Division of Aging Services

Access to Services

2026-01-21

Table of Contents

5200 Access to Aging and Disability Services

	Department of Human Services **Policy and Manual Management System**	**Index:**	**POL 5200**
		Revised:	**07/01/2023**
		Next Review:	**07/01/2025**

Subject: Access to Aging and Disability Services

Policy

The policy of the Department of Human Services is to assure access to older individuals and individuals with disabilities of all ages, to information and resources that supports living in the setting of their choice.

Authority

O.C.G.A. 49-6-2 to O.C.G.A. 49-6-3

References

Title I of the Older Americans Act, 42 USC 3001

Applicability

Area Agencies on Aging (AAA) and/or non-profit organizations fulfill the requirements of the above-stated DHS policy.

Definitions

Older individuals are persons in the age group 60 and over.

Responsibilities

The Division of Aging Services is responsible for oversight of the development and updating of requirement for the individual programs in this section which include the Elderly Legal Assistance Program, Aging & Disability Resource Connection, Money Follows the Person and the GeorgiaCares Program.

History

None.

Evaluation

The Division of Aging Services evaluate the program by reviewing performance measures quarterly to assess program results and to evaluate the outcomes of this directive.

MAN 5200 Access to Services Manual

	Department of Human Services **Policy and Manual Management System**	**Index:**	**MAN 5200**
		Revised:	**07/01/2023**
		Next Review:	**07/01/2025**

1000 Access to Services

1010 Overview of Access to Services

	Georgia Division of Aging Services **Access to Services Manual**			
	Chapter:	1000 Access to Services	**Effective Date:**	
	Section Title:	Overview of Access to Services	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	1010	**Previous Update:**	

The Access to Services Section of the Department of Human Services Division of Aging Services consists of program specialists who manage and coordinate multiple statewide programs focused on providing information and services to help individuals remain safely in their own homes and communities. These programs are:

- **Aging & Disability Resource Connection (ADRC)**: the larger community of partners including Area Agencies on Aging (AAAs), Department of Behavioral Health and Developmental Disabilities (DBHDD), Centers for Independent Living (CILs), and others. ADRCs are a collaborative effort from the national to the local level that serves as single points of entry or “No Wrong Door” systems. The ADRC is not limited to the single-entry point for aging services but includes all programs with the goal of keeping individuals in the community.

  Fund sources include: Older American’s Act funds, Administration for Community Living grants, Department of Community Health (special projects), Social Service Block Grants, state ADRC funds and Community Based Services. ADRC staff and counselors accept phone, email, web, and face-to-face requests, assess individuals for program eligibility, and provide information/assistance/referral.

- **Elderly Legal Assistance Program**: This is an Older Americans Act program providing legal counseling and direct representation in select civil legal matters to individuals who are sixty years of age and older. The State Legal Services Developer, who manages the program, is housed in Access to Services. Services are provided by legal organizations contracting with the Area Agencies on Aging.
- **GeorgiaCares**: the State Health Insurance Assistance Program (SHIP) a volunteer-based program that is federally funded. SHIP provides personalized counseling, education, and outreach to assist Medicare beneficiaries with their Medicare questions. Services provided by SHIP help

beneficiaries identify and understand Medicare programs and plans, including Medicare Supplement Insurance (Medigap policies), Prescription Drug Coverage, Medicare Advantage Plans, long-term care insurance and other public and private health insurance coverage options.

- **Transitions**: This program includes two different funding streams. **Money Follows the Person (MFP)** is an initiative by the Centers for Medicare/Medicaid Services focusing on rebalancing long-term services and supports. This program transitions individuals on Medicaid from nursing homes back to their homes and communities. **Nursing Home Transitions** is a state-funded initiative for individuals who may not qualify for MFP. This program will also transition individuals from nursing homes back to the community, focusing on less time in the facility and fewer needs in the community.

Program specialists within the Access to Services Section work closely with all other program staff in the Division of Aging Services.

3000 Georgia State Health Insurance Assistance (SHIP) Program

3010 Georgia SHIP Overview

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	3000 Georgia State Health Insurance Assistance (SHIP) Program	**Effective Date:**	
	Section Title:	Georgia SHIP Overview	**Reviewed or Updated in:**	
	Section Number:	3010	**Previous Update:**	

Georgia SHIP is a trusted source for information and assistance regarding Medicare and other related health insurance. Georgia SHIP helps with financial assistance programs, long-term care insurance decisions, healthcare fraud and consumer protection issues. Georgia SHIP includes the State Health Insurance Assistance Program (SHIP) and SMP. Georgia SHIP is a program of the Department of Human Services Division of Aging Services.

