle.
- Must have someone else arrange for and provide the transportation, person can use transportation.
- Does not have access to transportation --- appropriate mode of transportation unavailable.

**Status #3:** Person needs maximum assistance. Specify degree of assistance required:

- Person can not leave home.
- Person requires maximum assistance to arrange, help in and out of the vehicle and provide the transportation.

**Status #4:** Does not perform the activity due to unwillingness.

- E. Prepare and Cook Meals:** To be able to chop, cut, measure foods to prepare a recipe, to know how long food should cook to be edible. Person is able to use the stove or oven, be able to lift and move pots and pans, be able to boil water, etc.

**Status #1:** Able to plan and prepare all meals for self. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- Able to fix main meals but not on a regular basis.
- Able to fix light meals (e.g., cereal, sandwich) or reheat but not on a regular basis.

**Status #3:** Unable to prepare any meals, even reheat. Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

- F. Self-Administration of Medications:** To be able to perform all tasks involved with the use of medications, whether prescribed or over the counter. Includes tasks such as being able to follow the schedule for taking medications, identifying container having proper medication, opening the container, counting out or measuring the medication, doing any procedures

to prepare the medication for use, and the acts of ingesting, applying or injecting the medication.

**Status #1:** Able to self-administer medication without any assistance or supervision. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- Requires supervision to keep track of which medications must be taken, or to take medications at the proper time. Otherwise capable of taking medication as directed by others.
- Requires assistance in identifying the proper medication, opening the container, counting out pills or preparing for applying, ingesting or injecting medications; otherwise capable of taking medication prepared by others.

**Status #3:** Totally incapable of managing self-administration of medication, and completely dependent on others for supervision and assistance.

**Status #4:** Does not perform the activity due to unwillingness.

- G. Handle Personal Business/Finances:** To understand how to pay bills; balance a checkbook; keep accounts; answer correspondence; write and keep track of when to pay which bills; handle money, understand the cost of items and count change.

**Status #1:** Able to pay bills (on time and for correct amount), balance checkbook/handle bank account and make contracts independently. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- May need to be reminded to pay bills or take care of other personal business.
- May need assistance in getting materials needed (e.g., checkbook, stamps) or assistance in writing checks, letters, and balancing checkbook.
- May need assistance or guidance in handling financial matters (home mortgage, investments).

**Status #3:** Needs someone to write checks, pay bills and handle personal business. Person does not participate in decisions. Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

**H. Telephone:** To be able to use phone book or know numbers of parties desired to be reached, or to actually be able to dial and use telephone regardless if person has a telephone.

**Status #1:** Able to look up phone numbers, dial number and receive phone calls. Person is totally able.

**Status #2:** Person needs some assistance. Specify degree of assistance required:

- Able to use the phone as needed, but needs some help to get to the phone.
- Able to use phone with assistance and/or supervision (look up numbers, dialing).

**Status #3:** Unable to use phone. Person needs maximum assistance.

**Status #4:** Does not perform the activity due to unwillingness.

**Are changes in IADL functional capacity expected in the next 6 months?**

Self-explanatory.

## **VIII: ACTIVITIES OF DAILY LIVING (ADLS)**

Use the following qualifiers in answering each ADL question:

**Time period: Past four weeks.**

**Frequency:** Assess how the person completed each ADL, with or without an adaptive/assistive device, 60% or more of time it was performed (ADL status may fluctuate during the day or over the past four weeks).

**Changed Condition Rule: When a person's capacity to perform ADLs has improved or deteriorated during the past four weeks and this course is unlikely to change, measure the ADL according to its status during the past seven days.**

**Changes in Functional Capacity:** Consider whether the degree to which the person can no longer do the activity is a temporary condition or whether it is longer term. For example, a person might need total assistance with bathing because he/she is recovering from an operation or broken limb, but the level of assistance may diminish as the person recovers. Indicate whether the current situation is temporary and, if so, how much the person can be trained to perform the ADL, or the person will improve. Indicate if the person's functional capacity is expected to decline over time. The goal is to allow the person to be as independent as possible.

**Is Need Met:** At the time of the assessment are the needs for these activities being met?

**Activity Status: What Can the Person Do?** The ADLs are those basic functions that people must be able to do to take care of themselves on a daily basis. For each ADL question, four functional levels are provided to choose from. Select the most accurate level and enter its number to the right of the ADL in the box provided.

**Check if Assistance Is/Will be Provided by Informal and/or Formal Supports:** If the person is not able to complete any specific activity alone, carefully consider whether the help that is required can be that of a family member or friend (Informal Supports) and/or needs to be that of a professional or a service from an agency (Formal Services). A formal service might only be necessary at the beginning to train either the person or the informal caregiver or it might be needed on an ongoing basis to monitor or deliver the care. Check either or both boxes for the source of assistance to the person, as applicable.

Assess carefully if the care can be done by an informal caregiver rather than a formal service. However, if the person has no informal supports or if the informal supports cannot supply all the assistance needed, specify the help required from formal services. State the name of the informal caregiver and the specific days/hours the person is required. If a formal service or professional is required, be sure to state the specific reason, i.e., "to train the person," "to monitor the activity," and/or "to perform the task," and indicate the specific hours needed.

**Comments:** Describe any specific limitations or needs there might be for each activity, parts of tasks to be done and responsibilities of informal and formal services and/or any other factor important for developing and/or implementing the Care Plan. You may organize the comments in any way that is convenient and clear for you and your supervisors. You may enter information on a task-by-task basis or you may enter information on a group of tasks together.

**General Definitions:**

- A. Intermittent:** A caregiver (informal or formal) does not have to be present during the entire activity.
- B. Supervision:** Verbal encouragement and observation, not physical hands-on care, is needed by the person.
- C. Assistance:** Physical hands-on care is needed by the person.
- D. Continual:** One to one care is needed by the person; if a provider is not present the person will not complete the activity.

## Definitions of Activities

- A. Bathing:** To wash the body or body parts, whether tub, shower, or basin, including getting to the bath, obtaining the bath water, and getting into the tub or shower.

**Status #1:** Requires no human supervision or support. May use adaptive equipment.

**Status #2:** Requires intermittent checking and observing. May require assistance for minor parts of the task, such as transferring in and out of the bath and bathing back and feet.

**Status #3:** Requires continual help (supervision or physical assistance) with most parts of bathing.

**Status #4:** Person does not participate. Person is bathed in bath, shower or bed by another.

- B. Personal Hygiene:** Grooming, including combing hair, washing face, shaving and brushing teeth.

**Status #1:** Responsible for self, and receives no human supervision or assistance with personal grooming.

**Status #2:** Requires intermittent verbal cuing or observation, and/or requires assistance with difficult parts of grooming.

**Status #3:** Requires continual help (supervision and/or physical assistance) with most or all of personal grooming.

**Status #4:** Person does not participate; another person performs all aspects of personal hygiene.

- C. Dressing:** Putting on, fastening and taking off all items of clothing (including braces or artificial limbs worn daily) and obtaining and replacing these items in their usual storage places.

**Status #1:** Needs no human supervision or physical assistance.

**Status #2:** May need intermittent supervision (verbal encouragement and/or minimal physical assistance) for the proper arrangement and retrieval of clothing.

**Status #3:** Requires continual help (encouragement, teaching, and/or physical assistance) with difficult parts of dressing.

**Status #4:** Specify degree of assistance required:

- Has to be completely dressed by another: person does not participate.
- Bed gown is generally worn due to condition of person.

**D. Mobility:** How the person moves about from place to place with adaptive equipment, wheelchair, or by self.

**Status #1:** Walks with no supervision or human assistance. May require mechanical device (for example, a walker) but not a wheelchair.

**Status #2:** Walks with intermittent supervision (that is, verbal cuing and observation.) May require human assistance for difficult parts of walking (for example, negotiating stairs or ramps.)

**Status #3:** Walks with constant one-to-one supervision and/or constant physical assistance.

**Status #4:** Specify degree of assistance required:

- Wheels with no supervision or assistance, except for difficult maneuvers (for example, using elevator or wheeling over ramps.) May actually be able to walk, but generally does not move.
- Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

**E. Transfer:** Moving between the bed and chair, getting in and out of bed or a chair or wheelchair.

**Status #1:** Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings or a trapeze.

**Status #2:** Requires intermittent supervision (that is, verbal cuing/guidance) and/or physical assistance for difficult maneuvers only.

**Status #3:** Requires one person to provide constant guidance, steadiness and/or physical assistance. Person participates in transfer.

**Status #4:** Specify degree of assistance required:

- Requires lifting equipment and at least one person to provide constant supervision and/or physically lift.
- Cannot transfer and is not taken out of bed.

**F. Toileting:** Getting to and from the toilet, transferring on and off the toilet (commode, bedpan), cleaning self after elimination, adjusting clothing, and continence.

**Status #1:** Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

**Status #2:** Requires intermittent supervision for safety or encouragement, or minor physical assistance (for example, clothes adjustment or washing hands.)

**Status #3:** Requires constant supervision and/or physical assistance with major/all parts of task, including appliances (for example, colostomy, ileostomy, or urinary catheter.) Continent of bowel and bladder.

**Status #4:** Incontinent of bowel and/or bladder, whether or not taken to a toilet. (Incontinent: 60% or more of the time the person loses control of his/her bowel or bladder functions with or without equipment.)

**G. Eating:** Getting food by any means from the receptacle (plate, cup, etc.) into the body and to swallow the food served.

**Status #1:** Feeds self without supervision or physical assistance. May use adaptive equipment.

**Status #2:** Requires intermittent supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread, or opening milk carton.

**Status #3:** Requires continual help (encouragement, teaching, physical assistance) with eating or meal will not be completed.

**Status #4:** Specify degree of assistance required:

- Totally fed by hand. Person does not manually participate.
- Tube or parenteral feeding for primary intake of food, not just for supplemental nourishments.

**Are Changes in ADL Functional Capacity Expected in the Next 6 Months?**  
Self-explanatory.

## IX. SERVICES CLIENT CURRENTLY IS RECEIVING

Check all formal services currently being provided. Indicate provider name, address, telephone number and contact person. Exclude assistance provided by informal caregivers as this information is recorded elsewhere.

## X. INFORMAL SUPPORT STATUS

Unless otherwise stated, the questions in this section apply to the entire informal support system. Several questions in this section assess the capacity and needs of the informal caregivers. When possible they should be directed to both the informal caregiver(s) and the person during the assessment interview(s). When this is not possible, the question(s) should be directed to the person and the responses recorded. The assessor should contact the informal caregiver(s) directly, but only after receiving the person's permission to do so, to verify the information and get additional information as may be necessary. If permission is denied by the person, then contact should not be made with the informal caregivers that have been identified.

Space has been provided to record information for two (primary and secondary) informal caregivers if appropriate.

**A. Does the Person Have Family, Friends and/or Neighbors That Could Help with Care?** Check yes or no as appropriate.

*If no informal supports are present, skip to question D. Of this section.*

**1&2 Primary and Secondary Informal Supports:** Identify those who provide care for the person. Include their name, address, relationship to the person, email addresses and telephone number(s). Under "involvement", include the specific types of assistance and tasks, and specify the times they are done.

For each informal support noted, check the following questions.

- a. **Does the Person Appear to Have a Good Relationship with This Person?** Check yes or no as appropriate. Clarify the response in the space provided. Do not "lead" the person to a particular answer; however, it may be necessary to help the person describe the relationship by asking probing questions or giving examples. ***For example: you might ask questions like -- How are things between you and your daughter? When you speak to your daughter what are the kinds of things you talk about -- Does she talk things over with you?***
- b. **Would the Person Accept Help or More Help from this Person to Stay at Home and/or Maintain Independence?** Check the appropriate answer based on the information provided. Ascertain

from the person to what extent she/he is willing to accept help from informal supports. It may help to provide examples. Listen to what is said as well as how things are said. Assessor observations and comments should be carefully noted as such and distinguished from what the person says. Explain in the space provided.

- c. **Are There Any Factors that May Limit this Person's Involvement?** Check all of the appropriate answers based on the information provided. Ask this question in a neutral and understanding manner. ***For example: Are there other things that take a lot of your daughter's attention, or that make it hard for her to see you more often?***
- d. **Would this person be considered to be a caregiver?** A caregiver is a traditional or non-traditional family member, friend or neighbor who is helping another person they are concerned about with the everyday tasks of living. The caregiver and care receiver may live together, near each other or far away from one another.
- e. Is Caregiver **respite** needed? Check Yes or No. If yes, check all that apply.
- f. **If respite is needed select from the list of possible non-institutional respite services, the ones that could be provided to the client that will provide respite to the caregiver.**
- g. **Ask if the caregiver would like information about other caregiver services.**

**B. Can Other Informal Supports Provide Temporary Care to Relieve the Caregiver(s)?** Check yes or no as appropriate. If yes, include the detail in the space provided to explain who might be available, when they might be available and what they may be able to do. Before considering the options available in the formal system, review the capacity of the person's family, friends and neighbors to determine their potential for providing a break to the primary informal supports. ***Additional follow up with these other individuals may be necessary to further explore their capacity.***

**C. Does the Person Have Any Community/Neighborhood/ Religious Affiliations that Could Provide Assistance?** Check yes or no as appropriate. If yes, provide the necessary detail in the space provided. Before exploring the options that are available in the formal system, seek out all low cost/no cost options for addressing the person's needs. Since various organizations sometimes provide community services, explore what might be available in the community.

## XI. MONTHLY INCOME

The information requested in this section pertains to the monthly income of the person being assessed, their spouse and includes other family/household income. This information will help the assessor in determining the person's appropriateness for benefit and entitlement programs, such as those found in the next section. A person is under no obligation to disclose income information. However, if during care planning, EISEP or CSE EISEP-like services are identified as needed services, the person who refuses to disclose financial information will be required to pay the full cost of services in order to receive these services.

- A. Monthly Income:** Determine the monthly amount received from each source of income for the individual being assessed, their spouse, and other family/household members. Use the net income, after expenses incurred in producing the income, --- as well as after federal, state and local income taxes --- have been deducted. Net income cannot be less than \$0.00. Be sure to use the most up-to-date income information that is available. In the last column enter the total family/household income. This amount is used to determine poverty status.
1. **Social Security (net):** The person's monthly income from Social Security. Enter the net amount, which is the amount after the Medicare Part B premium has been deducted.
  2. **Supplemental Security Income: (SSI)** The person's amount of SSI received each month. If the person receives SSI, he/she is automatically Medicaid certified. If the person has not received a Medicaid card, contact LDSS. If the person receiving SSI needs Personal Care, refer him/her to the Local Department of Social Services (LDSS) for Personal Care.
  3. **Pension/Retirement Income:** The amount of the person's pension/retirement benefit each month. The sources may be from private/government pensions, veteran's benefits, annuities, IRAs, etc.
  4. **Interest:** The amount of interest the person regularly receives each month from monies held in accounts such as savings, checking, Certificates of Deposit, etc.
  5. **Dividends:** The amount of money received each month from stocks, bonds, and other sources.
  6. **Salary/Wages:** The monthly income the person derives from employment.
  7. **Other:**

Other income must include any:

- net income from farm and non-farm self employment,
- net income from buying and selling real or personal property which produces income, i.e., capital gains,
- net income from roomers, boarders, or from the rental of property, and
- all other regular sources of income not listed or explicitly excluded below.

***Do not include income from the following sources:***

- German War Reparations (or reparations from any country)
- Earned income from wages, salary, or stipends received under:
  - Title V
  - JTPA
  - Foster Grandparents
  - Other programs established to foster employment of lower income elderly, such as the Green Thumb Employment Program;
- Unearned income from:
  - One time lump sum payments such as insurance benefits (however, interest or other regular income subsequently received from one-time lump sum payment will be counted as income)
  - Occasional gifts, IT-214, Property Tax Credit/Rebate; and
  - Income from home equity conversion plans, i.e., "Reverse Mortgages" (funds received from such plans are debts that must be paid in future).

Do not use the value of goods, services or benefits received in-kind when you calculate monthly income. The value of Food Stamps, HEAP benefits and all other goods, services or benefits received in-kind are not considered income.

**B. Number of people in household. Used with total family/household income to determine poverty status.**

**C. Is client a veteran? Used in determining other services which may be available.**

**D. Person will provide no financial information.**

Check the box if person will not provide any financial information. Describe why.

Please continue on to XII. Benefits/Entitlements. Even though the person has refused to provide income information, he/she may be willing to provide other information regarding benefits and entitlements.

***Note: Additional information is required from persons who will be receiving EISEP services or CSE-funded EISEP-like services. To gather this information, use the EISEP "Financial Information & Client Agreement" form, or a locally developed form that includes all of the required information.***

## **XII. BENEFITS AND ENTITLEMENTS**

Information obtained in this section will assist the assessor in determining if a person is currently receiving any one of a variety of benefit/entitlement programs. For each of the benefits listed, ascertain and record A, B, C or D under the Benefit Status Code column using the following:

- A. Has the benefit/entitlement;**
- B. Does not have the benefit/entitlement;**
- C. May be eligible and is willing to pursue the benefit/ entitlement; or**
- D. Refuses to provide information.**

***Also assess whether the person needs information and/or counseling on benefits and entitlement programs.***

As you go through the list, it is important to determine if the person was in receipt of a benefit in the past and is no longer in receipt. For example, the person received HEAP benefits in the past, but now the person no longer is receiving HEAP, the assessor can ascertain the reason and may be instrumental in assisting this person to receive the benefit again.

### **Entitlements and Benefit Categories**

#### **Income Related Benefits**

**Social Security (SS):** Self Explanatory

**Supplemental Security Income (SSI):** A federal program that pays monthly checks to people in need who are 65 years of age or older and to people in need at any age who are blind and disabled. The purpose of the program is to provide

sufficient resources so that anyone who is blind or disabled can have a basic monthly income. Eligibility is based on income and assets. A person in receipt of SSI is categorically eligible for Medicaid and should have a Medicaid card.