Georgia SHIP is a statewide coalition of private and public partners that seeks to provide education and assistance to individuals who need help making challenging health insurance decisions. Georgia SHIP includes the SHIP (State Health Insurance Assistance Program), which seeks to answer complex questions related to Medicare, prescription assistance programs, long-term care insurance and supplemental insurance. This includes helping beneficiaries enroll in the new Medicare Prescription Drug benefit. Georgia SHIP also includes SMP formerly the Senior Medicare Patrol. SMP provides education to beneficiaries and their families on Medicare fraud, error and abuse and reports such occurrences to law enforcement agencies.

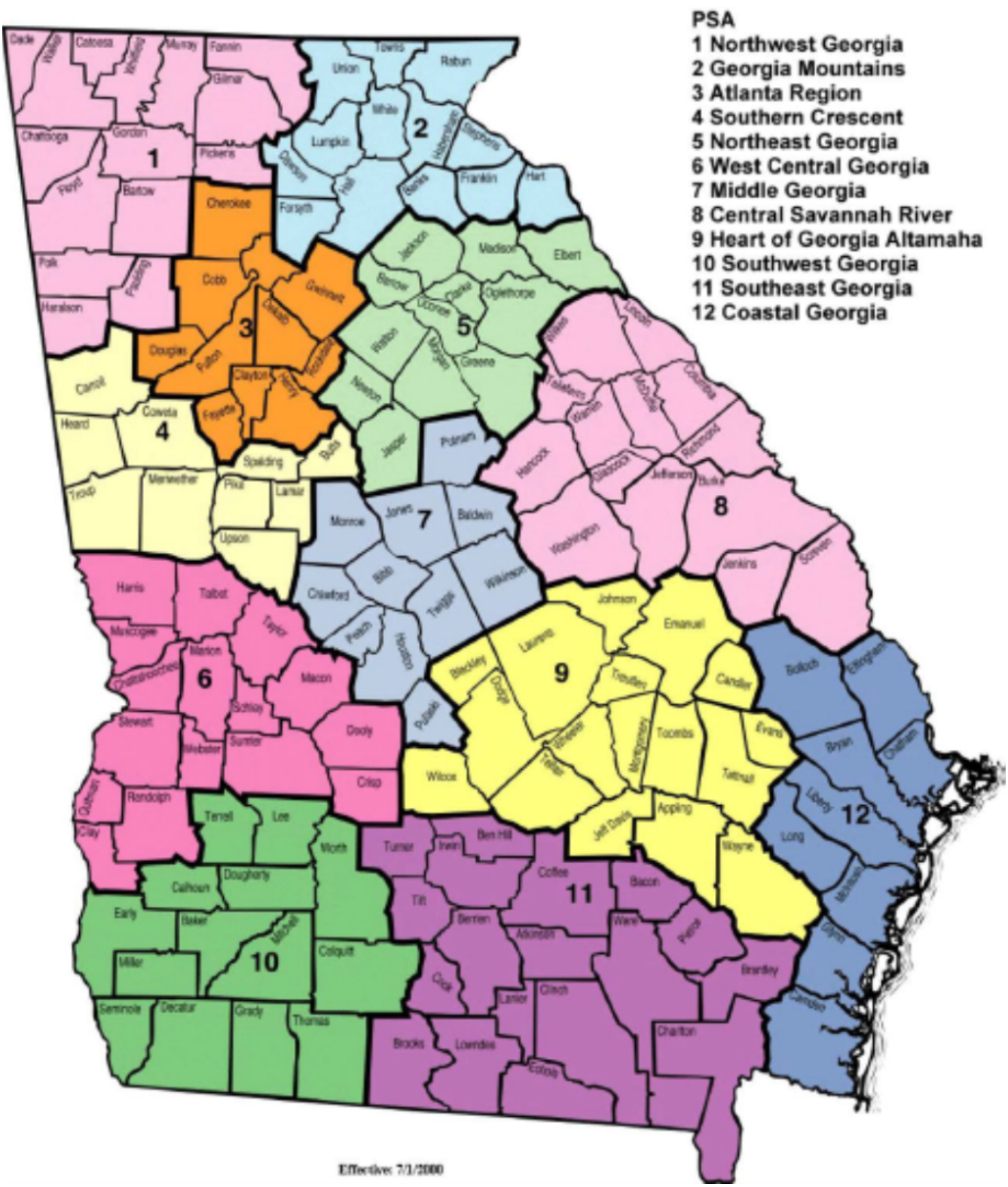
Georgia SHIP has multiple partnerships throughout the state. These partnerships include state universities, pharmaceutical companies, hospitals, physicians, drug stores, medical and pharmacy associations, financial institutions, FDIC, Office of the Insurance Commissioner, Secretary of State, Department of Community Health, fraud investigators, and a number of volunteer organizations.

Georgia is the eleventh most populated state for Medicare beneficiaries. The number of Medicare beneficiaries is growing at an almost exponential rate with the Georgia Medicare population expected to better than double over the next 20 years.

State Fiscal Year	Medicare Population	Population Increase
2003	904,111	Base year for this report
2005	932,747	28,636 (4%)
2007	973,614	40,867 (4%)
2008	1,024,180	50,566 (5%)
2009	Estimated: 1,123,763	99,583 (9%)

As the table above indicates we are well on our way to reaching the estimated population increase.

Georgia SHIP services are available across Georgia through 12 local Area Agencies on Aging. Georgia SHIP has 15 trained local counselors, over 250 trained volunteers and 4 state staff who provide one-on-one counseling and educational sessions to groups of interested individuals. The Georgia SHIP toll free number, 1-800-669-8387, automatically routes callers to local offices. Every effort is made to respond to callers within 48 hours.



State Health Insurance Assistance Program (SHIP)

SHIP is a program funded by the Centers for Medicare & Medicaid Services (CMS) to provide counseling and assistance to people with Medicare and their families. SHIP funding is only available to states. SHIP provides free counseling and assistance via telephone and face-to-face interactive sessions, public education presentations and programs and media activities. While Georgia SHIP has a

wide latitude in providing services we must offer locally accessible services to all eligible persons requesting assistance, develop an intra-state agency referral system, and communicate timely and accurate health care information.

Services Offered by Georgia SHIP SHIP Project:

- Information, counseling & assistance on a wide range of Medicare, Medicaid and Medigap matters
  - Enrollment in Medicare prescription drug programs
  - Medicare Advantage options
  - Long-term care insurance
  - Claims and billing resolution
  - Information and referral on public benefit programs for those with limited income and assets
  - Other health insurance benefit information as requested.

SMP – Formerly Senior Medicare Patrol is a project funded through the Administration on Aging via a demonstration grant that is available to states, public and private non-profits, and federally recognized tribes. SMP projects provide trained advocates, preferably retired professionals, engaged in fighting fraud, error and abuse in Medicare. The focus of the SMP is to engage older Americans in taking responsibility for their health care and to educate them on how to recognize and report Medicare fraud, error and abuse. The program helps seniors make informed decisions about their health care as well as ensuring that the seniors we serve safeguard their personal information.

Services Offered by Georgia SHIP SMP Project:

- Media and private organization outreach activities
- Community events and other efforts to educate beneficiaries on erroneous, abusive and fraudulent activities associated with Medicare
- Individual counseling regarding Medicare billing
- Refer complaints of fraud cases to the proper authorities
- Track complaints and concerns for reporting requirements.

The Georgia SHIP SMP project has one of the best records in the nation for reporting Medicare fraud, error and abuse. Georgia was ranked 17 out of 54, which includes every state in the nation plus the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands.

History of Georgia SHIP

1992 The Division of Aging Services (DAS) received a Health Information, Counseling and Assistance Grant from the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services or CMS).

- In the early years the program was named HICARE (Health Insurance Counseling, Assistance and Referral for the Elderly) and operated in only 6 regional Planning

and Service areas (PSAs).

1998 HICARE expanded to statewide coverage

- From the beginning, coordinators and volunteers conducted community education to prevent Medicare and Medicaid fraud, waste, and abuse.

1999 U.S. Administration on Aging provided a grant that expanded program efforts in this area and launched the Senior Medicare Patrol (SMP).

- On July 1, HICARE was again expanded and renamed GeorgiaCares.

2002 With additional state funds and in collaboration with many partners including pharmaceutical companies, pharmacies, hospitals, Schools of Pharmacy, and other organizations, GeorgiaCares set out to enroll every eligible Medicare beneficiary in Georgia in all available low-cost prescription assistance programs.