**Railroad Retirement:** Persons who worked for a railroad company are entitled to the benefits at retirement (includes Medicare).

**Social Security Disability (SSD):** A worker who is permanently disabled or has a disability that is expected to last one year or longer may be entitled to the payment of monthly Social Security Disability Insurance benefits if they are covered under Social Security guidelines.

**Veteran Benefits:** The person may be eligible for veteran benefits if any of the following conditions exist: the person is a veteran, the person's spouse is/was a veteran, or the person has a deceased child who was a veteran. If any of these criteria are met and the person does not have the benefit, refer the person to the veteran's service agency serving the locality.

**Other:** Specify.

### **Entitlements**

**Medicaid Number:** Specify the person's Medicaid number. Medicaid is a government assistance program which pays for a comprehensive range of medical services for persons with low income and assets. There are a number of community based services that a Medicaid eligible individual can receive, such as in-home personal care, Personal Emergency Response Systems (PERS) and transportation, administered by the local Department of Social Services. For persons requiring nursing home care, a separate Medicaid application must be pursued to ensure coverage of the person's nursing home bills. This must be pursued irrespective of the person's current eligibility for "community" Medicaid.

**Food Stamps:** Coupons that are issued monthly which may be used at any participating store or supermarket to purchase food. Elderly participants may also be qualified to use their food stamps at USDA-approved restaurants. Food stamp eligibility is based upon the person's income and assets.

**Public Assistance:** A cash benefit that is furnished to individuals or families to provide for essential shelter, food and clothing needs. Public Assistance is divided into two categories, Aid to Families with Dependant Children (AFDC) and Home Relief (HR). Public Assistance (PA) recipients receive semi-monthly cash grants based on financial need, living arrangement and household size. All PA recipients automatically receive Medicaid and most receive Food Stamps.

**Other:** Specify.

## **Health Related Benefits**

**Medicare Number:** Specify the person's Medicare number. Medicare is the federal health insurance program for people 65 or older and certain disabled people. Medicare has two parts. Part A, known as Hospital Insurance, covers hospital, skilled nursing facility, home health and hospice care. Part A has deductibles and coinsurance. Part B, known as Medical Insurance, primarily covers doctor's fees, most outpatient hospital services, durable medical equipment and a number of other medical services and supplies that are not covered by Part A. There is a monthly premium for Part B coverage, which is automatically deducted from the person's Social Security check. Part B also has an annual deductible and coinsurance amounts.

**Qualified Medicare Beneficiary (QMB):** A federal program requiring states to pay the Medicare premiums, deductibles and co-payments for Medicare beneficiaries who qualify based on income and resources.

**Specified Low Income Medicare Beneficiary (SLMB):** A program that pays a person's Medicare Part B premiums. This program is based on income and assets, however income can be somewhat higher than the income limit for the QMB described above.

**Elderly Pharmaceutical Insurance Coverage (EPIC):** A program that assists a person with paying for prescription costs. To be eligible, the person must be 65 years of age or older and meet certain financial criteria.

**Medigap Insurance/HMO:** Medigap insurance is designed to supplement Medicare's benefits by providing specific coverage that helps to fill the gaps in a person's Medicare coverage. There are ten standard medigap plans.

Medicare beneficiaries have a choice in how they may receive their Medicare benefits -- either through traditional, fee-for-service Medicare or through a Medicare managed care plan or HMO. One choice to fill Medicare gaps is enrollment in a Medicare managed care plan or HMO. A Medicare HMO must provide all Medicare-covered services and benefits and most offer additional benefits such as preventive services, prescription coverage, dental care, hearing and or eyeglasses. The person must continue to pay the Medicare Part B premium, some plans charge an additional monthly premium. The HMO usually offers all regular Medicare benefits and may add extra benefits such as preventive care services and prescriptions.

If the person has the benefit, specify the Medigap insurance or HMO.

**Long Term Care Insurance:** A policy designed to help cover some of the costs associated with long-term care. Policies covering long term care services currently being sold in New York State are indemnity policies. They pay a specific dollar amount for each day you spend in a nursing facility or for each home health or home care visit. ***New York has established minimum standards for four***

***classifications of insurance policies: long term care insurance, nursing home and home care insurance, nursing home insurance only and home care insurance only. An additional form of LTC insurance is the NYS Partnership for Long Term Care.*** The Partnership program allows those persons who purchase a Partnership policy to qualify for Medicaid without spending down their assets once the benefits under the long term care policy are exhausted. One must contribute their income toward the cost of their care. If person has the benefit, specify the type of LTC insurance.

**Other Health Insurance:** Person has additional insurance that provides health coverage, such as an employer-sponsored retiree plan, hospital indemnity or specific disease insurance. If the person has the benefit, specify the type of other insurance.

### **Housing Related Benefits**

**Senior Citizen Rent Increase Exemption (SCRIE):** Tenants aged 62 and over who live in rent controlled or rent stabilized apartments ***in New York City and in several municipalities in Nassau and Westchester Counties*** may qualify for an exemption to rental incomes if their incomes and proportion of their incomes spent on rent meet eligibility guidelines.

**Section 8:** Federal rental vouchers and rent certificates to provide financial assistance for very low income elderly and families in rental housing, enabling those residents to pay no more than 30% of their incomes on rent.

**IT 214:** Also known as the Circuit Breaker Program, provides income tax credits or rebates to older homeowners and renters who are paying a disproportionate amount on housing expenses in relation to their household income. A person may qualify for a rebate even if he pays no income tax.

**Veteran Tax Exemption:** A reduction in property taxes may be available to the veteran or spouse of a veteran. Since there are various options under the Veteran's Tax Exemption, refer the person to the Veteran's Service Agency serving the locality.

**Reverse Mortgage:** Community banks and financial lenders offer various financial options which allow an older homeowner to use the equity he/she has built up in his/her home as additional sources of regular income. These loans may specify a specific pay-back date for the principal and interest, but most are repayable upon the death of the homeowner or sale of the home.

**Real Property Tax Exemption:** New York State allows up to 50% exemption in local real property taxes for older homeowners, with each locality allowed to set its own maximum income eligibility standard.

**Home Energy Assistance Program (HEAP):** A federally funded program to provide financial assistance to low income persons 60 years of age or older to help pay heating bills.

**Weatherization Referral and Packaging Program (WRAP):** This program uses special energy case management to provide safe, affordable, energy efficient housing to low income, vulnerable elderly.

**Other:** Specify.

### XIII. CARE PLAN

The Care Plan section aggregates the key information from the rest of this assessment instrument. Through the assessment process, the assessor has identified (1) the person's situation: home environment; health; nutritional status; mental health; functional ability; (2) the person's needs including needs for referrals; and (3) implications for the involvement of formal and informal caregivers to be defined and described in the Care Plan. The Care Plan section of the assessment should be used to bring all the assessment information together and to develop and implement a coordinated plan of care.

While the Care Plan is developed to reflect the person's current situation, the individual developing the Care Plan needs to be sensitive to person's evolving situation. This means that, where indicated, the person developing the Care Plan should note areas to be watchful for because of an unstable or a potentially changing situation (e.g., potential change in caregiver situation, or change in service requirements due to level of need).

The Care Plan should be developed when the assessor completes the assessment. A delay increases the likelihood of changes in the person's condition, resulting in the need to conduct a reassessment. ***If the care plan includes EISEP-funded services or CSE-funded EISEP-like services, it is necessary to complete a Financial Information and Client Agreement or equivalent form.***

Assessors should not be limited to brokering or authorizing existing services. The assessor should strive to challenge the paid formal service system to be more flexible and to accommodate consumer values and preferences, to expand the range of service options available, and to cover new and/or traditional services.

To implement the Care Plan, the assessor should build on the strengths of the person, be familiar with current community resources, be able to maximize informal supports, be knowledgeable about financing of services, and understand cost arrangements to obtain services.

## COMPLETE ALL ITEMS

**Date:** Enter the date the Care Plan was completed using two digits each for month, day and four for the year. For example, March 12, 2013 would be entered as 03/12/2013.

**Prepared by:** Self-explanatory.

**Person's Name:** Self-explanatory.

**Person's Phone:** Self-explanatory.

**Address:** Specify the address, where services will be provided.

### A. Is the person self-directing/able to direct care?

Check yes or no. Determine the person's capacity to make choices about his/her care and ability to understand the impact of those choices. In addition, determine if the person understands the tasks required for his or her care and whether he/she can supervise the staff who will perform the tasks. If the person is not able to direct home care staff, specify who will provide direction.

### B. Problems to be Addressed, Goals, Care Plan Objectives, Proposed Time Frame:

**Problem(s) to be Addressed:** List the problems identified during the assessment that will be addressed in the care plan through the authorization/arrangement of service(s).

**Goal(s):** The assessor, in consultation with the person and, with the consent of the person, his/her informal caregivers, should prepare goal statements for each problem/need identified through the assessment process that will be addressed. Specify goals only for problems for which some type of service or care is indicated. Do not list activities that the person can do alone or for which the person has compensated and requires no additional intervention. (**See example, below.**)

Goal statements should be concise and specific. Whenever possible, they should be stated in functional terms that are observable or measurable so that the person, informal caregiver(s) and assessor can tell whether the person has reached goals and related objectives.

For each goal, it will become possible to identify desired outcomes that the person, informal caregiver, and assessor expect will result from the service intervention. At the point when a service or the care plan is being terminated, it will be possible to compare the stated goal(s) to client outcomes to determine if the goal(s) have been reached.

**Care Plan Objectives:** The objective(s) are steps toward reaching a stated goal. Objectives should be concise and specific. (**See example, below.**)

**Proposed Time Frame:** For all goal statements, a reasonable time frame/limit for achievement of the goal should be specified. This applies to persons where the goal relates to maintenance of function, intervention to help with person's declining ability, as well as goals for improvement. (**See example, below.**)

An example of client problems, goals, objectives and proposed time frames follows. In this example, the client is expected to improve with the service intervention in terms of ability to manage at home, and maintain this status over time:

**Example:** Problems: Person has difficulty preparing food, and with bathing and dressing due to arthritis limiting use of hands.

<p><b>Goals:</b> <u>Nutrition</u> - Stable nutritional status.  <u>Bathing</u> - Self-manage bathing with caregiver assistance.  <u>Dressing</u> - Independent dressing with fastening assistance from caregiver.</p>	
<p><u>1. Objectives:</u></p> <p>(1) Train person in content of modified diet so can select appropriate groceries and plan menus.</p> <p>(2) Supply utensils so person can prepare nutritious meals at home.</p> <p>(3) Supplement with home delivered meals.</p>	<p>Proposed time frame:</p> <p>(1) 12 weeks</p> <p>(2) 4 weeks</p> <p>(3) on-going</p>
<p><u>2. Objective:</u> Bathing: Have home care worker sponge bathe client and teach client and caregiver how to do properly.</p>	<p>Proposed time frame:</p> <p>3 weeks</p>
<p><u>3. Objectives:</u> Dressing:</p> <p>(1) Develop skills of client and informal caregiver to help the client with dressing.</p> <p>(2) Discuss with person availability of clothing that she can manage.</p>	<p>Proposed time frame:</p> <p>(1) 12 weeks</p> <p>(2) 2 Weeks</p>

**PLEASE NOTE THE FOLLOWING:**

- Problems to be addressed can include inability to perform IADL or ADL tasks, psycho-behavioral condition of the person, or the person's treatment of caregivers; anything, that is, that affects the development and implementation of a plan of care for the person.
- State problems in functional terms, e.g., "cannot do . . .," "has difficulty with
- Provide the reason for each problem. These statements are important because they can imply root cause or different service requirements. For example, "cannot cook" might be due to blindness, or because the person lacks a stove or does not know how to cook.
- Group together all problems that are similar or have the same root cause or reason, and might be met by the same service. ***For example, the person cannot do household chores and shopping because he or she is blind; person cannot do bathing, dressing, toileting due to limited mobility caused by a broken hip. Be specific and brief.***

Goal statements are different from the list of services to be provided.

**C. What are the person's preferences regarding the provision of services?**

Unless there are very unusual circumstances, the person and, with the person's consent, his/her informal caregiver(s) should always be present and involved in the development of the Care Plan. To the extent possible within the context of payer requirements, the Care Plan should reflect the choices, values and preferences of the person and his/her informal caregiver(s). This would include timing and frequency of services delivered, how services are to be delivered, how instructions to the care provider will be handled, and preferences concerning cultural beliefs and language.

- D. Types of Services to be provided:** The Care Plan should list the specific types of help the person needs to reach specified goals. Enter any service to be provided, whether it is a paid formal service or services provided by informal caregivers. Enter services by service name (i.e., case management, housekeeping/chore, homemaking/personal care, home delivered meals, social adult day care, etc.). When both a paid formal provider and an informal caregiver will provide the same type of service (e.g., personal care), list that service twice. You should specify tasks the informal and/or formal provider(s) are to do, for all services the person will be receiving, regardless of payer. The types of formal providers vary somewhat according to the county in which the person lives, but can include the Medicaid Personal Care Program, Public Health Nursing, Social Adult Day Care Program, Home Delivered Meals, Counseling Services, Friendly Visitor Program, Telephone Reassurance, and/or other formal services available in the county.

**How Much:** How many days per week and how many hours per day/week.

**When:** The specific days of the week when services are to be provided i.e. Monday AM, Wednesday PM at 1:00, etc.

**Frequency:** Enter the appropriate frequency for the delivery of the service (i.e. daily, every week, every other week, once a month, etc.). Specify "one time only" if the service is provided once (for example, an EISEP ancillary service, or weatherization).

**Start Date** for the service. Enter as ten digits, e.g., 05-09-1997. For ancillary services, enter purchase date or project starting date, as appropriate. This date may be left blank if the person is placed on a waiting list for a service.

**Projected End Date** (if known). Enter as ten digits, e.g., 08-09-1997. This date may be left blank if no projection of service duration can be made at the time of completion of the Care Plan.

**Formal/Informal:** Specify if the care will be provided by a formal service provider or through an informal caregiver such as family, friends, neighbors, and/or community/neighborhood group.

**Name of the Provider** who will be providing services.

- E. Problems to be Referred** to other programs: List other problems indicated in the assessment that are to be addressed by other agencies or programs. Services to which the person is to be referred must be considered in the development and implementation of the Care Plan. ***Please see the Appendix for INDICATORS FOR REFERRALS.***

Specify all services for which the person will be referred to address these assessed needs. Referrals may also be made to supplement services listed in D. above.

**Referred to:** Specify the name of the provider ( i.e. Public Health Agency, Adult Protective Services, etc.) who will be providing services.

- F. Information/Special Instructions That Have Direct Bearing on Implementation of This Care Plan:** Include any additional information/instructions that have direct bearing on implementation of the Care Plan. For example -- person has large dog that is not friendly to others.

- G. Has the person been placed on a waiting list for any service need?** Check yes or no. If yes, indicate the name of the service, provider name, and the date the person was placed on the waiting list. As much as

possible, the Care Plan should be carried out according to the timetable set forth in the Care Plan. If too long a delay occurs, a reassessment of the person may be necessary.

- H. Plan has been discussed and accepted by client and/or informal supports:** Check yes or no to indicate whether the person and/or informal supports accept the Care Plan. We expect that in most instances the person would be involved in these discussions and decisions, and the informal supports would be involved as appropriate and necessary. If not, explain why not.

***Please Note The Following:*** The person and his or her informal caregivers have the right to comment on the Care Plan. This includes commenting on the adequacy of the Care Plan; refusing services on any part of the Care Plan without fear of loss of other services, except if the person's safety becomes at-risk or if parts of the care plan are essential to meet program requirements. For example, case management is required to receive other EISEP-funded services.

If the Care Plan includes EISEP or CSE EISEP-like services, the assessor must complete the EISEP Cost Share Determination and Client Agreement or equivalent form. The person and his or her informal caregiver(s), as appropriate must be informed about cost-sharing responsibilities, if any.

The assessor must inform the person's informal caregiver(s) and service providers that will be involved in the person's care of relevant information from the assessment and Care Plan. At a minimum, this includes goals of care delivery, information about types of services to meet the person's needs and time frame. For some services, greater detail will be required.

Care providers, both formal and informal, should know which care providers will be participating in the person's care and the extent and timing of their help. The assessor should discuss and delineate the roles and responsibilities of the consumer in ensuring the success of the Care Plan.

The assessor should carefully discuss all reasonable care and residential housing options with the person and her/his informal caregiver(s). The assessor should discuss advantages and disadvantages of each including the risks associated with care and the costs and funding sources available. The assessor should leave the final decision to the person and, if appropriate, her/his informal caregiver(s).

- I. Plan Approved By:** If someone other than the assessor approves the Care Plan, enter name, signature and title of the person who approved the Care Plan. Enter the date the Care Plan was approved using two digits each for month and day and four for the year. For example, March 12, 2013 would be entered as 03/12/2013.

## APPENDIX

### A. INDICATORS FOR REFERRAL

**PLEASE NOTE THE FOLLOWING:** Indicators for Health Assessment and/or Mental Health Assessment Referral are gathered from Section III, Health Status and Section V, Psycho-Social Status.

#### BACKGROUND:

A person in need of non-medical support services may have an undiagnosed and/or untreated condition that requires attention. Or, a previously known condition may have worsened so that assessment and treatment may become necessary. The indicators for health or mental health referral discussed here identify certain observations that may suggest the need for a health or mental health professional's examination.