- Through the years, GeorgiaCares has educated thousands of Georgians about Medicare and related health insurance issues.
- Most importantly, GeorgiaCares has provided the state's Medicare beneficiaries with increased opportunities to save millions of dollars in health care costs

2005 GeorgiaCares expanded under a Lifelong Planning initiative to educate Georgians in the use of personal planning tools and private funding options to meet future long-term care needs.

2007 January 1, 2007, the Senior Medicare Patrol was renamed nationally to SMP.

2009 The LifeLong Planning program and the state funded prescription assistance service was discontinued from the Division of Aging Services due to an economic recession in SFY 2009.

Georgia SHIP Programmatic Goals

- Educate Medicare beneficiaries, their families and caregivers about health insurance coverage, benefits, consumer rights and healthcare fraud.
- Provide in-depth information and assistance to consumers in order to increase their understanding of Medicare and other health insurance issues; help Medicare beneficiaries resolve problems related to their health insurance coverage; inform them about the eligibility criteria for various health insurance programs and help them enroll when applicable.
- Provide consumer education in understanding Long-Term Care insurance and the Georgia Long-Term Care Partnership program.
- Protect Consumers from health care fraud, error and abuse by educating them on prevention and how to report potential claims.
- Empower consumers to make informed decisions concerning health insurance options, exercising their appeal and grievance rights.
- Demonstrate the effectiveness of recruiting and training volunteers to teach, educate, and assist Medicare beneficiaries.

Georgia SHIP Funding Sources

This program is funded through grants from the Centers for Medicare and Medicaid Services (CMS), the U.S. Administration on Aging (AoA), and state funds appropriated by the Georgia General Assembly.

In addition to administering the program, the DHS Division of Aging Services operates the statewide Georgia SHIP hotline and contracts with all 12 Area Agencies on Aging (AAA) for the provision of Georgia SHIP services locally.

The AAA operates the Georgia SHIP program directly or subcontracts with a service provider for program service delivery.

3020 Georgia SHIP Guidelines and Standards

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	3000 Georgia State Health Insurance Assistance (SHIP) Program	**Effective Date:**	
	Section Title:	Georgia SHIP Guidelines and Standards	**Reviewed or Updated in:**	MT 2013-02
	Section Number:	3020	**Previous Update:**	

100 Georgia SHIP Overview

101 General

Georgia SHIP helps beneficiaries and their families understand rights, benefits and choices under

the Medicare and Medicaid programs. Georgia's State Health Insurance Assistance Program (SHIP) and Senior Medicare Patrol (SMP) are components of Georgia SHIP. Through SHIP and SMP, a statewide coalition of staff, volunteers and partners provide free, unbiased and factual health insurance related information and assistance. Georgia SHIP assists recipients in making informed decisions about healthcare options and Medicare plans that best meet their needs.

Georgia SHIP serves to:

1. Educate beneficiaries, caregivers, professionals and the aging network about Medicare and related insurance benefits, consumer rights and protections;
2. Assist in the resolution of Medicare billing and related health insurance issues;
3. Provide advocacy and one-on-one assistance to Medicare beneficiaries in applying for Medicare assistance programs, including, but not limited to: Medicare Savings Programs (MSP), Low-Income Subsidy (LIS) and prescription assistance programs (PAP);
4. Empower Medicare beneficiaries to prevent health care fraud, error and abuse by educating how to prevent, detect and report suspicious activity;
5. Empower consumers to make informed decisions concerning health insurance options and to exercise their appeal and grievance rights;
6. Educate consumers about long-term care insurance including Georgia's Long-Term Care Partnership;
7. Recruit, train and retain volunteers to assist in the fulfillment of the program objectives;
8. Demonstrate program effectiveness through data management; and
9. Develop partnerships to assist in the dissemination of information to Georgia's Medicare population.

102 History

The Georgia Department of Human Resources (now Georgia Department of Human Services) Division of Aging Services (DAS) received a Health Information, Counseling and Assistance Grant from the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services or CMS) in 1992. The program was named HICARE (Health Insurance Counseling, Assistance and Referral for the Elderly) and operated in six regional planning and service areas (PSAs) in Georgia. In State Fiscal Year (SFY) 1998, HICARE expanded to statewide coverage. In 1999, a grant from the U. S. Administration on Aging (AoA) further expanded HICARE and launched the Senior Medicare Patrol (SMP) project. On July 1, 2002, HICARE became a public-private partnership to include state funded prescription assistance and was renamed GeorgiaCares. In 2005, GeorgiaCares expanded under a state funded LifeLong Planning initiative to educate Georgians in the use of personal planning tools and private funding options to meet future long-term care needs. The LifeLong Planning program and the state funded prescription assistance service were discontinued from the Division of Aging Services due to an economic recession in SFY 2009.