The indicators should be considered during any contact with the person: assessment, reassessment, home visits to assure quality of care, or in any other part of the ongoing case management process. Further, they can be used to inform any other individuals coming in contact with the person, including informal supports or formal caregivers.

#### PROCESS FOR IDENTIFYING INDICATORS:

1. **Observation:** Certain conditions may be identified by the case manager through observation. Use the following indicators list as a guide for things to look for. Looking closely at the person can disclose abnormalities; in general, what would look abnormal on the case manager is also abnormal when seen on an older person (e.g., swelling of an extremity or puffiness around the eyes).
2. **Ask about conditions and changes in conditions:** The case manager can ask in a general way for the person to identify any conditions or changes in conditions that the person thinks might be important for the case manager to know about. If observation shows a condition not mentioned by the person, further probing is appropriate. It is also appropriate to seek further information from other knowledgeable individuals.
3. **Discover if a physician or other health professional has diagnosed a condition.** Whether observed by the case manager or identified by the person in response to questions, ask if the condition has been diagnosed by a physician or other health professional. If the person states a condition in terms of a diagnosis or disease (i.e., "I have high blood pressure" or "I have congestive heart failure"), find out if the statement reflects a physician diagnosis.

If the person states that the condition has been diagnosed, the assessor may, if necessary to verify the diagnosis, seek confirmation from other knowledgeable persons: family members, informal supports, etc. Confirmation can help identify circumstances in which the diagnosis has not been made by a health professional, or provide more detail on duration and incidence than remembered by the person.

On a first assessment, the only source of information about changes in condition will come from the person, informal supports, family, etc.

4. **Ask about treatments ordered:** If the condition has been diagnosed by a physician or other health professional, ask if treatment has been ordered and determine if the treatment is being followed.

#### **REFERRAL IS NEEDED IF:**

- The condition has not been diagnosed;
- The condition has changed;
- Treatment has not been ordered; or
- The treatment is not being followed.

#### **REFERRAL ORDER:**

1. Usually, referral should be to the person's primary medical provider: personal physician or usual medical provider (clinic, HMO, etc.) if any.
2. Follow the instructions of the primary provider if referral to another health professional is indicated (e.g., a physical therapist if ordered by a physician).
3. When the person has no regular medical provider, referral will be to a local public health nursing service.

**Exception:** In the case of a psycho-behavioral indicator, referral may be directly to a mental health professional.

**Follow-up:** After referral, determine the results of the professional assessment and the effect on the care plan.

#### **INDICATORS:**

**General:** With some persons, there may be a tendency to minimize the importance of a condition, especially if long lasting. The important criteria are whether diagnosis and treatment have occurred, and if change has occurred from chronic to acute distress. Acute distress usually is suggested as the condition becomes the total object of the person's attention. Another useful guide is the swiftness of onset of a condition or change. A condition that has developed over the course of a few hours to a day is more likely to be serious.

The following lists contain indicators of need for referral if the condition exists and is not under treatment, or if change has occurred. The first three are noted as indicators of need for emergency treatment to prevent serious illness, injury or death. Other items may indicate need for emergency treatment, especially if change has been abrupt or distress is acute.

## **THE FOLLOWING ARE INDICATORS OF PHYSICAL CONDITIONS NEEDING REFERRAL:**

- Person appears to be sleeping comfortably but cannot be wakened: emergency;
- Frequent falls: if a fall is associated with severe pain or bruising, or obvious broken limb: emergency;
- Chest pain, chest pressure, pain radiating from chest down arms, or severe indigestion or vomiting: emergency;
- Swelling of a body part; report which part(s) is swollen;
- Poor skin color, especially on face or in limbs;
- Difficulty breathing, or easily winded whether with exertion or just in conversation;
- Strong odors of urine or feces;
- Frequent inebriation;
- Open sores, whether they appear infected or not, and especially if not healing promptly;
- Very dry, flaking skin;
- Frequent going to the bathroom, whether voiding urine or feces, not related to an acute condition;
- Frequent or unusual nausea, vomiting or dizziness;
- Frequent headaches;
- Several bruises, particularly if on extremities;
- Bleeding, from wound on body or into urine or feces.

## **THE FOLLOWING ARE INDICATORS OF PSYCHO-BEHAVIORAL CONDITIONS NEEDING MENTAL HEALTH REFERRAL:**

- Memory loss;
- Hallucinations.

## **THE FOLLOWING TWO LISTS ARE INDICATORS OF NEED FOR REFERRAL WHEN THERE ARE SIGNIFICANT CHANGES IN PHYSICAL OR PSYCHO-BEHAVIORAL CONDITION:**

### **CHANGE IN PHYSICAL CONDITIONS NEEDING REFERRAL:**

- Large **INVOLUNTARY** change in weight (more than 10 pounds in six months);
- Change in capacity to perform IADLs or ADLs if such change is not directly related to an obvious cause. For example, change in capacity due to an acute respiratory infection or after surgery would not count here;
- Loss of appetite, or other major change in appetite or dietary intake;
- Change in sleep pattern, whether to much more or much less than previous normal;
- Increase in thirst;
- Change in ability to communicate verbally (oral or writing);
- Change in strength or stamina;

- Change in awareness of or interest in surroundings;
- Change in sensory ability.

#### **CHANGE IN PSYCHO-BEHAVIORAL CONDITIONS NEEDING REFERRAL:**

- Change in social interactions, reducing previously maintained contacts;
- Change in personal behavior, as in mode of dressing, aggressiveness, or ability to make judgments not related to change in physical capacity.

#### **OTHER CONSIDERATIONS:**

**Follow up:** While the COMPASS does not record this, the assessor or other case manager will follow up on the referral(s). The assessor or case manager will have to decide whether the assessment for non-medical services must wait for a report from the referral before a care plan can be made and put into operation. In such cases, inform the person of the need for a report of the referral.

**Refusal to accept referral:** A person retains the right to refuse medical treatment, including assessment. If you decide that such choice may not reflect informed decision-making or subjects the person to imminent risk of serious harm, you should employ the usual procedures to refer the case to Protective Services for Adults of the local Department of Social Services.

If referral is refused, you may have to conclude that the information to be gained from the referral is necessary to decide that the person can be maintained safely at home. If you believe that the person can not be served safely at home you must make an appropriate referral, e.g., police department, fire department, Protective Services for Adults.

#### **B. Assistance With Questions Regarding Sexual Orientation and Transgender Status - Provided by Services & Advocacy for Gay, Lesbian Bisexual and Transgender Elders, (SAGE)**

Transgender - If the client is confused or put off by this, you can say something like this: I understand that this issue might be very clear for you, but some people have an experience of their gender that is unique to them, and that other people might not be able to see. I want to give all my clients the respect and freedom of defining themselves.

If a person seems confused by the wording of the question but is struggling because they may indeed identify as transgender but not with that term, you could clarify by saying: If a client needs help with this idea: For some people, their body is a male body but inside they feel like a woman. Or they have a female body, but inside, they feel like a man. Have you ever had feelings like that?

If the client says they are transgender, say:

I'm glad you told me that.

What would you like me to call you?

What pronoun would you like me to use?

If the client identifies their gender or sexuality by using a word you're not familiar with; say OK, that's a new word for me. But I want to support you and I want to understand you, so, what does that mean to you? Is that a word that would be appropriate for me to use too, or is that a word that only someone who sees themselves as [genderqueer] would use?

Sexual Orientation – These questions, along with all the other questions you are being asked, are designed for us to get to know you better so that we can offer you the best care possible. It is important for us to understand your needs and the services we may be able to provide for you.

Emphasize that a client's sexual orientation or gender identity will not be discussed with his/her family or friends without the client's specific permission.

If a client does not understand what some of the terms may mean, consider the following definitions:

Heterosexual or straight: Used to describe people whose primary physical, romantic, and/or emotional attraction is to people of the opposite sex.

Lesbian: A woman whose primary physical, romantic, and or/emotional attraction is to other women. Some lesbians may prefer to identify as gay (adj.) or as gay women.

Gay: A word used to describe anyone, mainly men, who have primary physical, romantic, and/or emotional attraction to someone of the same sex, e.g., gay man, gay people. Many gay people prefer this term over "homosexual" which retains negative connotations.

Bisexual: An individual who is physically, romantically, and/or emotionally attracted to both men and women. "Bisexual" does not suggest having equal sexual experience with both men and women.

Not sure: If a client says "not sure," attempt to clarify if the person is unsure of their own sexual orientation (perhaps because they are questioning it themselves) or if they are unclear of what the question means. If the latter, attempt to clarify the question and answers. If the former, consider making a note in the client's chart so as to consider this when developing the care plan.

Did not answer: If a client does not answer because they feel the question is intrusive, attempt to remind the person of the level of confidentiality they can expect, as well as why all of the questions are being asked. If the person still does not want to answer, do not force them to give you this information and check this box instead.

Other: There may be other categories that a person considers, such as "asexual." If the category the person suggests is not one of the options, "other" is the appropriate box to check.

## SERVICE/CARE PLAN TERMINATION

***This section is completed only when service(s) that the client is currently receiving is/are being discontinued or the Care Plan is being terminated.*** Its purpose is to document when and why Service(s) or the Care Plan is/are being discontinued and to identify the outcome(s) from the service(s) provided.

- A. What is being terminated?** Check service when service(s) will no longer be provided. **Note that this does not apply to a change in the amount or frequency of a particular service.** Specify which service(s) will be discontinued.

Check Care Plan if all services the client currently is receiving are being discontinued.

- B. Termination Date:** Enter the date that the service(s) or Care Plan is/are being terminated using two digits for the month and day and four for the year. For example, June 19, 1998 would be entered as 06/10/1998.

- C. Reason for Termination:** Check the reason which best describes why the service(s) or care plan is/are being discontinued.

1. **Goal Met:** The Goal(s) listed in the Care Plan has/have been met and therefore service(s) is/are no longer needed. Specify which goal(s) has/have been met as indicated in the Care Plan.
2. **Independence:** The client has regained enough capacity so that he/she no longer requires the service(s).
3. **Client Request:** The client asks that the service(s) be discontinued.
4. **Client Relocated:** Self explanatory.
5. **Hospitalization:** Self explanatory.
6. **Nursing Home or Assisted Living Facility Placement:** Self explanatory
7. **Death:** Self explanatory
8. **Other:** If service(s) is/are being discontinued for another reason, check and specify the reason. For example, when a service is being replaced by another, such as Home Delivered Meals being replaced by a home care worker who will prepare a meal.

- D. Service or Care Plan Related Client Outcome Statements:**  
Client outcome statements should be concise and specific showing whether the person has reached goals and related objectives for each problem addressed by the particular service or care plan as appropriate, in the targeted time

frame(s). For example, if problem was "difficulty with preparing food" (due to arthritis limiting use of hands), and a desired goal was "Stable Nutrition Status," state whether the service(s) helped the person reach this goal, and if not, explain why not, if appropriate.

- E. Plan Terminated By: *Complete this only when the care plan is being terminated.*** The person terminating the care plan must sign on the appropriate line. Enter the title of the person and his/her phone number. Enter the date using two digits for the month and day and four for the year. For example, July 20, 2013 would be entered as 07/20/2013.

## **COMPASS – Comprehensive Assessment for Aging Network Community-Based Long Term Care Services**

### **INTAKE INFORMATION**

A. Person's Name:

B. Address:

C. Phone #: H: \_\_\_\_\_ C: \_\_\_\_\_ E-mail: \_\_\_\_\_

D. Date of Referral:

E. Referral Source (*Specify Name, Agency and Phone*):

F. Presenting Problem/Person's Concern(s):

G. Does the person know that a referral has been made? [ ] Yes [ ] No if no why not?

H. Intake Workers Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

*The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.*

**NYSOFA 246 (04/14) CO M PASS - Comprehensive Assessment for Aging Network  
Community Based Long Term Care Services**

The client information contained in this assessment instrument is confidential and may be shared with others only as necessary to implement the client's care plan and comply with program requirements, including but not limited to monitoring, research and evaluation.

**CASE IDENTIFICATION**

Client Case  
Assessment Date: Assessor Name:  
  
Assessment Agency:  
  
Reason for COMPASS Completion:  
 Initial Assessment  
 Reassessment  
  
Next Assessment Date: \_\_\_\_\_

**CLIENT INFORMATION**

- A. Person's Name:
- B. Address (including zip code):
- C. E-mail:
- D. Telephone No.:
- E. Social Security No.:

F. Marital Status: (Check one)

- Married  Widowed  Domestic Partner or Significant Other  Divorced
- Separated  Single

G. Sex:

What was your sex at birth (on your original birth certificate)?

- Female  Male

H. Transgender - Gender Identity or Expression?

Some people describe themselves as transgender when they experience a different gender identity from their sex at birth. For example, a person, born into a male body, but who feels female or lives as a woman. Do you consider yourself to be transgender?

- No;
- Yes, transgender male to female;
- Yes, transgender female to male;
- Yes, transgender, do not identify as male or female.
- Did not answer.

I. Birth Date (mm/dd/yyyy): \_\_\_\_\_ Age: \_\_\_\_\_

J. Race/Ethnicity Check one

- American Indian/Native Alaskan  Asian  Black, Non-Hispanic
- Native Hawaiian/Other Pacific Islander  White (Alone) Hispanic  Other Race
- 2 or More Races  White, Not Hispanic  Hispanic

K. Sexual Orientation

- Do you think of yourself as:     Heterosexual or Straight     Homosexual or Gay  
 Lesbian     Bisexual     Not Sure  
 Did Not Answer     Other

- L. Creed:  Christianity  Islam  Hinduism  Buddhism  Judaism  Did Not Answer  
 Other

M. National Origin: \_\_\_\_\_

N. Primary Language (Check all that apply)

	English	Spanish	Chinese	Russian	Italian	French\ Haitian Creole	Korean	Other
Speaks	<input type="checkbox"/>							
Reads	<input type="checkbox"/>							
Understands orally	<input type="checkbox"/>							

- O. Client does not speak English as their primary language and has ONLY a limited ability to read, speak, write or understand English.  Yes     No

P. Living-Arrangement:

- Alone     With Spouse Only     With Spouse & others  
 With Relatives (excludes spouse)     With Non-Relative(s), Domestic Partner  
 Others Not listed

Q. During the last 6 months have you experienced any of the following forms of abuse?

- Physical Abuse     Active and Passive Neglect  
 Sexual Abuse     Self Neglect  
 Emotional Abuse     Domestic Violence  
 Financial Exploitation     Other (e.g. Abandonment)

Was this referred to:

- Adult Protective Services     AAA  
 Police Agency     Other \_\_\_\_\_  
 Domestic Violence Service Provider     Not Referred

R. Emergency Contact: \_\_\_\_\_

**Primary**

Name:  
Address:  
Relationship:  
Home Phone:  
Cell Phone:

**Secondary**

Name:  
Address:  
Relationship:  
Home Phone:  
Cell Phone:

- S. a. Is the client frail?     Yes     No
- b. Is the client disabled?  Yes     No

**II HOUSING STATUS**

A. Type of Housing:

- multi-unit housing     single family home     other

B. Person (check):     owns     rents     other Specify

C. Home Safety Checklist: (Check all that apply)

- Accumulated garbage
- Bad odors
- Carbon monoxide detectors not present/not working
- Doorway widths are inadequate
- Floors and stairways dirty and cluttered
- Loose scatter rugs present in one or more rooms
- No lights in the bathroom or in the hallway
- No handrails on the stairway
- No lamp or light switch within easy reach of the bed
- No locks on doors or not working
- No grab bar in tub or shower
- No rubber mats or non-slip decals in the tub or shower
- Smoke detectors not present/not working
- Stairs are not lit
- Stairways are not in good condition
- Telephone and appliance cords are strung across areas where people walk,
- Traffic lane from the bedroom to the bathroom is not clear of obstacles
- Other (specify)

D. Is neighborhood safety an issue?     Yes (If Yes, Describe)     No

Comments:

**III HEALTH STATUS**

A. Primary Physician: \_\_\_\_\_  
 Clinic/HMO: \_\_\_\_\_  
 Hospital: \_\_\_\_\_  
 Other: \_\_\_\_\_

B. Indicate date of last visit to primary medical provider: Month \_\_\_\_\_ Year \_\_\_\_\_

C. Does the person have a self-declared chronic illness and/or disability? (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> alcoholism                                   | <input type="checkbox"/> diarrhea             | <input type="checkbox"/> Parkinson's             |
| <input type="checkbox"/> Alzheimer's                                  | <input type="checkbox"/> digestive problems*  | <input type="checkbox"/> Pernicious anemia       |
| <input type="checkbox"/> anorexia                                     | <input type="checkbox"/> diverticulitis       | <input type="checkbox"/> renal disease           |
| <input type="checkbox"/> arthritis                                    | <input type="checkbox"/> fractures (recent)   | <input type="checkbox"/> respiratory problems    |
| <input type="checkbox"/> cancer                                       | <input type="checkbox"/> frequent falls       | <input type="checkbox"/> shingles                |
| <input type="checkbox"/> cellulitis                                   | <input type="checkbox"/> gall bladder disease | <input type="checkbox"/> smelling impairment     |
| <input type="checkbox"/> chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> hearing impairment   | <input type="checkbox"/> speech problems         |
| <input type="checkbox"/> chronic pain                                 | <input type="checkbox"/> heart disease        | <input type="checkbox"/> stroke                  |
| <input type="checkbox"/> colitis                                      | <input type="checkbox"/> hiatal hernia        | <input type="checkbox"/> swallowing difficulties |
| <input type="checkbox"/> colostomy                                    | <input type="checkbox"/> high blood pressure  | <input type="checkbox"/> taste impairment        |
| <input type="checkbox"/> congestive heart failure                     | <input type="checkbox"/> high cholesterol*    | <input type="checkbox"/> traumatic brain injury  |
| <input type="checkbox"/> constipation                                 | <input type="checkbox"/> hypoglycemia         | <input type="checkbox"/> tremors                 |
| <input type="checkbox"/> decubitus ulcers                             | <input type="checkbox"/> legally blind        | <input type="checkbox"/> ulcer                   |
| <input type="checkbox"/> dehydration                                  | <input type="checkbox"/> liver disease        | <input type="checkbox"/> urinary Tract infection |
| <input type="checkbox"/> dental problems*                             | <input type="checkbox"/> low blood pressure   | <input type="checkbox"/> visual impairment       |
| <input type="checkbox"/> developmental disabilities                   | <input type="checkbox"/> osteoporosis         | <input type="checkbox"/> other (Specify)         |
| <input type="checkbox"/> diabetes                                     | <input type="checkbox"/> oxygen dependent     | _____  |
| <input type="checkbox"/> dialysis                                     | <input type="checkbox"/> paralysis            |  |