103 Funding and Organization

The Georgia Department of Human Services Division of Aging Services is funded through grants from the Centers for Medicare and Medicaid Services (CMS), the U.S. Administration on Aging (AoA) and state funds appropriated by the Georgia General Assembly and allocates funding to Georgia

SHIP. The Division of Aging Services (DAS) administers the statewide Georgia SHIP program and contracts with all twelve of the state's Area Agencies on Aging (AAAs) for the provision of Georgia SHIP services locally. The AAAs operate Georgia SHIP directly or subcontract with a service provider(s) for program service delivery.

104 Program Activities

The AAA or service provider has considerable flexibility in pursuing various methods of providing Georgia SHIP outreach, counseling and assistance services in their PSA. However, each must provide information and assistance about:

1. Original Medicare (Medicare Parts A and B);
2. Medicare Supplement Insurance (Medigap policies);
3. Medicare Advantage Plans (Medicare Part C);
4. Medicare Prescription Drug Plans (Medicare Part D);
5. Medicare appeals and grievances;
6. Health Care Fraud, Error and Abuse;
7. Medicare assistance programs;
8. Long-Term Care Insurance;
9. Georgia Long-Term Care Partnership;
10. Consumer Protection; and
11. Volunteer Opportunities.

200 Georgia SHIP Coordinator

201 General

Area Agencies on Aging assigns the local Georgia SHIP Coordinator to provide public education, outreach, and assistance to Medicare beneficiaries, volunteers, caregivers, professionals and the aging network. The Georgia SHIP Coordinator is employed locally and the position is a full-time equivalent.

202 Minimum Qualifications for a Georgia SHIP Coordinator

The recommended qualifications for a Georgia SHIP Coordinator are:

1. An undergraduate degree from a four-year college or university, or equivalent work experience;
2. The equivalent of three (3) years of full-time work experience with at least two (2) years in aging, Medicare, Medicaid, insurance, volunteer coordination or related fields. Comparable experience and/or graduate education may be substituted at the discretion of the Area Agency on Aging;
3. Good program management skills;
4. Excellent verbal and written communication skills, including strong presentation skills;
5. Good interpersonal skills and;

6. Good organizational skills.

203 Georgia SHIP Coordinator Responsibilities

The Coordinator directly manages all local Georgia SHIP program components, including the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol).

The primary job responsibilities of the Georgia SHIP Coordinator shall be to:

1. Develop and implement an ongoing volunteer management process in compliance with Volunteer Risk and Program Management (VRPM) policies to ensure coverage in each county of the PSA (see 302 Volunteer Recruitment, 303 Volunteer Retention, 304 Volunteer Recognition);
2. Provide training to volunteers using DAS Georgia SHIP approved training tools, AoA/CMS publications, the National SHIP Resource Center materials and/or SMP Resource Center materials;
3. Provide quarterly in-service trainings for volunteers or at least eight (8) hours of update training per year;
4. Provide technical assistance and distribute program related information to individuals in the PSA with special consideration for time-sensitive information;
5. Develop and maintain public-private partnerships with various agencies and community-based organizations on the local level and cooperate with state level partners;
6. Assure the availability and provision for various methods of counseling services, including, but not limited to, in-person, telephone, email, mail, fax, etc.;
7. Organize, each month, at a minimum, three (3) outreach/education events to an AoA/CMS/DAS targeted population group including, but not limited to:
    a. Faith-based organization;
    b. Dual eligibles with mental disabilities (DMD);
    c. Low income;
    d. Limited English Proficiency/Sensory Impairment (LEP/SI);
    e. Rural;
    f. Homebound;
    g. Minority;
    h. Disabled; and/or
    i. Caregivers;
8. Provide at least two (2) events per county in the PSA per SFY (July 1 through June 30 of each year);
9. Establish and maintain a regularly scheduled off-site counseling station in every county in the PSA;
10. Coordinate special events as appropriate (e.g., CMS initiatives, Older Americans Month activities, DAS initiatives, etc.);
11. Assist in the development and revision of Georgia SHIP publications, including outreach, training and marketing materials, when requested;