\*May indicate need for assessment by nutritionist

D. Does the person have an assistive device?  Yes (If yes, check all that apply)  No

- |  |   |
|--|---|
| <input type="checkbox"/> Accessible vehicle  | <input type="checkbox"/> Hearing Aid                      |
| <input type="checkbox"/> Bed rail  | <input type="checkbox"/> Lift chair                       |
| <input type="checkbox"/> Cane  | <input type="checkbox"/> Scooter                          |
| <input type="checkbox"/> Denture: <input type="checkbox"/> Full <input type="checkbox"/> Partial | <input type="checkbox"/> Walker                           |
| <input type="checkbox"/> Glasses   | <input type="checkbox"/> Wheelchair\Transportable folding |

E. Does the person need an assistive device?  Yes  No (If yes, specify device)

F. Does the person and/or caregiver need training on the use of an assistive device?

Yes (If yes, describe training needs)  No

G. Has the person been hospitalized in the last 6 months?

Yes (If yes, describe the reason for the recent hospitalization) Month: Year:

No

H. Has the person been taken to the emergency room within the last 6 months?

Yes (If yes, describe the reason for the most recent ER visit) Month: Year:  No

I. Has a PRI and/or DMS-1 been completed in the past 6 months?

Yes (If Yes, describe the reason for, completion)  No

\_\_\_DMS-1 Score:

Completed by \_\_\_\_\_

(Name and Affiliation)

Date completed: Month: \_\_\_\_\_ Year: \_\_\_\_\_

\_\_\_PRI Score:

Completed by: \_\_\_\_\_

(Name and Affiliation)

Date completed: Month: \_\_\_\_\_ Year: \_\_\_\_\_

Comments:

J. Alcohol Screening Test - The CAGE Questionnaire

*Check all that apply*

Have you ever felt you should cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you ever felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

#### **IV. NUTRITION**

A. Person's height \_\_\_\_\_ Source: \_\_\_\_\_

B. Person's weight \_\_\_\_\_ Source: \_\_\_\_\_

C. Body Mass Index \_\_\_ calculated from height and weight as follows: weight in pounds x 703: Divide this number by height in Inches then divide by height in Inches again. Healthy older adults should have a BMI between 22 and 27. A BMI outside of this range may indicate the need for a referral to a dietitian.)

D. Are the person's refrigerator/freezer and cooking facilities adequate?  Yes  No (if no, describe

E. Is the person able to open containers/cartons and cut up food?  Yes  No if no, describe

F. Does the person have a physician prescribed modified therapeutic diet?

Yes (If yes, check all that apply)

Texture-Modified     Calorie Controlled Diet     Sodium Restricted

Fat Restricted     High Calorie     Renal

Other {Specify} \_\_\_\_\_

No (If No, Check all that apply)

Regular     Special Diet (Check all//that apply)

Ethnic/Religious (specify) \_\_\_\_\_  Vegetarian

G. Does the person have a physician-diagnosed food allergy?  Yes (If yes, describe)  No

H. Does the person use nutritional supplements?

Yes (If yes specify who described and the supplement)     No

I. Nutritional Risk Status

Check all that apply and circle the corresponding number at right

	Score
<input type="checkbox"/> Has an illness or conditions that made me change the kind and/or amount of food eat.	2
<input type="checkbox"/> Eats fewer than 2 meals per day.	3
<input type="checkbox"/> Eats few fruits or vegetables, or milk products.	2
<input type="checkbox"/> Has 3 or more drinks of beer, liquor, or wine almost every day.	2
<input type="checkbox"/> Has tooth or mouth problems that make it hard for me to eat.	2
<input type="checkbox"/> Does not always have enough money to buy the food I need.	4
<input type="checkbox"/> Eat alone most of the time.	1
<input type="checkbox"/> Take 3 or more different prescribed or over-the-counter drugs a day.	1
<input type="checkbox"/> Without wanting to, I lost or gained 10 or more pounds in the last 6 months.	2
<input type="checkbox"/> Not always physically able to shop, cook, and/or feed myself.	2

NSI Score: \_\_\_\_\_

A score of 6 or more indicates "High" nutrition risk. 3-5 Indicates "Moderate " nutrition risk, and 2 or less Indicates "Low" nutritional risk.

Conclusion: Based on the NSI score, this person is at check one:

High Risk     Moderate Risk     Low Risk

Comments:

**V. PSYCHO-SOCIAL STATUS**

A. Psycho-Social Condition

Does the person appear, demonstrate and/or report any of the following (check all that apply)?

- alert
- impaired decision making
- self-neglect
- cooperative
- lonely
- suicidal behavior
- dementia
- memory deficit
- worried or anxious
- depressed
- physical aggression
- other (specify)
- disruptive socially
- sleeping problems
- hallucinations
- suicidal thoughts
- hoarding
- verbal disruption

B. Evidence of substance abuse problems?  Yes (if yes describe)  No

C. Problem behavior reported?  Yes (if yes describe)  No

D. Diagnosed mental health problems?  Yes (if yes describe)  No

E. History of mental health treatment?  Yes (if yes describe)  No

F. Does it appear that a mental health evaluation is needed?

- Yes (If Yes, note Referral Plan In the Care Plan)  No

Comments:

**VI. PRESCRIBED**

A. MEDICATIONS.

Name	Dose/Frequency	Reason Taken

B. Primary Pharmacy Name Phone

C. Does the person have any problems taking medications?

D. Adverse reactions/allergies/sensitivities?  Yes, if Yes. Describe  No

E. Cost of medication  Yes, if Yes. Describe  No

F. Obtaining medications  Yes, if Yes. Describe  No

G. Other (Describe)

Comments :

**VII. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)  
STATUS/UNMET NEED**

**Activity Status:**      **1=Totally Able**  
*(Use for Sec. VII & VIII)*      **2=Requires intermittent supervision and/or minimal assistance.**  
                                  **3=Requires continual help with all or most of this task**  
                                  **4=Person does not participate; another person performs all aspects of this task.**

*Check if assistance is/will be provided by*

Activity: *What can person do?*      Enter Person's Activity Status

	Is Need Met*	Activity Status	Informal Supports	Formal Services	Comments: <i>Describe limitations, parts of tasks to be done and responsibilities of informal supports and formal Services.</i>
A. Housework/cleaning					
B. Shopping					
C. Laundry					
D. Use transportation					
E. Prepare & cook meals					
F. Handle Personal business/finances					
G. Use Telephone					
H. Self-admin of medications					

\*Is Need Met Currently (at time of Assessment)?

ARE CHANGES IN IADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS?  Yes *(If Yes, describe)*  No

**VIII. ACTIVITIES OF DAILY LIVING (ADLs)  
STATUS/UNMET NEED**

Activity: *What can person do?*    Enter Person's Activity Status    *Check if assistance is/will be provided by*

	Is Need Met*	Activity Status	Informal Supports	Formal Services	Comments <i>Describe limitations, parts of tasks to be done and responsibilities of informal supports and formal services.</i>
A. Bathing 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent checking and observing/minimal assistance at times 3. Requires continual help. 4. Person does not participate.					
B. Personal Hygiene 1. Requires no supervision or assistance 2. Requires intermittent supervision and/or minimal assistance. 3. Requires continual help with all or most of personal grooming. 4. Person does not participate; another person performs all aspects of personal hygiene					
C. Dressing 1. Needs no supervision or assistance. 2. Needs intermittent supervision/minimal assistance at times. 3. Requires continual help and/or physical assistance. 4. Person does not participate, is dressed by another, or bed gown is generally worn due to condition of person.					
D. Mobility 1. Walks with no supervision or assistance. May use adaptive equipment. 2. Walks with intermittent supervision. May require human assistance at times. 3. Walks with constant supervision and/or physical assistance. 4. Wheels with no supervision or assistance, except for difficult maneuvers, or is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.					
E. Transfer 1. Requires no supervision or assistance. May use adaptive equipment. 2. Requires intermittent supervision. May require human assistance at times. 3. Requires constant supervision and/or physical assistance. 4. Requires lifting equipment and at least one person to provide constant supervision and/or physically lift, or cannot and is not taken out of bed.					
F. Toileting 1. Requires no supervision or physical assistance. May require special equipment, such as raised toilet or grab bars. 2. Requires intermittent supervision and/or minimal assistance. 3. Continent of bowel and bladder. Requires constant supervision and/or physical assistance. 4. Incontinent of bowel and/or bladder.					
G. Eating 1. Requires no supervision or assistance. 2. Requires intermittent supervision and/or minimal physical assistance. 3. Requires continual help and/or physical assistance. 4. Person does not manually participate. Totally fed by hand, a tube or parental feeding for primary intake of food,					

\*Is Need Met Currently (at time of Assessment)?

ARE CHANGES IN ADL CAPACITY EXPECTED IN THE NEXT 6 MONTHS?  Yes (If Yes, describe)     No

**IX. SERVICES CLIENT CURRENTLY IS RECEIVING**

A. What formal service(s) does the person currently receive? *(Check all that apply)*

none utilized

Provider Information

adult day health care

assisted transportation

caregiver support

case management

community-based food program

consumer directed in-home services

congregate meals

equipment/supplies

friendly visitor/telephone reassurance

health promotion

health insurance counseling

home health aide

home delivered meals

hospice

housing assistance

legal services

mental health services

nutrition counseling

occupational therapy

outreach

personal care level 1

personal care level 2

personal emergency response system (PERS)

physical therapy

protective services

respite

respiratory therapy

senior center

senior companions

services for the blind

shopping

skilled nursing

social adult day care

speech therapy

transportation

other (specify)\_\_\_\_\_

**X. INFORMAL SUPPORT STATUS**

- A. Does the person have family, friends and/or neighbors who help or could help with care?  
 Yes  No (If No, skip to question C of this section)

## Primary Informal Support

1. Name:

Address:

Relationship:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

1. a. Does the consumer appear to have a good relationship with this informal support?  
 Yes  No (Explain)
1. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)  
 willing to accept help  unwilling to accept any help
1. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)  
 job  finances  family  responsibilities  physical burden  transportation  
 emotional burden  health problems  reliability  living distance
1. d. Would this informal support be considered the caregiver? (Definition of caregiver can be found on page 39 of the instructions.)  Yes  No
1. e. Does the caregiver identify the need for **respite**?  Yes  No  
 If yes, when?  Morning  Afternoon  
 Evening  Overnight  
 Weekend  Other
1. f. Which of these services could be provided as respite for the caregiver?  
 Adult Day Services  Personal Care Level 1  Personal Care Level 2  
 In Home Contact & Support (Paid Supervision)
- 1.g. Would the caregiver like to receive information about other caregiver services?  
 Yes  No

Secondary Informal Support:

2. Name:

Address:

Relationship:

Home Phone:

Work Phone:

Cell Phone:

E-mail:

Involvement: (Type of help/frequency)

2. a. Does the consumer appear to have a good relationship with this informal support?  Yes  
 No (Explain)

2. b. Would the consumer accept help, or more help, from this informal support in order to remain at home and/or maintain independence? (Check one)

willing to accept help       unwilling to accept any help

2. c. Are there any factors that might limit this informal support's involvement? (Check all that apply)

job  finances     family  responsibilities     physical burden     transportation

emotional burden  health problems  reliability  living distance

2. d. Would this informal support be considered the caregiver? (Definition of caregiver can be found on page 39 of the instructions.)  Yes  No

2. e. Does the caregiver identify the need for respite?  Yes  No

If yes, when?       Morning       Afternoon

Evening       Overnight

Weekend       Other

2. f. Which of these services could be provided as respite for the caregiver?

Adult Day Services  Personal Care Level 1  Personal Care Level 2

In Home Contact & Support (Paid Supervision)

2.g. Would the caregiver like to receive information about other caregiver services?

Yes  No

B. Can other Informal supports) provide temporary care to relieve the caregiver(s)?

Yes (if yes, describe)       No

C. Does the person have any community, neighborhood or religious affiliations that could provide assistance?  Yes (If Yes, describe who might be available, when they might be available and what they might be willing to do)

Comments:

**XI. MONTHLY INCOME**

A.

		Monthly Income			
		A. Individual Being Assessed	B. Person's Spouse	C. Other Family/ Household Income	D. Total Family/ Household Income
1.	Social Security (net)				
2.	Supplemental Security Income: (SSI)				
3.	Personal Retirement Income				
4.	Interest				
5.	Dividends				
6.	Salary/Wages				
7.	Other				
	Total:				

B. Number of people in household \_\_\_\_\_

C. Is client a veteran? \_\_\_\_\_

D.  Check if person will provide no financial information (Describe)

**XII. BENEFITS/ENTITLEMENTS**

<b>Benefit Status Code must be noted:</b>	A. Has the benefit/entitlement
	B. Does not have the benefit/entitlement
	C. May be eligible and is willing to pursue benefit/entitlement
	D. Refuses to provide Information

Benefit	Benefit Status Code	Comments
<b><i>Income Related Benefits</i></b>		
Social Security		
SSI*		
Railroad retirement		
SSD		
Veteran's Benefits (Specify)		
Other (Specify)		
<b><i>Entitlements</i></b>		
Medicaid Number		
Food Stamps (SNAP)		
Public Assistance		
Other (Specify)		
<b><i>Health Related Benefits</i></b>		
Medicare Number		
QMB		
SLIMB		
EPIC		
Medicare Part D		
Medigap Insurance/HMO (Specify)		
Long Term Care Insurance (Specify)		
Other Health Insurance (Specify)		
<b><i>Housing Related Benefits</i></b>		
SCRIE		
Section 8		
IT214		
Veteran Tax Exemption		
Reverse Mortgage		
Real Property Tax Exemption (STAR)		
HEAP		
Other		

\*Persons receiving SSI is categorically eligible for Medicaid and should have a Medicaid card.

**XIII. CARE PLAN**

Person's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Prepared by: \_\_\_\_\_

Person's Phone: \_\_\_\_\_

A. Is the person self-directing/able to direct care?  Yes  No *(If No, who will provide direction?)*

B. Problems to be addressed?	Goals	Care Plan Objectives	Proposed Time Frame

C. What are the person's preferences regarding provision of services?

D. Types of services to be provided	How Much? When? Frequency	Start Date	Projected End Date	Provided: Informal/ Formal	Provider

E. Problems to be referred	Referred to:	(Reminders - some possible referrals)
		Hospital, Nursing Home, Adult Home, Health Assessment, Long Term Care Home Health Care Program, Personal Care Program, Mental Health Assessment, Housing Assessment, Certified Home Health Agency, Licensed Home Care Services Agency, Protective Services for Adults, Other

F. Information/special Instructions that have direct bearing on Implementation of the care plan:

G. Has person been placed on waiting list for any service need?  Yes (If Yes List)  No

Service

Provider

Date Placed on List

H. Plan has been discussed and accepted by client and/or Informal supports?  Yes  No (If No, explain)

I. Plan approved by: \_\_\_\_\_ Date: / / Phone: \_\_\_\_\_

Signature and Title

**SERVICE/CARE PLAN TERMINATION**

A. What is being terminated? Services(s) Care Plan  
If Service, Specify which one(s)

B. Termination Date:

C. Reason for termination: (Check all that apply)

- None (Reason Unknown)
- Goal Met: (Specify) \_\_\_\_\_
- Client Request
- Client Moved
- Hospitalization
- Nursing Facility
- Assisting Living
- Death
- Other: (specify) \_\_\_\_\_

D. Service of Care Plan Related Client Outcome(s) Statements: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E. Terminated by: \_\_\_\_\_

\_\_\_\_\_  
Signature Title

\_\_\_\_\_  
Date: Work Phone: Cell Phone: E-mail

**Attachment K**  
**CAARS\Client\Verified\Plan Reports 2014**  
*(Reports available on NYSOFA Report Viewer are Underlined.)*

**Quarterly Units of Service Report (11)** – There is a one page report for each county and a one page statewide report. Reported units of service are compared to units of service projected in the AIP to determine if the units reported are a reasonable percent of those projected for the time period.

**Error Checks (30)** – Checks data by period for errors involving fiscal data (CAARS quarterly report).

**Title V Expenditure Report (31)** – A one page report listing all counties and showing Totals for Federal expenditures, Admin. Enrollee Wages and Other Costs.

**Summary of Expenditures (32A)** - Expenditure information by service and funding stream. There is a one page report for each county and a one page Statewide.

**Comparison of Expenditures and Revenues (32B)** - An individual three page report for each funding stream showing all counties.

**Summary of Expenditures (32C)** - Expenditure information by service and funding stream. There is a one page report for each county which provides percent of projected expended and a one page Statewide.

**EISEP Status Report (33)** – This three page report shows EISEP data for units, expenditures, persons served, etc.

**Quarterly Meal Units Report (35A)** – This is a two page report for congregate meals which compares two quarters and shows percent of change.

**Quarterly Meal Cost Report (35B)** – This two page report lists area agencies by size. Unit cost for Home Delivered Meals and Congregate meals are calculated by dividing the total expenditures by total units.

**QUARTERLY STATUS REPORT - Demographic Information (36A)** - This is a one page report for each county. A statewide report is also available. This report shows the total persons served by program and in total and includes projections and actual and counts for ethnic\racial characteristics.

**Quarterly Status Report (36B)** (Expenditure information page 2) Note: Expenditure information is generated from the grants database and is for the program quarter which is noted below the funding source.

**Units and Expenditures (39A)** – This one page report summarizes unit cost by funding stream for Transportation, Personal Care Level II, Personal Care Level I, Home Delivered Meals, Congregate Meals, Case Management and Adult Day Services. The report helps readers to determine if units of service reasonably are spread across funding streams.

**Quarterly Summary of Unit Costs (39B)** – This report is the same as above but shows data by funding source.

**Comparison of Costs Per Unit Budgeted vs. Reported (39C)** - Report compares AIP data to reported CAARS data and shows the percent of variance. Required action is also indicated.

**Budgeted vs. Actual Title V Expenditures (41)** – by quarter showing total for year and percent of actual budgeted.

**Title III-E Summary Report (42)** – Report provides information on Caregivers and the services they receive.

**Cost Per Service/Client (43)** - Report provides an overall picture of number of clients, units and expenditures for each service with an average cost per unit and client.

**Total Served Comparison Report (44)** – Allows user to compare multiple years.

**Estimated Allocations (61)** - Information is gathered for this report from the resource allocation pages of the plan (this information may be revised by budget mod or letter to ASR). This information is used on the CAARS 11, 33 and 36 reports to compare projected versus reported data.

**Reported and Actual Expenditures (81)** - Available after budget closeout and compares CAARS expenditures to voucher data showing details by county.

### **Verified Data Reports**

Two Year Client Count Comparison (36D) – this one page report shows number of people served for selected programs and services. The report uses verified data and allows users to make two year count comparison.

Two Year Service Data Comparison (36E) – this one page report have people, units, expenditures data for major aging network services. The report uses verified data and allows users to make two year count comparison.

Verified NSIP Congregate Meals (35A) - The report used verified congregate meals data, compares two quarters, shows percent of change between quarters, and yearend total.

Verified NSIP Home Delivered Meals (35A) - The report used verified home delivered meals data, compares two quarters, shows percent of change between quarters, and yearend total.

Verified Title III-E Summary (42) – Report uses IIIE verified counts, provides information on Caregivers and the services they receive.

Verified Cost Per Service/Client (43) - Report uses verified Client Unit counts, provides an overall picture of number of clients, units and expenditures for each service with an average cost per unit and client.

### **Client Data Reports**

**Client Unit Data Comparison Report** – (ClientDataVsVerifiedData) – Compares reported data for persons served and units provided with yearend AAA submitted verification. Allows users to see what is actually reported and compare it to the totals they have verified.

**NAPIS Data Review** – This report shows the total number of persons served by service. It also shows for the registered services the percent of data missing for selected required fields.

**Title IIIE Client Unit Comparison Report** – Compare IIIE reported data for persons served and units provided with AAA year end submitted verified data. Allow users to see what is actually reported and compare it to the numbers they have verified.

**Missing Caregiver Relationships** – **Title IIIE group 1 clients** are required to report Relationship data. Some clients have IIIE group 1 service records but do not have relationship record reported to us. This report is to identify IIIE group 1 client recordkey with missing relationship record.

**Missing ADL/IADL Records** – this type of missing occurs when **clients received cluster 1** services but do not report ADL IADL record. This report is for identifying client recordkey with this type of missing.

**Missing Characteristics Records** – the missing occurs when **clients received cluster 1** services but do not have health characteristics record reported. This report is to identify client recordkey with this type of missing.

**Missing Health Events Records** – this type of missing occurs when **clients received cluster 1** services but do not report Health Events record. This report is to identify client recordkey with this type of missing.

**Missing Care Plans** – this type of missing occurs when **clients received cluster 1** services but do not report Care Plan record. This report is for identifying client recordkey with this type of missing.

### **Plan Reports**

**AIP/4 Year Plan Narratives** – Provides users with a way of printing out narrative and Attachment sections of the AIP/4 Year Plan.

**End of Year AIP Variance Report** – Compares AIP data with end of year CAARS data. Each county report is 10 pages.

**Subcontractor Services** – Information for each subcontractor entered into the system is reflected in this report.

**AIP Landscape and Portrait pages** - available for 2012-16, 2013-14

**AIP One Report** - for full AIP for 2014-15

### **NYSOFA Report Viewer**

The dates are entered year and month, so that April 1, 2010 – December 31, 2010 would have a start date of 201004 and an end date of 201012. These reports can be printed or exported to a PDF file or MS Excel format.

The link for this site is: <http://www.boedmz.ofa.state.ny.us/infoviewapp/logon.aspx>

**Attachment L**  
**Examples of Case Managed and Non Case Managed Clients**  
*Numbers in brackets are for NYSOFA use.*

Case Management is a comprehensive process that helps older persons with diminished functioning capacity, and/or their caregivers, gain access to and coordinate appropriate services, benefits and entitlements. Case management consists of assessment and reassessment, care planning, arranging for services, follow-up and monitoring with a contact at least once every two months and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor.

In each of the examples the client will receive units of case management for the time spent doing the assessment.

**Example 1**

The AAA gets a call that Bob, an elderly tenant has suffered a stroke and is having trouble taking care of himself. The AAA makes contact and a complete MDS assessment is done. The proposed care plan calls for daily home delivered meals and 3 hours per week of Personal Care Level 1. Bob accepts the care plan and signs the EISEP financial agreement. He will be a case managed client and receive at a minimum a contact every two months and a reassessment every year.

In this case Bob would be reported as an Active (1) Case Managed Client (20) client. MDS required assessment data must be entered and maintained. Units of case management can be reported for the time spent doing the assessment.

**Example 2**

Bobbie Jo calls the AAA and says she has severe arthritis and is confined to her home. Her arthritis makes cooking difficult. A complete MDS assessment is done and the assessor finds that she is able to take care of most daily activities but is unable to cook. Bobbie Jo accepts the proposed care plan calling for daily home delivered meals. Since this is the only service she will be receiving, she will not be case managed. She will be reassessed every year and have a six month contact as defined in 97-PI-20.

In this case Bobbi Jo would be reported as an Active (1) Non Case Managed Client (35). MDS required assessment data must be entered and maintained. Units of case management can be reported for the time spent doing the assessment.

**Example 3**

An outreach contact identifies Tom as a potential client. An assessment is begun but it quickly determined that Tom does not need any in-home services. Tom does however become a client for transportation, legal and congregate meals.

In this case Tom would be reported as an Active (1) Non Case Managed Client (35). No MDS required assessment data need be entered although information shown on the Sample NAPIS Client Registration Form would still need to be entered. Units of case management could be reported for the time spent doing the assessment.

#### **Example 4**

A hospital discharge planner contacts the AAA to say that Ya-Lin has been released from the hospital and sent home. The planner believes that Ya-Lin may require assistance. The AAA makes contact and Ya-Lin says that she is 70 years of age and due to her recent surgery, is unable to cook or leave her home. The AAA arranges for home delivered meals to be provided and schedules an assessment to be done in ten days. On day nine, Ya-Lin contacts the AAA and notifies them that she is mobile and cancels the service and assessment visit.

In this case Ya-Lin would be reported as an Inactive (2) Client refuse service (14). The meals provided will be reported. If enough information was collected and entered to create a unique client ID, If there was not enough information collected to create a unique ID meals would still be reported anonymously.

#### **Example 5**

A hospital discharge planner contacts the AAA to say that Ann has been released from the hospital and sent home. The planner believes that Ann may require assistance. The AAA makes contact and Ann agrees to be assessed. Midway through the assessment Ann tells the assessor that she is not interested in receiving any of the services offered.

In this case Ann would be reported as an Inactive (2) Client refuse service (14). Units of case management would be reported for the time spent doing the assessment.

## **Attachment M - Areas to Be Covered During the Six-Month Contact for Non-Case Managed Home Delivered Meals Clients**

Clients receiving only a home delivered meal are required to be contacted six months after the assessment/reassessment. This contact should explore the nine areas listed below to determine if any changes have occurred since the last assessment/reassessment. This requirement was implemented by 97-PI-20, Program and Policy Changes Related to Implementation of MDS: (A) Home Delivered Meals; (B) EISEP and CSE EISEP-Like Services; and (C) All Six Community-Based Long Term Care Services dated July 10, 1997.

The client software used by your county should include a date field for when the contact is made.

Starred items indicate possible probes to help the assessor identify the changes.

### 1. Health status

- Ask date of last visit to primary medical provider and reason for visit.
- Ask of status of chronic illnesses or self-declared disabilities -- If client has been to his/her physician in the past six months, staff may want to contact the physician to further identify/confirm any changes in the client's physical health status the client seems uncertain about.
- Ask about change in need for assistive device and reason for device.
- Ask of any hospitalization within the past six months and reason for admission.
- Ask of any emergency room visit within the past six months and reason for visit.

### 2. Nutrition (Status and Service)

Please address each of the following items:

- Ask if the meals are still needed.
- Ask about the adequacy of the meal service (quality, quantity, food preferences).
- Determine if there has been any unwanted weight change (i.e., at least 10 lbs within past 6 months). If unwanted change, ask current weight; calculate body mass index.
- Review adequacy of food storage and heating facilities (refrigerator/freezer, oven, stove top, microwave).
- Review ability to open HDM containers and cut up food.
- Determine if there has been a diet change.
- Determine if client continues to use or is now using nutritional supplements.

### 3. Psycho-Social Status

- Indirectly evaluate through speaking with client about other items to determine if there has been a change.

### 4. Medication Usage

Review medication/dosage changes if changes have been noted in health status, item #1.

- Ask about prescribed and over the counter medications currently taken and any problems that the client may have with medications.

- May want to contact the physician to further identify/confirm changes in the client's medications since information may be difficult to accurately obtain over the telephone.

#### 5. Instrumental Activities of Daily Living

Reference the most recent assessment to determine if there are any changes in client's ability to perform any instrumental activities of daily living.

#### 6. Activities of Daily Living

Reference the most recent assessment to determine if there are any changes in client's ability to perform any activities of daily living.

#### 7. Informal Support Status

- Verify continued involvement of informal caregivers.
- Note any change in living arrangement, emergency contact.

#### 8. Services Client is Currently Receiving

- Confirm information reported during the initial assessment, and ask client about the need for additional services.

#### 9. Continued Eligibility

- May want to ask the client regarding what he/she does for other meals, i.e., meals not provided by the Nutrition Program. This may give insight into the continued need for HDMs.

**Attachment N**  
**Quarterly Data Quality Review**

**Beginning with Program Period April – June 2014:** Submitted consumer-based data **not meeting any of the following criteria** will result in a letter being sent to you and the County's Chief Executive Officer/Chairperson of the Governing Board advising that NYSOFA will **withhold funding reimbursements** until corrected data are received or a work plan is provided to address these issues with reasonable timelines and accepted by NYSOFA.

- **Missing Service Records: Two or more Cluster 1 services (Personal Care Services, Case Management, Home Delivered Meals, Adult Day Services) with more than 50% service records not reported as compared to the number of clients reported through the verification report.**
- **Missing Functional Status (ADL/IADL): More than 50% of Case Management missing functional status counts.**
- **Missing Nutrition Risk Score: More than 50% of Home Delivered Meals or Congregate Meals clients missing nutrition risk score.**

**This review will be conducted on a quarterly basis.**

**Please see Review Examples on page 2 to learn more about how we review the count.**

**Review Examples:**

**Missing Service Records: Two or more Cluster 1 services (Personal Care Services, Case Management, Home Delivered Meals, Adult Day Services) with more than 50% service records not reported as compared to the number of clients reported through the verification report.**

SAMPE AAA	Verified Data	Client Data	% Difference	Comment
Personal Care II	387	0	100%	More than 50%
Personal Care I	179	0	100%	More than 50%
Home Delivered Meals	659	366	44.5%	
Adult Day Services	83	1	98.8%	More than 50%
Case Management	566	156	72.4%	More than 50%

- **Four Cluster 1 services have severe incomplete reporting issue. This will trigger voucher reimbursement withhold.**

**Missing Functional Status (ADL/IADL): More than 50% of Case Management clients missing functional status counts.**

SAMPE AAA	Number of Clients (Verified Data)	Number of Clients reported with ADL Count (Client Data)	% of Clients missing ADL Count	Comment
Personal Care II	387	0	100%	
Personal Care I	179	0	100%	
Home Delivered Meals	659	366	45%	
Adult Day Services	83	1	100%	
Case Management	566	156	72%	More than 50%

- **Case Management clients ADL missing rate is too high. This will trigger voucher reimbursement withhold.**

**Missing Nutrition Risk Score: More than 50% of Home Delivered Meals or Congregate Meals clients missing nutrition risk score.**

SAMPE AAA	Number of Clients (Verified Data)	Number of Clients reported with Nutrition Risk Count (Client Data)	% of Clients missing NR Count	Comment
Home Delivered Meals	659	366	45%	
Congregate Meals	2448	671	73%	More than 50%

- **Congregate Meals clients Nutrition Risk missing rate is too high. This will trigger voucher reimbursement withhold.**

## Sample Title III-E Registration Form

*Dear Participant: By providing the information requested below, you will help us to demonstrate the effectiveness of the services we provide to caregivers and enable us to obtain future funding to continue to provide you with services and support. This information is strictly confidential.*

Last Name: <input type="text"/>	First Name: <input type="text"/>	Mid Init <input type="text"/>
Address: <input type="text"/>		County <input type="text"/>
City: <input type="text"/>	St: <input type="text"/>	Zip + 4: <input type="text"/>
Phone: <input type="text"/>	Gender: <input type="radio"/> Male <input type="radio"/> Female	Ethnicity <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino
DOB: <input type="text"/>	Limited English Proficiency: <input checked="" type="radio"/>	
Race: <input type="radio"/> American Indian/ Alaskan Native <input type="radio"/> White not Hispanic <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Black <input type="radio"/> Other Race <input type="radio"/> White Hispanic <input type="radio"/> 2 or More Races		



# Sample NAPIS Client Registration Form

New York State Office for the Aging

*Use a medium black pen and keep letters and number in the boxes. Fill in circles completely and use an X instead of checkmarks. Note this form should only be completed with staff assistance.*

<b>PROVIDER ID:</b> <input type="text"/> - <input type="text"/>		<b>Intake Date:</b> <input type="text"/> /	
<b>CLIENT INFORMATION:</b>		Gender: <input type="radio"/> Male <input type="radio"/> Female	DOB: <input type="text"/> - <input type="text"/> - <input type="text"/>
		Veteran: <input type="radio"/> Yes <input type="radio"/> No	
Last Name: <input type="text"/>		First Name: <input type="text"/>	
Mid Init <input type="text"/>			
Address: <input type="text"/>			
City: <input type="text"/>		St: <input type="text"/>	Zip + 4: <input type="text"/> - <input type="text"/>
Co: <input type="text"/>			
Phone: ( <input type="text"/> ) <input type="text"/> - <input type="text"/>		Living Status: <input type="checkbox"/> 1=Alone, 2=With Spouse Only, 3=With relatives, 4=With non-relatives, 5=With Spouse and others, 6=Others	
Marital Status: <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Never Married <input type="radio"/> Domestic Partner or Significant Other		Number in Household: <input type="text"/>	Ethnicity: <input type="radio"/> Hispanic <input type="radio"/> Non-Hispanic
Race: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> American Indian/Alaskan Native <input type="radio"/> Asian <input type="radio"/> Native Hawaiian/Pacific Islander <input type="radio"/> Other Race <input type="radio"/> 2 or More Races <input type="radio"/> White (Alone) Hispanic			
Income Status: (Below Poverty Level) 100% <input type="radio"/> Yes <input type="radio"/> No 150% <input type="radio"/> Yes <input type="radio"/> No			Frail/Disabled: <input type="radio"/> Yes <input type="radio"/> No
Emergency Contact: <input type="text"/>		Phone: ( <input type="text"/> ) <input type="text"/> - <input type="text"/>	
<b>SERVICES INFORMATION:</b>		Limited English Proficiency: <input type="checkbox"/> Primary Language: _____	
<b>Cluster II Services</b> <input type="checkbox"/> Congregate Meals <input type="checkbox"/> Nutrition Counseling <input type="checkbox"/> Assisted Trans.		<b>Cluster III Services</b> <input type="checkbox"/> Info & Referral <input type="checkbox"/> Legal Services <input type="checkbox"/> Transportation <input type="checkbox"/> Nutrition Education <input type="checkbox"/> Outreach <input type="checkbox"/> Other	
<b>Determining Nutritional Health</b>			
Read the statements below. Circle the number in the "YES" column for those that apply to you or someone you know. For each answer, score that number in the box. Total your nutritional score and compare below.			
			<b>YES</b>
I have an illness/condition that made me change the kind/amount of food I eat.			2
I eat fewer than 2 meals a day.			3
I eat few fruits or vegetables, or milk products.			2
I have 3 or more drinks of beer, liquor or wine almost every day.			2
I have tooth or mouth problems that make it hard for me to eat.			2
I don't always have enough money to buy the food I need.			4
I eat alone most of the time.			1
I take 3 or more different prescribed or over-the-counter drugs a day.			1
Without wanting to, I have lost or gained 10 pounds in the last 6 months.			2
I am not always physically able to shop, cook and/or feed myself.			2
<b>TOTAL</b>			
A score of 0-2 means Good, recheck at six months.			
A score of 3-5 means you are at moderate nutritional risk and need to see what you can do to improve eating habits and make life-style changes.			
A score of 6 or more means you are at a high nutritional risk. Take the checklist to a doctor, dietitian or qualified health or social service professional and talk to them. Ask for definite ways to improve your nutritional health.			