12. Maintain an adequate supply of up-to-date program related literature and promotional materials;
13. Attend all regularly scheduled Coordinators meetings and additional required trainings or program meetings. When the Coordinator is unable to attend a required event, notice must be given to DAS Georgia SHIP staff in advance and training scheduled for an alternate time;
14. Participate in mandatory DAS-sponsored conferences (e.g., Elder Rights Conference, Joint Aging and Disability Resource Connection (ADRC) / Georgia SHIP Conference, etc.);
15. Participate actively on the Elder Rights Team in the PSA (see 408 Elder Rights Teams) and on the local ADRC Advisory Council;
16. Assure that all data is entered accurately and timely into the Aging Information Management System (AIMS) and/or other DAS designated data collection systems;
17. Assure all reports are accurate and received in a timely manner to the appropriate Georgia SHIP DAS staff person;
18. Assure that the local program satisfactorily accomplishes the goals and objectives reflected in the AAA Area Plan; and
19. Inform DAS Georgia SHIP staff on all legislative and federal funding contacts and interactions concerning Georgia SHIP.

300 Georgia SHIP Volunteers

301 General

SHIP and SMP are volunteer-based programs mandated by CMS and AoA. DAS Georgia SHIP supports and strongly encourages the recruitment and utilization of volunteers to sustain these programs. Each local program is required to recruit, retain and recognize volunteers based on funding guidelines, e.g., VRPM, P.E.A.C.H. Pals.

302 Volunteer Recruitment

Local programs will maintain an ongoing volunteer management process, including recruitment. Methods for recruitment include newsletter articles, local media, open house events, volunteer fairs, local college groups, senior centers, internet websites or other methods as the Coordinator and AAA deem appropriate.

If an individual contacts the local program for volunteer opportunities, the Coordinator is responsible for follow-up within two (2) working days.

302.1 Number of Recruits

The Coordinator will ensure volunteer coverage in every county of their PSA. Each region is required to have a minimum of six (6) active volunteers (see 303.1 Active Volunteer).

302.2 Bilingual Volunteer

The Coordinator should recruit at least one bilingual volunteer in the language most commonly spoken in the PSA other than English. Also, the local program will utilize translation services made available by the AAA (see 403 Area Agency on Aging Responsibilities).

303 Volunteer Retention

Due to the extensive training provided to each Georgia SHIP volunteer, a commitment of six (6) months of active service is preferred.

303.1 Active Volunteer

To maintain an active status with the program, a volunteer must conduct Georgia SHIP activities during a 6-month period of time. Active status is determined by the local Coordinator for volunteers who are "seasonal" or unable to fulfill this obligation due to travel, illness, family crisis, etc. Active volunteers should be documented in AIMS and other program databases (i.e., SMART FACTS and SHIP NPR).

303.2 Inactive Volunteer

An inactive volunteer has resigned or not conducted Georgia SHIP activities within a 6-month period. Inactive volunteers should be removed from AIMS and other program databases (i.e., SMART FACTS and SHIP NPR) on a monthly basis. DAS Georgia SHIP staff should be notified of all volunteer changes.

304 Volunteer Recognition

Each local program should recognize volunteers, at least annually, through an event or function to provide volunteers with a token of appreciation (i.e., certificate, award plaque, etc.) when funding is available. DAS Georgia SHIP will also provide an annual volunteer recognition event when funding is available. Coordinators are required to attend DAS-sponsored volunteer recognition events and when requested participate in the planning of the statewide recognition event. When the Coordinator is unable to attend a required event, notice must be given to DAS Georgia SHIP staff in advance. Coordinators should encourage volunteers to attend.

305 Volunteer Application, Documentation and Files

Volunteer applications are provided by DAS Georgia SHIP. AAAs or provider agencies will maintain a volunteer application for each volunteer. An original of the completed application is maintained at the local Georgia SHIP office, with one copy retained by the volunteer and one copy sent to DAS Georgia SHIP. The following documentation will also be maintained for each Georgia SHIP volunteer and reviewed during monitoring:

1. Documentation of training received;
2. Signed time sheets reflecting actual hours worked;
3. Acknowledgement of receipt of Health Insurance Portability and Accountability Act (HIPAA) training;
4. If applicable, a copy of volunteer's valid driver's license, driver's record check and proof of insurance or a signed waiver form verifying proof of insurance (see 405 Vehicle Insurance Liability);
5. Verification of a federal level criminal records check for volunteers in a position of trust. A position of trust involves access to beneficiaries or other vulnerable people's personal and/or confidential information;

6. Verification of a background check to include, but may not be limited to, verification of:
    - Identity
    - Volunteer history and experience
    - Employment history and experience
    - Education
    - Social security number; and
7. If applicable, a certificate of ability to attest to their ability to perform their assigned duties.