## *Protecting their privacy*

Trust is an important aspect of any relationship. Many people are concerned about their personal information being seen by others. Reduce these concerns by following good privacy practices:



Keep all paperwork in a secure storage unit that is accessed only by authorized personnel.

Make sure that computers are password-protected and accessible only by authorized personnel.

Don't identify the source of a person's information with their name or social security number; use a code.

Provide people with a private location to fill out paperwork and encourage them to ask questions.

The word "**CONFIDENTIAL**" written on registration forms will make some people feel more comfortable when providing information.

jan14

## *Tips on reaching people:*

Consumers say that these practices would increase their comfort level while providing information.

1. Let them know that they cannot be denied a meal for failure to provide information.
2. Make sure that staff fully answer elders' questions about why information is being collected.
3. Be patient.
4. Empathize with them about their data collection concerns and follow up on their issues.
5. Respect their concerns and privacy.

*If you have any questions, contact your local area agency on aging:*



*Or contact the  
New York State Office for the Aging's  
Senior Citizens' Help Line at:*

**1-800-342-9871**

**[www.aging.ny.gov](http://www.aging.ny.gov)**

# caring respect trust



*A guide to gathering  
personal information  
at your meal site*

  
New York State  
Office for the Aging  
Andrew M. Cuomo  
Governor  
Corinda Crossdale  
Acting Director

Meal sites for elders that receive funding through the New York State Office for the Aging are **required** to collect personal information about the people who attend.

Staff may not feel comfortable asking for this information. Elders often do not feel comfortable providing it.



Focus groups, composed of staff and elders at meal sites, have offered suggestions to reduce that discomfort. Their expert feedback may be helpful to you and your agency.

### ***KEY POINTS:***

***Explain to elders and other consumers why information is being requested.***

***Think creatively about how data can be gathered.***

### ***Why is collecting this information important?***

Good information about the conditions and needs of elders helps the Aging Network advocate for needed services. Locally, the information is used to improve services at your meal site. Federal rules also require that the information be collected.

### ***Okay, it's important but how can it be done?***

We know that collecting this information takes time. Here are some suggestions on how to manage your valuable time:

Training lets staff know why collecting data is important and helps them understand the importance of protecting and reporting consumer information. Your local area agency on aging will be glad to help you develop a training program on collecting information.

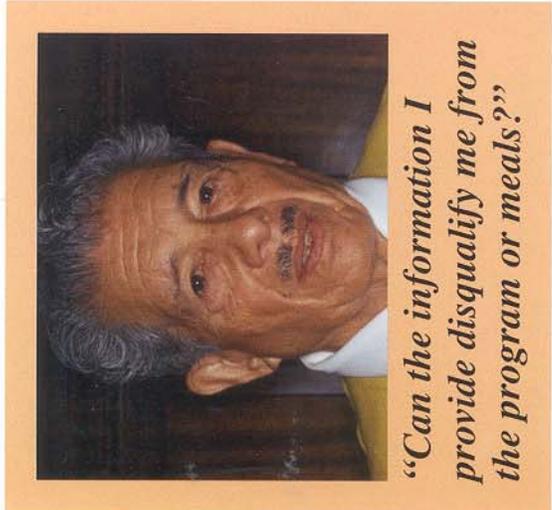
Survey your staff and see if any have collected data before. If not, you may consider creating a team to collect the information.

College students, seniors, and other community members may wish to volunteer. Students may even be able to earn credit for their work (*Note: volunteers should always receive the same training on privacy and confidentiality as staff*).

Data entry and reporting can be done at each meal site, but - for small sites - it may be more efficient to have data entry occur at one central location.

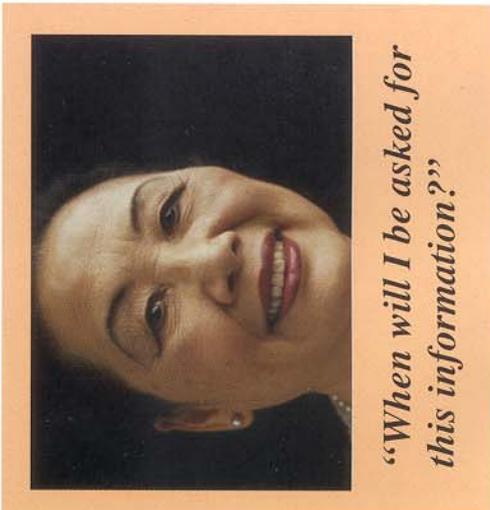


Registration forms are the key to information gathering and will include personal information such as name, address and phone number. This information helps the meal site if emergencies occur. This information is also used to create a unique identifier for each person. The unique identifier allows information to be coded and remain anonymous when responses are shared with the State and federal governments.



*“Can the information I provide disqualify me from the program or meals?”*

Absolutely not. Your answers will not affect your ability to participate. In fact, your responses will help improve this program’s vitality.



*“When will I be asked for this information?”*

You will be asked the questions when you register. If you are already enrolled, we will ask you as part of updating our site’s records.

Registration serves other purposes as well. It helps us protect you in emergency situations and may be the first step in your accessing services.

Finally, you can fill out the form in private, and/or ask for a staff member to assist you. So let’s keep dining together - by making our meal site the best that it can be!

*If you have any questions, contact your local area agency on aging:*



*The New York State Office for the Aging is also available. Call the Senior Citizens’ Hot Line at:*

**1-800-342-9871**

# Let’s keep dining together...



*... by making our meal site the best that it can be!*

Welcome to the dining program. We hope you enjoy your meals and the other services offered here.

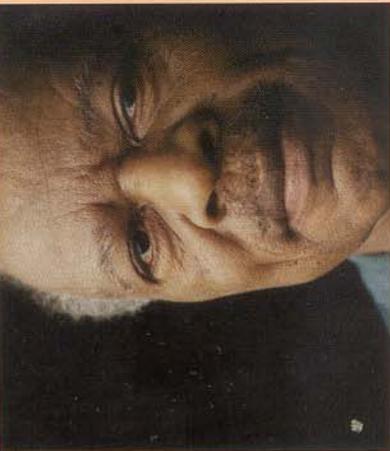
We use federal, state and local money to pay for these meals and activities. In turn, we are asked to collect some information about those of you who dine with us. We use that information to serve you better, create new programs and make our meals healthier.

Each dining site, including this one, has written policies to guard your information. Our staff and volunteers have been trained to respect and protect your privacy. Finally, we carefully limit the staff members who can see your information.

---

***The information you provide can directly improve the services we offer here.***

---



***“How do I know that my information is safe and secure?”***



***“Why are you collecting this information at my meal site?”***

Meal sites are just one of the places where this information is collected.

Dining programs like ours, however, draw a large number of people from their neighborhoods. There is no better place to measure a community’s “pulse” than at a meal site. Beyond that, the information we collect here helps us better meet your needs.

Your name is removed from your responses before any information is sent to the State or federal government. Your responses are combined locally with others’ and are then studied by people who support and fund programs for elders.

Your responses let those people know how much you, and others, benefit from the nutrition and all of the social activities that we offer here.

# STANDARD DEFINITIONS OF SERVICE

Definitions for other program items may be found in the Glossary section of the Reporting Guide  
CAARS and Client Data

April 2014

SERVICE NAME	<b>Adult Day Services</b>
<b>SERVICE DEFINITION</b>	<p><b>Adult Day Services (Social Adult Day and Adult Day Health)</b></p> <p>There are two types of adult day services (ADS) – social adult day services (SADS) which do not include a medical component in the program and is regulated by the NYS Office for the Aging when funded with aging funds, and adult day health care (ADH) which includes a medical component and is regulated by the NYS Department of Health.</p> <p><b><u>Social Adult Day Services</u></b> A structured, comprehensive program which provides functionally impaired individuals with socialization, supervision and monitoring, personal care and nutrition in a protective setting during any part of the day, but for less than a 24 hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, caregiver assistance and case coordination and assistance. Programs must meet the NYSOFA Regulations for Social Day Care (Title 9, section 6654.20).</p> <p><b><u>Adult Day Health Care</u></b> Health care services and activities provided to a group of registrants with functional impairments to maintain their health status and enable them to remain in the community. Programs are located at a licensed residential health care facility or an extension site. Programs are approved by the NYS Department of Health. (Note: regulations prohibit the use of EISEP funding for adult day health care.)</p>
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, EISEP (Only for SADS), CSE, Other
<b>EXAMPLES &amp; REPORTING</b>	<p><b>Reporting Clarification:</b> Regardless of what type it is (SADS or ADH) it is reported as ADS. The unit includes all required components; and these components are not reported separately. However, there are exceptions for SADS as noted below.</p> <p><b><u>Meal Component</u></b></p> <p>Meals provided using Title IIIC-1, Title III-E, SNAP, or CSE\EISEP funds (for which it does not claim USDA reimbursement through the Child and Adult Care Food Program) the meal must be reported separately to draw down NSIP USDA reimbursement.</p> <ul style="list-style-type: none"> <li>• Unit – one meal on the congregate meal line under the Title IIIC-1, III-E, SNAP, EISEP, CSE or Other column</li> <li>• Expenditure – cost is included in the expenditures reported for the adult day services</li> </ul>

<p><b>EXAMPLES &amp; REPORTING (continued)</b></p>	<p>Client - reported as an ADS client</p> <p>When the AAA does not fund the adult day service, but funds the meal provided to the adult day services participants, the unit, expenditure and client are counted in the same way as congregate meals.</p> <ul style="list-style-type: none"> <li>• Unit – one meal on the congregate meal line under the Title IIIC, SNAP, CSE or Other column.</li> <li>• Expenditure – cost included in the expenditures reported for congregate meals.</li> <li>• Client - reported as congregate meal client.</li> </ul> <p>When the AAA is providing the meal to ADS participants under a catering agreement (and thus the Adult Day Services program is paying for the full cost of the meals), the persons served, units of service and expenditures are not reported.</p> <p><b>Assisted Transportation</b></p> <p>Assisted Transportation is an optional component under SADS. If the transportation component is paid for separately it must be reported separately (units, expenditures and clients) rather than included in the reporting under adult day services.</p>
<p><b>SERVICE NAME</b></p>	<p><b>Assisted Transportation</b></p>
<p><b>SERVICE DEFINITION</b></p>	<p>Assistance and transportation, including escort, to a person who has difficulties (physical or cognitive) using regular vehicular transportation.</p>
<p><b>UNIT OF SERVICE</b></p>	<p>Each one-way trip</p>
<p><b>FUNDING SOURCES</b></p>	<p>Title III-B, Title IIIC-1, Title III-E, <b>EISEP</b>, CSE, CSI, SNAP, Other</p>
<p><b>EXAMPLES &amp; REPORTING</b></p>	<p>Assisted transportation/escort is <u>not</u> assisting a client to the ladies room in a Senior Center or to the counter to receive their meal at a congregate site.</p> <p>The Administration on Aging (AoA) states that services reported in the assisted transportation/escort category must involve the personal accompaniment of the older person throughout an outing or trip. Thus, assistance offered by a van driver in operating a wheelchair lift or walking with an older person from the van to his/her front door is not considered assisted transportation/escort—the driver is simply being helpful to the older person as part of regular transportation activities.</p>
<p><b>SERVICE NAME</b></p>	<p><b>Caregiver Services</b></p>
<p><b>SERVICE DEFINITION</b></p>	<p>Services included are support groups for caregivers, caregiver counseling on issues to help caregivers in making decisions and solving problems related to their care giving roles and training workshops for caregivers. For state funded CRC's it also includes lending libraries. These are services designed to support caregivers and help sustain their efforts to provide care.</p>
<p><b>UNIT OF SERVICE</b></p>	<p><b><u>Each participant of a group or individual session receives one unit of service.</u></b></p>
<p><b>FUNDING SOURCES</b></p>	<p>Title III-B, Title III-E, Title III-D, CSE, CSI, Other</p>

<p><b>EXAMPLES &amp; REPORTING</b></p>	<p><b>Example 1:</b> A daughter who is caring for her father meets with a caregiver coordinator for 45 minutes to discuss various options for meeting his increasing needs. During this time they also discuss the impact it is having on her and her relationship with her husband and children. This reported as 1 unit.</p> <p><b>Example 2:</b> Eight grandmothers, all over the age of 55, attend a two-hour workshop designed to help grandparents better interact with the educational system. For reporting purposes -- eight persons served and eight units provided for the workshop.</p> <p><b>Caregiver Services are not:</b></p> <p>A woman walks into the AAA’s offices to inquire about services available to older people. While there, she picks up a brochure on the stresses associated with care giving and tips for handling such stress. The woman’s selection of the brochure is not counted as a unit of caregiver services. However, since information is obtained on available services from the AAA staff, this is reported as one unit of information &amp; assistance services. (1 contact = 1 unit, regardless of the amount of staff time spent with the woman and the number of items taken from the AAA’s brochure rack.)</p>
<p><b>SERVICE NAME</b></p>	<p style="text-align: center;"><b>Case Management</b></p>
<p><b>SERVICE DEFINITION</b></p>	<p>A comprehensive process that helps older persons with diminished functioning capacity, and/or their caregivers, gain access to and coordinate appropriate services, benefits and entitlements. Case management consists of assessment and reassessment, care planning, arranging for services, follow-up and monitoring at least every two months and discharge. These activities must be provided by or under the direction of the designated case manager or case manager supervisor.</p> <p>Note: please see CAARS instructions regarding the acceptability of reporting assessments for those seeking/receiving home delivered meals <b><u>as the only community based long term care service they will receive.</u></b></p> <p>Case Management activities for clients receiving community-based long term care services:</p> <ul style="list-style-type: none"> <li>• A comprehensive MDS-compliant assessment is the collection of information about a person’s situation and functioning, and that of his/her caregivers, which allows identification of the person’s specific strengths and needs in the major functional areas.</li> <li>• A care plan is a formal agreement between the client and case manager and, if appropriate, the client’s caregivers regarding client strengths and problems, goals and the services to be pursued in support of goals.</li> <li>• Implementation of the care plan (arranging and authorizing services) includes contacting service providers, conducting case conferences and negotiating with providers for the delivery of needed services to the client as stated in the care plan.</li> <li>• <b><u>Follow-up and monitoring of the care plan every two months at a minimum,</u></b> ensures that service delivery is meeting the client’s needs and being delivered at the appropriate levels and quality <b><u>Contact with the service providers is regular and ongoing.</u></b> Reassessment is the formal re-examination of the client’s situation and functioning and that of his/her caregivers to identify changes which occurred since the initial assessment/last reassessment and to measure progress toward goals outlined in the care plan. It is done at least annually and more frequently if needed.</li> </ul>

	<p>Changes are made to the care plan as necessary.</p> <ul style="list-style-type: none"> <li>• Discharge is the termination of case management services. Reasons for discharge may include the client requesting discharge, the attainment of goals described in the care plan, the client needing a type of service other than case management or ineligibility for the service.</li> </ul> <p>Case managers may also be functioning in the role of a support coordinator or consultant to informal caregivers. In this role, the case manager may be acting as a teacher, networker, counselor and/or family guide.</p>
<b>UNIT OF SERVICE</b>	One hour of service including travel time.
<b>FUNDING SOURCES</b>	Title III-B, Title III-D, Title III-E, CSE, EISEP, SNAP , Other
<b>EXAMPLES &amp; REPORTING</b>	<p><u>Counting Clients:</u> For a <i>client</i> to be reported as a case management client, he/she must be receiving or expected to receive all the components summarized above.</p> <p><u>Counting Units of Service:</u> <i>Time</i> spent in any of the following is appropriately reported as case management <i>units</i> (one hour = one unit): traveling to an older person’s home and conducting an assessment, telephoning clients to follow-up on service delivery, discussing services for a specific client with the service provider, and organizing and conducting a case conference concerning a specific client and the case manager inputting client data into the computerized system.</p> <p>While a case manager typically works a seven and a half or eight hour day, this does not imply that each day he/she will generate seven and a half or eight hours of case management units. Time spent in administrative, educational or general activities cannot be counted as units of service. For example, time spent in such activities is <u>not</u> appropriate to report as case management units:</p> <ul style="list-style-type: none"> <li>• traveling to and participating in the Adult Abuse Training Institute;</li> <li>• participating in a video conference on conducting client assessments;</li> <li>• developing a new form for monitoring in-home service providers;</li> <li>• comparing the in-home service provider’s bill for the month to the number of hours authorized for each client and the number of hours actually provided for each client;</li> <li>• participating in the monthly meetings of the AAA’s program coordinators which feature general discussions of aging network issues, implementation of county budget and personnel procedures.</li> </ul> <p><b>Example 1: General Example</b></p> <p>The EISEP case manager receives a call from a widower interested in receiving in-home services. Based on this call, the case manager sets up the face-to-face meeting and assessment. The case manager meets with the older man and completes an assessment document. As the care plan is being developed, the older man decides to decline all services. In this instance, the activity involved would be reported as follows:</p> <ul style="list-style-type: none"> <li>• units of service: two hours of case management services (the time involved in meeting with the older person and travel time to and from the house);</li> <li>• expenditures: the travel and personnel costs would be reported under EISEP on the case management line;</li> </ul>

- unduplicated client count: the older person is not included in the unduplicated count for EISEP case management, because he is not a case management client.

**Example 2: “Expected” to Receive Case Management**

On Friday, March 29<sup>th</sup> Mrs. Jones receives an assessment and a care plan is developed and agreed to. This takes 2.25 hours plus 45 minutes in travel time to and from the person’s home. Care plan implementation (e.g., contacting home care providers and home care services actually provided) will take place during the first week in April, the first quarter of the new year.

This is an example of a person who is expected to receive case management that includes all of the components. Therefore, in addition to reporting three units of case management, the person is reported as a client.

**Example 3 - Maintaining a Waiting List and Not Providing Case Management**

**Background:** An AAA has developed a prioritization process that includes the completion of an MDS compliant assessment in order to determine the person’s placement on waiting lists and to make referrals for other appropriate services. The process includes a follow-up call every three months to determine if there are any major changes in the person’s situation that would warrant changing their placement on the waiting lists. The call may or may not be made by case management staff.

A person calls seeking home care. The AAA staff knows that there is a waiting list for home care but does an assessment because this: 1) is how the AAA places older persons on the waiting list for home care; 2) allows the AAA to develop a care plan so that the individual can private pay for services if able and 3) permits the AAA to identify other services for which referrals can be made. The time spent conducting the assessment and any travel time to and from the person’s home would be counted as case management units. The person is not counted as a case management client because the case management staff is not planning to conduct ongoing services follow-up and client monitoring. Case management staff is not actively engaged on an ongoing basis with the person. The periodic contact is primarily a mechanism to keep the waiting list viable (by keeping it up-to-date). The conduct of the assessment is part of the prioritization process and does not trigger the case management requirements as specified in the regulations.

**Example 4: A Client Receiving Case Management While Waiting for Home Care**

An AAA is providing case management to a person who is on the waiting list for home care. Case management staff has conducted an assessment and developed a care plan. The plan calls for home delivered meals (which are arranged for and begin) and home care (for which he is put on a waiting list). The client has some other issues -- such as housing and medical care – which the case manager will address.

In this example, the person is receiving case management and will be reported as a client. The time the case management staff spends with the client or with others on behalf of the client will be reported as units of case management.

**Example 5: A Family Member Seeking Assistance with Caregiving**

A wife calls seeking services to ease the burden she is under due to providing personal care to her frail husband. The case manager does an in-home assessment of the husband to

	<p>determine his eligibility to receive in-home services as a form of III-E Respite for the wife. Based on the assessment of the husband, a care plan is developed to provide III-E Respite to the wife in the form of Personal Care Level II to the husband. The on- going case management will be funded under III-E and provided to the husband.</p> <p>In this example, the husband is receiving case management and will be reported as a client. The time the case management staff spends with the husband or with others, including the wife, on behalf of the husband will be reported as units of case management.</p>
<b>SERVICE NAME</b>	<b>Congregate Meal</b>
<b>SERVICE DEFINITION</b>	A hot or other appropriate meal which meets nutritional requirements and is served to an eligible participant in a group setting.
<b>UNIT OF SERVICE</b>	Each meal served. Meals served to individuals through means-tested programs such as Medicaid Title XIX waiver meals are excluded from the NSIP meals count.
<b>FUNDING SOURCES</b>	Title IIIC-1, Title III-E, EISEP, CSE, SNAP, Other
<b>SERVICE NAME</b>	<b>Consumer Directed In Home Services</b>
<b>SERVICE DEFINITION</b>	A service that provides assistance with the tasks that are the same or similar to those included in the definitions of Personal Care Level I and Personal Care Level II, and which is managed by the consumer, or a representative selected by the consumer. This includes such activities as recruitment, selection, training, supervision and dismissal of the in-home services worker.
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	<u>Title III-B, Title III-E</u> , EISEP, CSE, Other
<b>SERVICE NAME</b>	<b>Health Promotion</b>
<b>SERVICE DEFINITION</b>	<p>Services and activities that <b><u>promote chronic disease prevention and management</u></b>, promote physical and mental health, improve or maintain <b><u>quality of life</u></b>, and increase awareness and understanding of healthy lifestyles,. These include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Evidence-based health promotion programs</li> <li>• Medication management to prevent incorrect medication and adverse drug reactions</li> <li>• Routine health screenings such as vision, diabetes, bone density and nutrition</li> <li>• Medicare preventive services such as education programs on the availability, benefits, and appropriate use of preventive health services</li> <li>• Preventive nutrition services such as nutrition counseling and education</li> <li>• Physical fitness programs</li> <li>• Home injury control services such as screening home environments and education programs on injury and falls prevention at home</li> <li>• Mental Health services such as screening for depression, provision of educational activities</li> </ul>
<b>UNIT OF SERVICE</b>	<p>One unit = Each participant or attendee of a group session, class or event</p> <p>One unit = Each distribution of a health related topic in a newsletter, newspaper, radio or TV show</p>

<b>FUNDING SOURCES</b>	Title III-B, Title III-D (if meet criteria for being evidence-based and approved through AIP process), Title III-E, EISEP, CSE, CSI, ,Other
<b>EXAMPLES &amp; REPORTING</b>	<ul style="list-style-type: none"> <li>• 14 enrollees of a 12-week evidence-based program attended all 12 sessions = 168 units</li> <li>• Eighteen participants receive flu shots at one senior center = 18 units</li> <li>• 100 flu shots administered at eight senior centers in one day = 100 units</li> <li>• A health fair for seniors where 150 are served at the agency's booth = 150 units</li> <li>• An article prepared by an appropriate professional on a health related topic and printed in a newsletter or newspaper, with 1200 readers over the age of 60 (estimated) = 1 unit (not counted if handouts are part of a presentation or are left on display to be picked up by participants).</li> <li>• A weekly walking program with 5 participants a week = 260 units (52 weeks x 5)</li> <li>• One diabetes screening event that screened 72 older adults = 72 units</li> <li>• Screening 150 high-risk home environments as part of a Falls Prevention campaign = 150 units</li> <li>• Screened medications for 90 participants at a pill screening event led by local pharmacists = 90 units</li> </ul>
<b>SERVICE NAME</b>	<b>Home Delivered Meal</b>
<b>SERVICE DEFINITION</b>	A hot or other appropriate meal which meets nutritional requirements and is provided to an eligible person for home consumption.
<b>UNIT OF SERVICE</b>	Each meal served. Meals served to individuals through means-tested programs such as Medicaid Title XIX waiver meals are excluded from the NSIP meals count.
<b>FUNDING SOURCES</b>	Title III-E, Title IIIC-2, <b>EISEP</b> , CSE, SNAP, Other
<b>SERVICE NAME</b>	<b>Home Health Aide Service</b>
<b>SERVICE DEFINITION</b>	<p>The provision of health care tasks, personal hygiene services, housekeeping tasks and other related support services essential to the client's health including:</p> <ol style="list-style-type: none"> <li>1. Assisting with tasks listed under Personal Care Level II services;</li> <li>2. Performing simple measurements and tests to routinely monitor the patient's medical condition;</li> <li>3. Preparing meals in accordance with modified diets or complex modified diets;</li> <li>4. Performing a maintenance exercise program;</li> <li>5. Using medical equipment, supplies and devices;</li> <li>6. Changing dressings to stabilize surface wounds;</li> <li>7. Caring for an ostomy after the ostomy has achieved its normal function;</li> <li>8. Providing special skin care; and</li> <li>9. Administering of medication.</li> </ol>
<b>UNIT OF SERVICE</b>	One hour of service excluding travel time.
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, CSE, Other

SERVICE NAME	<b>Information and Assistance</b>
<b>SERVICE DEFINITION</b>	<p>The provision of Information and Assistance may include three components :</p> <ol style="list-style-type: none"> <li>1. The provision of information on services, benefits, entitlements and other areas of concern to consumers or their representatives which enables them to locate and obtain needed resources on their own.</li> <li>2. Assistance to consumers in obtaining access to the services and resources available within their community. An individual is provided with information on a one-to-one basis about available services and opportunities in the community, assisted in defining problems/needs and capacities, receives direction or guidance relative to those identified issues and is linked to services and opportunities to meet the problems/needs. When appropriate, case assistance may also involve worker intervention, negotiation and advocacy with providers on the client's behalf to ensure the delivery of needed services and benefits. Also included in this is follow-up, to the extent possible, that the consumer receives the service.</li> <li>3. Referral is a two-step process involving the initiation of a linkage between a client and a service provider, and follow-up contact(s) to determine whether the service has been or is being provided.</li> </ol>
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	Title III-B, Title IIIC-1, Title IIIC-2, Title III-D, Title III-E, HIICAP, WRAP, NY Connects, CSE, CSI, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<p>People receiving only information are not included in the unduplicated count.</p> <p>A call comes in to the Office and it is referred to the Case Manager as the caller is requesting information about long term care plans for their elderly parent who is to be discharged from the hospital. The Case Manager provides a wealth of information to the caller, including information about post discharge Medicare in-home services, what is a PRI and how to obtain and discusses community and institutional Medicaid and custodial home care that may be available from the Office for the Aging when appropriate. The Case Manager is on the phone with this caller for 30 minutes. The Case Manager provided information to the caller and the transaction is recorded as .5 units of Information and Assistance.</p> <p><b>I &amp; A is not:</b>  The caller calls back to speak with the Case Manager a month after the initial call with some additional questions. The Case Manger provides additional technical assistance and during the conversation, determines that the elderly person appears to be in need of custodial long term care. An EISEP screen is completed and an appointment is scheduled for an assessment in four days. Although additional/clarifying information was imparted during this phone call, this transaction is a unit of Case Management. The Case Manager has initiated the process of setting up a home visit, thus meeting initial requirements of the multi component Case Manager service definition.</p>

SERVICE NAME	<b>In-Home Contact and Support</b>
<b>SERVICE DEFINITION</b>	<p>Services and activities designed to provide support to older people who are isolated because of physical and/or cognitive limitations. These services are not defined separately elsewhere in the standard definitions and may include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Shopping Assistance – Shopping on behalf of an older person</li> <li>• Friendly Visiting – A scheduled visit to an older person to provide socialization, recreation and the opportunity to observe and report the person’s condition and circumstances.</li> <li>• Telephone Reassurance (including automated systems) – Regularly scheduled telephone contact with an older person with follow-up as necessary and appropriate.</li> <li>• <u>Supervision - Services provided in the home to monitor, guide and oversee the older person’s actions and activities. Supervision services funded by EISEP or III-E as respite for a client’s informal caregivers "paid supervision."</u></li> <li>• Other services – Provided in the home to support the person including house cleaning, laundry service, bill paying/other essential errands, items provided on loan such as assistive devices</li> </ul>
<b>UNIT OF SERVICE</b>	One contact
<b>FUNDING SOURCES</b>	Title III-B, Title IIIC-1, Title IIIC-2, Title III-E, EISEP, CSE, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<p><b>Example 1:</b></p> <p>A worker goes to the Greene home to provide supervision/monitoring and oversight of Mr. Greene while Mrs. Greene goes out to dinner and a movie with her daughter. The worker engages Mr. Greene in conversation plays cards and watches TV with him. She also helps him reheat his dinner that had already been prepared by Mrs. Greene. Mr. Greene does not need assistance with any of his activities of daily living although sometimes he needs reminding where the bathroom and bedroom are. The worker arrives at 6 P.M. and leaves at 9 P.M. The time spent by the worker is reported as 1 unit (because “contact” is the unit for in-home contact and support.)</p> <p><b>Example 2:</b></p> <p>A laundry service picks up Ms. Brown’s soiled laundry every Tuesday morning and returns it clean every Tuesday afternoon. This is reported as one unit for each Tuesday’s pick up and return.</p> <p><b>Example 3:</b></p> <p>Two workers from Spick n Span Cleaners come to clean Ms. Jones’ home every 3rd Thursday. While there, they will also do a load of laundry. They spend approximately 4 hours. This is reported as 1 unit.</p>

<b>SERVICE NAME</b>	<b>Legal Assistance</b>
<b>SERVICE DEFINITION</b>	Provision of legal advice, counseling and representation by an attorney or other person acting under the supervision of an attorney.
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, CSE, Other
<b>SERVICE NAME</b>	<b>Long Term Care Ombudsman</b>
<b>SERVICE DEFINITION</b>	Services provided by duly authorized patient advocates on behalf of people residing in long term care facilities and their families. Primary activities include identifying, investigating and resolving complaints, concerning resident care, quality of life and residents' rights. Identification of adverse issues and conditions affecting residents, promoting the development of resident and family councils, and ensuring residents have regular and timely access to ombudsman advocacy services.
<b>UNIT OF SERVICE</b>	No unit or people served reporting required for the client data systems. This information is reported under the Ombudsman Reporting System. All clients identifying information is confidential and subject to disclosure according to requirements under the OAA. Report expenditures only using the CAARS quarterly on line system.
<b>FUNDING SOURCES</b>	Title III-B, Other
<b>SERVICE NAME</b>	<b>Nutrition Counseling</b>
<b>SERVICE DEFINITION</b>	Individualized guidance to individuals who are at nutritional risk because of their health or nutrition history, dietary intake, chronic illnesses, or medications use. Counseling is provided one-on-one by a nutrition professional, who evaluates the person's nutritional needs, develops and implements a nutrition counseling plan, evaluates the client's outcome, maintains documentation and distributes appropriate literature. It is recommended that initial counseling be provided face-to-face at a congregate site, in the home or in an office setting. Follow up nutrition counseling may be provided face-to-face at a congregate site, in the home, office setting or by telephone. A nutrition professional is defined as a Registered Dietitian (RD), a Registered Dietitian-Eligible who must successfully complete the exam within 18 months (RDE), or a NYS Certified Dietitian/Nutritionist (CDN). Certified Diabetic Educators (CDE) is appropriate only for nutrition counseling with older individuals with diabetes. Nutrition counseling services are available to an older individual and/or her/his caregiver upon referral and/or request.
<b>UNIT OF SERVICE</b>	One hour of service (time with individual and travel time).
<b>FUNDING SOURCES</b>	Title IIIC-1, Title IIIC-2, Title III-D, Title III-E, <b>EISEP</b> , CSE, CSI, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<b>Example 1:</b> Initial nutrition counseling.  An MDS compliant assessment tool was completed for a person seeking home delivered meals. Results of the nutrition screening questions within MDS indicate the client is at high nutrition risk because, without wanting to, he lost 10 pounds in the last six months and has an illness that changes the amount of food eaten. He is referred to the nutrition professional (RD, RDE, CDN) for possible nutrition counseling. An initial face-to-face meeting between

**EXAMPLES &  
REPORTING  
(CONTINUED)**

the older person and nutrition professional takes place in the person's home and a nutritional counseling plan is completed. This meeting lasts one hour. The nutrition professional traveled 15 minutes one way to the individual's home (30 minutes round trip).  
1 hour counseling + 30 minutes round trip travel = 1.5 hours  
1.5 hours = 1.5 units

**Example 2:** Initial nutrition counseling.

At the congregate meal site, staff receives a request from an older person for nutrition counseling to help manage his diabetes. The person is referred to the nutrition professional (RD, RDE, CDN, CDE) for possible nutrition counseling. An initial face-to-face meeting between the person and nutrition professional takes place in the AAA's office and a nutritional plan is completed. This meeting lasts 45 minutes = .75 hours = .75 units.

**Example 3:** Initial nutrition counseling.

A new congregate meal site participant completes a client registration form and answers all the nutrition questions. Their score was 6 points indicating they may be at high nutrition risk. The participant is referred to the nutrition professional (RD, RDE, CDN) for possible nutrition counseling. An initial face-to-face meeting between the older person and nutrition professional takes place in the office at the meal site. The nutrition professional reviews the participant's answers, confirms the score and tells them nutrition counseling would be appropriate. A nutritional counseling plan is completed. This meeting lasts 60 minutes = 1 hour = 1 unit

**Example 4:** Follow-up nutrition counseling;

The older person requests follow-up nutrition counseling by the nutrition professional or the care plan indicates a follow-up is needed. A face-to-face meeting or a telephone call occurs between the person and the nutrition professional and lasts for 30 minutes total. The nutrition professional will assess and reinforce the initial nutrition counseling plan, make changes as appropriate and provide additional nutrition information as needed.  
30 minutes = .5 hours = .5 units

**Example 5:** This example only applies to the use of III-E funds.

A caregiver requests information on how best to meet the nutritional needs of her care receiver for whom she prepares meals. The caregiver is referred to the nutrition professional (RD, RDE, CDN, CDE) for possible nutrition counseling. An initial 15 minute face-to-face meeting between the caregiver and nutrition professional takes place in the AAA's office and a follow up in-home visit to assess the care receiver is scheduled. The meeting in the home lasts 45 minutes with the nutrition professional traveling 15 minutes one way to the individual's home (30 minutes round trip). The in-home visit to the care recipient identifies the need for nutritional guidance which is provided during the visit.

The service would be reported as:

Caregiver:	15 minute initial meeting	=	.25	Units of service
	45 minutes in home	=	.75	Units of service
	30 minutes travel time	=	.50	Units of service
	<b>Total Supplemental units of service</b>	<b>=</b>	<b>1.5</b>	<b>Units of service</b>

<b>EXAMPLES &amp; REPORTING (CONTINUED)</b>	<p>Care receiver: 45 minutes in home = .75 Units of service  30 minutes travel time = .50 Units of service  Total Nutrition Counseling units of service = 1.25 Units of service</p> <p><b>Nutrition counseling is not:</b></p> <ul style="list-style-type: none"> <li>• Sending nutrition literature by post office mail or computer email without verbal or face-to-face contact.</li> <li>• Leaving a message on a telephone answering machine.</li> <li>• Providing nutrition information that is not associated with the person’s nutritional needs or counseling plan.</li> <li>• Providing counseling in a group setting.</li> </ul>
<b>SERVICE NAME</b>	<b>Nutrition Education</b>
<b>SERVICE DEFINITION</b>	<p>A planned program to promote better nutrition, physical fitness and health through information and instruction on nutrition and related consumer topics of general interest. The program is provided by or under the direction of a Registered Dietitian (RD), Registered Dietitian-Eligible (RDE), NYS Certified Dietitian-Nutritionist (CDN), or a Dietetic Technician-Registered (DTR). Information and instruction may occur in group settings and/or through distribution of materials to individuals. A minimum of 6 group or class presentations must be provided at each congregate meal site annually. Nutrition information or handouts are provided to congregate and home delivered meal participants at least monthly.</p>
<b>UNIT OF SERVICE</b>	<p><b><u>Each participant of a group or individual session receives one unit of service.</u></b></p> <p>Each distribution of handouts to congregate and/or homebound participants (not counted if handouts are part of a presentation or are left on display to be picked up by participants). = One unit per participant</p> <p>Each article prepared and printed in a newsletter or newspaper; each radio or television presentation= One unit</p>
<b>FUNDING SOURCES</b>	<p>Title IIIC-1, Title IIIC-2, Title III-D, Title III-E, CSE, CSI, SNAP, Other</p>
<b>EXAMPLES &amp; REPORTING</b>	<p><b>Example 1:</b> A Registered Dietitian completes a planned nutrition education program (including handouts) on “Food Safety for Seniors” at 4 congregate sites. In total 50 Seniors attend the 4 sessions (Each participant = 50 units of nutrition education).</p> <p><b>Example 2:</b> A Registered Dietitian distributes a pamphlet to 75 home delivered meal clients with their meal (Each pamphlet = 75 units of nutrition education).</p> <p><b>Example 3:</b> The local newspaper has a section each week devoted to issues affecting seniors. Six times a year the AAAs registered dietitian has an article covering a nutrition related topic (Each article = 1 unit of nutrition education).</p>
<b>SERVICE NAME</b>	<b>Outreach</b>
<b>SERVICE DEFINITION</b>	<p>Activities initiated by the AAA or its subcontractors for the purpose of identifying potential clients (or their care givers) and encouraging their use of existing services and benefits. This includes face-to-face or telephone contact between a worker and an individual.</p>

<b>UNIT OF SERVICE</b>	Each contact
<b>FUNDING SOURCES</b>	Title III-B, Title IIIC-1, Title IIIC-2, Title III-E, CSE, CSI, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<p><b>Example 1:</b> Staff visits to a new senior housing building to locate isolated individuals who have never been clients of the AAA. This contact must be conducted one-on-one and not done as a group presentation.</p> <p><b>Example 2:</b> The AAA or its subcontractors have a table at a health event where providers conduct face-to-face identification of isolated individuals by discussing the individual's needs and available programs one-on-one.</p> <p><b>Reporting Clarification:</b> Outreach is when the AAA/subcontractor finds an isolated older person, <u>not</u> when an older person finds the AAA/subcontractor.</p>
<b>SERVICE NAME</b>	<b>Personal Care Level I</b>
<b>SERVICE DEFINITION</b>	<p><b><u>A service that includes some or total assistance with the following tasks on behalf of or to assist a person commensurate with the person's limitations in IADLs:</u></b></p> <ul style="list-style-type: none"> <li>• Making and changing beds</li> <li>• Dusting and vacuuming the rooms which the person uses</li> <li>• Light cleaning of the kitchen, bedroom and bathroom</li> <li>• Dishwashing</li> <li>• Listing needed supplies</li> <li>• Shopping for the person</li> <li>• The person's laundering, including necessary ironing and mending</li> <li>• Preparing meals, including simple modified diets</li> <li>• Paying bills and other essential errands</li> <li>• Escorting to appointments and community activities</li> </ul>
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, EISEP, CSE, Other
<b>EXAMPLES &amp; REPORTING</b>	<b>Reporting clarification:</b> When this service is provided to give respite to an informal caregiver who regularly provides assistance in these activities, it is reported as personal care level I.
<b>SERVICE NAME</b>	<b>Personal Care Level II</b>
<b>SERVICE DEFINITION</b>	<p>A service that includes assistance with the following tasks on behalf of or to assist a client commensurate with the person's limitations in ADLs or limitations in both ADLs and IADLs:</p> <p>Some or total assistance with:</p> <ul style="list-style-type: none"> <li>• All the tasks listed under Personal Care Level I;</li> <li>• Bathing of the person in the bed, tub or shower;</li> <li>• Dressing;</li> <li>• Grooming, including care of hair, shaving and ordinary care of nails, teeth and mouth;</li> </ul>

	<ul style="list-style-type: none"> <li>• Toileting, including assisting the person on and off the bedpan, commode or toilet</li> <li>• Walking, beyond that provided by durable medical equipment, within the home and outside the home;</li> <li>• Transferring from bed to chair or wheelchair;</li> <li>• Preparation of meals in accordance with modified diets, including low sugar, low fat, low salt and low residue diet;</li> <li>• Feeding;</li> <li>• Administration of medication by the client, including prompting the client of time, identifying the medication for the client, bringing the medication and any necessary supplies or equipment to the client, opening the container for the client, positioning the client for the medication and administration, disposing of used supplies and materials and storing the medication properly;</li> <li>• Providing routine skin care;</li> <li>• Using medical supplies and equipment such as walkers and wheelchairs;</li> <li>• Changing simple dressings.</li> </ul>
<b>UNIT OF SERVICE</b>	One hour of service
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, EISEP, CSE, Other
<b>EXAMPLES &amp; REPORTING</b>	<b>Reporting clarification:</b> When this service is provided to give respite to an informal caregiver who regularly provides assistance in these activities, it is reported as personal care level II.
<b>SERVICE NAME</b>	<b>Personal Emergency Response System</b>
<b>SERVICE DEFINITION</b>	A service which utilizes an electronic device to alert appropriate people of the need for immediate assistance in the event of an emergency situation in an older person's home.
<b>UNIT OF SERVICE</b>	One unit for each month or part of a calendar month that the device is in the person's home.
<b>FUNDING SOURCES</b>	Title III-B, Title III-E, EISEP, CSE, Other
<b>EXAMPLES &amp; REPORTING</b>	The service is initiated on January 1 and terminated on January 15 = 1 unit The service is initiated on January 15 and terminated on February 4 = 2 units (one for each month)
<b>SERVICE NAME</b>	<b>Senior Center, Recreation and Education</b>
<b>SERVICE DEFINITION</b>	Activities organized and scheduled through the AAA or its subcontractors which involve older persons in courses, workshops, other learning activities and satisfying use of free time.
<b>UNIT OF SERVICE</b>	One group session
<b>FUNDING SOURCES</b>	Title III-B, Title IIIC-1, Title III-D, CSE, CSI, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<b>Examples of senior center, recreation and education activities:</b> <ul style="list-style-type: none"> <li>• A yoga demonstration held at a senior center or congregate site. (Since this is a one-time demonstration, it is counted as a unit of senior center, recreation and education. If this was a formal class given on a regular basis, it would be counted as health promotion.);</li> <li>• Sports lessons and events;</li> </ul>

	<ul style="list-style-type: none"> <li>• Performing arts;</li> <li>• Games;</li> <li>• Crafts lessons and events;</li> <li>• Performing arts;</li> <li>• Games;</li> <li>• A nature walk conducted each spring at a senior center;</li> <li>• A day bus trip organized by the center, to Citi Field to see a baseball game. (The bus trip constitutes one unit or group session of senior center, recreation and education. The related units of transportation would be recorded in the transportation category.)</li> </ul>
<b>SERVICE NAME</b>	<b>Transportation</b>
<b>SERVICE DEFINITION</b>	Transportation from one location to another. Does not include any other activity.
<b>UNIT OF SERVICE</b>	One unit for each one way trip per person
<b>FUNDING SOURCES</b>	Title III-B, Title IIIC-1, Title III-E, EISEP, CSE, CSI, SNAP, Other
<b>EXAMPLES &amp; REPORTING</b>	<p><b>Example 1:</b> The provider takes five people to and from the local senior center. This is reported as ten units of transportation (five people x two trips each).</p> <p><b>Example 2:</b> The senior center organizes a day bus trip to Yankee Stadium to see a baseball game. Forty-three older individuals participate. This is reported as eighty-six units of transportation service (forty-three individuals x two trips each). Additionally, one unit of senior center recreation and education is generated and reported.</p> <p><b>Example 3:</b> The provider takes an older individual to the senior center. After lunch, the provider drives the older individual to a local shopping center to pick up medications and groceries. The older individual is then picked up and transported home. This generates three units of transportation service (one individual x three separate trips/locations).</p>
<b>Other Services Provided by the Area Agency</b>	
<i>(Enter these services using the Other line in CAARS and the Other Code for client data and units)</i>	
The number of people served and units of service provided are reported in the electronic client files using the 600 series service codes. Expenditures for these service categories are aggregated and reported on the "Other" line when completing Part III, A Program, Services and Expenditure Breakdown. Expenditures should be the accrued total expenditures under each column. "Other" services may also include any unique local services.	
<b>Alzheimer's Services</b>	
Services designed to provide support which may include counseling, information, etc. to the families/caregivers of elderly victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction.	
<b>Chore Services</b>	
Assistance such as heavy housework, yard work or sidewalk maintenance.	
<b>Counseling</b>	
A one-to-one relationship between an older person and a worker trained in counseling techniques. The service is designed to alleviate stress or anxiety and to help the client make appropriate choices and plans.	
<p>a. Psychosocial Counseling</p> <p>Those counseling activities which will assist older persons in coping with the problems and stresses which</p>	

interfere with normal health and social functioning.

b. Tax & Financial Counseling

Counseling provided to older persons on tax and financial matters.

c. Entitlements Counseling

Entitlements counseling includes assisting clients in the completion of applications for benefits. It also includes encouraging a client to accept an entitlement or benefit for which he or she is eligible.

### **Options Counseling**

Options Counseling is a person-centered process whereby individuals, family members and/or significant others are supported to develop a plan for addressing long term services and supports needs that aligns with their preferences, strengths, values, and needs.

It includes: 1) conducting a person-centered interview to discover what is important to and important for the individual, help them identify and weigh available options and make decisions, 2) assisting in developing a person-centered plan detailing the individual's decisions, immediate next steps and long term objectives, 3) assisting the individual to connect with public and privately funded services as needed, and 4) following-up over time to ensure individuals are meeting their objectives and accessing desired services

Examples of situations associated with the Options Counseling category:

- Individuals with immediate long term care needs (e.g. after major life changing event);
- Individuals who are planning for future needs;
- Caregivers who need help in caring for their loved one;
- Individuals who are transitioning from one setting to another, such as from the hospital to their homes.

### **Crime and Safety Program**

A program which provides elderly crime victims and potential crime victims with information designed to reduce the incidence and fear of crime.

### **Discount Program**

The preparation and issuance of an identification card which enables the card holder to receive a discount on goods and services offered by participating merchants.

### **Employment Related Services**

All activities which result in increased employment opportunities for older people, including recruitment of potential employees and employers, assessment of work experiences and skills, job counseling, subsidized employment, training for upgrading job seeking skills and training in new job skills, job development, job placement, referral services and supportive services. (Note: This does not include work by Title V Program enrollees unless they are directly involved in employment activities.)

### **Energy Assistance**

Activities on behalf of a client to access regular benefits/additional benefits provided through the HEAP, WRAP or Other funded activities, e.g., Department of State (DoS).

### **Friendly Visiting**

An organized visit to homebound older persons providing socialization, recreation, and the opportunity to observe and report the client's condition and circumstances.

## Group Respite

Group respite is care or supervision provided in a group setting to frail or disabled adults on behalf of and in the absence of the caregiver, for the purpose of providing caregivers with relief from the stress of caregiving. Group respite programs may provide a variety of services but minimally must provide socialization and appropriate snacks in a protective setting.

## Public Education

A planned effort to provide consumers information about services, resources, and entitlements. Activities include the distribution of newsletters, flyers, pamphlets, and brochures, the use of mass media for news, features, public activities, and public speaking by a service representative.

## Recreation

Activities organized and scheduled through the Area Agency or its subcontractors which are designed to foster the health and social well-being of older persons through social interaction and satisfying use of free time. This service may include educational activities as well as sports, performing arts, games, and crafts.

## Residential Repair and Maintenance

Repairs and activities to upgrade and/ or maintain housing for the elderly, including heavy cleaning.

## Respite Care

The provision of short-term substitute care and supervision of functionally impaired older individuals in order to offer their caregivers temporary rest and relief from caregiving responsibilities. (Note: Non-Institutional Respite refers to non-medical respite provided in a non institutional setting.)

## Weatherization

Referrals to other Federal, State or Local programs for the application of **weatherization/conservation** measures to the home. (excluding residential repair)

Unit: Each referral to the low income weatherization program on the state prescribed form or to the Energy Conservation Bank Program, Farmer's Home Administration Program or other similar programs.

## Title III-E Services

*The following are service definitions for the Title III-E funded services. Note for reporting purposes both the Title III-E service as well as the Standard Service to which it applies must be reported.*

**Counseling, Support Groups & Training:** to assist caregivers in making decisions and solving problems relating to their care giving roles. Area Agencies are required to provide at least one of the components, but may provide all three. **Note training events that do not require preregistration and are open to the public should be reported as Information.**

Counseling, support groups and training refer to a range of individual and/or group services that are intended to assist caregivers in gaining knowledge and/or skills related to their care giving role. Counseling can take place on an individual basis or in a group setting for caregivers who are involved with the same care receiver.

There are many different types of counseling. Examples include individual or group counseling, mediation resolution, peer counseling, grief counseling. Local programs may develop/implement support groups, as well as facilitate/maintain them. They may be in-person, on-line and/or telephone support groups. Support groups may be designed for anyone in a care giving role or they may be for specific caregivers, e.g., caregivers caring for someone with a particular type of disease, e.g., Alzheimer's disease, Parkinson's disease, or based on the caregiver/care receiver relationship, e.g., spouse, child. They may be educational and/or supportive and sharing, long term or short term. Training programs may be delivered in one session or in a series, the duration may vary from an hour to a full day or longer, and cover numerous topics that can help and support

the caregiver in their care giving capacity, e.g., skills related to assisting care receivers with activities of daily living, legal issues, e.g., power of attorney, living wills, managing difficult behaviors, nutrition, health/wellness, e.g., stress reduction exercises.

Standard Service: Caregiver Services

Unit of Service: **Each participant of a group or individual session receives one unit of service.**

**Respite:** Respite care to give caregivers a break and temporarily relieve them from their caregiving responsibilities. Respite care is temporary and provides substitute supports or living arrangements to allow for a brief period of relief or rest for caregivers. It can take the form of in-home respite (e.g., personal care level I or level II, home health aide or supervision/ companion), adult day services (social adult day care or adult day health care) or overnight respite (e.g., in nursing home, adult home, assisted living facility.)

Respite is designed to provide relief to the caregiver, while at the same time providing direct services to the care recipient. Thus it must meet the needs of both the caregiver and the care receiver. To be responsive to the varying needs, circumstances and preferences of caregivers, it is beneficial to have different types of respite available.

In order for the caregiver to be eligible for respite under the program, the care receiver must be frail as defined in the Older Americans Act. This means that the care receiver is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing or supervision . . . or due to a cognitive or 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. [Sect. 102(26) (A) and (B)]

Standard Service: PC Level I, PC Level II, Home Health Aide, Adult Day Services, In-home Contact and Support--when in-home supervision and monitoring will be provided, Other--for those services not separately defined, e.g., overnight nursing home or adult home placement.

Unit of Service: Refer to applicable service definition above.

**Supplemental Services:** to complement the care provided by caregivers. Supplemental services are other services, not listed above, to address the needs of the caregiver. Unlike the other 4 service components, supplemental services has a funding cap – a program may spend no more than 20% of its funding on supplemental services. By definition, supplemental services are meant to be flexible enhancements to caregiver support programs. Examples of supplemental services include such services as personal emergency response systems, assistive technology, home modifications, disposable supplies (e.g., incontinence supplies), nutrition services and transportation.

Similar to the requirements of Respite, to be eligible for supplemental services a caregiver must be caring for an older person who is defined as frail under the Older Americans Act. This means that the care receiver is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing or supervision . . . or due to a cognitive or 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. [Sect. 102(26) (A) and (B)].

Standard Service: Home Delivered Meals, Congregate Meals, Nutrition Counseling, Assisted Trans./Escort, Transportation, Legal Assistance, Nutrition Education, Personal Emergency Response Systems, Other--for those services not separately defined, e.g., home modifications, etc.

Unit of Service: Refer to applicable service definition above.

**Assistance:** for caregivers in gaining access to the services. Assistance refers to a service that assists caregivers in obtaining access to the services and resources available within their community. An individual

is provided with information on a one-to-one basis about available services and opportunities in the community, assisted in defining problems/needs and capacities, receives direction or guidance relative to those problems and is linked to services and opportunities to meet the problems/needs. Also included in this is follow-up, to the extent possible, that the caregiver receives the service. Both information and assistance and case management when provided to caregivers under III-E are considered a form of Assistance.

Standard Service: Case Management, Information and Assistance

Unit of Service: **Estimated unduplicated number of caregivers served.**

**Information:** for caregivers about available services. Information refers to group service activities designed to inform caregivers of available services. Information on resources and services can be provided by an Area Agency to persons within the community in methods such as articles in newspapers, brochures, public service announcements on radio or television, group presentations and at events such as health fairs. Information includes outreach activities – interventions initiated by the program for the purpose of identifying potential clients and encouraging their use of available services and benefits.

Standard Service: Outreach, Other Services, i.e., Public Information

Unit of Service: **Estimated Audience size**