306 Volunteer Opportunities and Training

The local program will ensure volunteers are recruited in accordance with established volunteer opportunities (e.g., PEACH Pals). The Coordinator and the volunteer will agree upon the scope of each individual volunteer's activities to meet the needs of the local program. Volunteer opportunities may include one-on-one counseling, enrollment assistance, data entry, administrative support, outreach and education.

Volunteer training will be conducted by the local Coordinator and/or DAS Georgia SHIP as outlined in the duties and responsibilities of the volunteer application.

307 Volunteer Certification

Volunteer certification is required for positions of trust. Certification may include, but is not limited to, orientation training, role specific training, and/or a volunteer skills assessment. Certification must be obtained before any position of trust can begin.

When a volunteer skills assessment is required, volunteers will be given two attempts to receive a pass rating (80% or greater); DAS Georgia SHIP and/or the local Coordinator will provide technical assistance as needed for preparation of retesting. If the volunteer fails to receive a pass rating after two (2) attempts, it will be up to the PSA to decide alternate volunteer opportunities.

308 Volunteer Dismissal or Refusal to Certify/Recertify

DAS and/or the local Georgia SHIP program(s) maintain the right to dismiss any volunteer who does not follow established policies and procedures. Justifiable causes for dismissal include, but are not limited to:

1. Providing counseling on a topic for which the volunteer did not successfully complete Georgia SHIP training;
2. Expressing opinions, either positive or negative, to beneficiaries, clients or others that damage the reputation of Georgia SHIP as an unbiased source of information;
3. Creating a discriminatory environment based on gender, race, nationality, age, disability, religion or sexual orientation;
4. Representing Georgia SHIP in an unfavorable or unprofessional manner;
5. Profiting, in any way, from providing Georgia SHIP services;
6. Engaging in activities that could be considered a conflict of interest (see 407 Conflict of Interest);

7. Acting inappropriately based on substantiated reports of misconduct by beneficiaries, clients or others involved in Georgia SHIP activities;
8. Failing to attend quarterly in-service meetings and other mandatory training sessions without reasonable cause (e.g., travel, illness, family crisis, etc.);
9. Refusing to help a Coordinator with counseling or outreach more than five (5) times in a year without reasonable cause;
10. Knowingly providing inaccurate or outdated information to beneficiaries, clients or others;
11. Failing to document activities and/or file necessary reports by the established deadline;
12. Providing medical, legal or financial advice to Georgia SHIP beneficiaries, clients or others;
13. Being under the influence of alcohol or illegal drugs while on volunteer duty or representing Georgia SHIP;
14. Unauthorized use or misuse of program equipment and/or materials;
15. Failing to adhere to policies and standards in place by administering agencies (i.e., the AAA, DAS, and DHS).

DAS and/or the local Georgia SHIP program(s) will maintain policies on notifying volunteers of the possible grounds for corrective action or termination from the program. If the decision is to terminate the volunteer, a copy of this action must be on file with DAS Georgia SHIP and the local program.

400 Inter/Intra-Agency Coordination

401 General

DHS/DAS contracts with all twelve of the state's Area Agencies on Aging (AAAs) for the provision of the Georgia SHIP program locally within their assigned PSA. The AAAs operate the Georgia SHIP program directly or subcontract with a service provider(s) for program delivery.

402 Division of Aging Services Responsibilities

DAS Georgia SHIP provides overall statewide leadership for Georgia SHIP and is responsible for the management, planning and direction of the program. DAS shall:

1. Evaluate statewide program outcomes and effectiveness at least annually and implement improvements based on analysis of programmatic data and feedback from CMS/AoA, AAAs, Coordinators, volunteers and clients;
2. Evaluate local Georgia SHIP program performance and compliance of these standards through reports, monitoring, mystery shopping, site visits and other quality improvement/assurance methods;
3. Develop, implement and maintain policies, procedures, standards and goals for the administration of the Georgia SHIP program;
4. Conduct a risk assessment on the roles, work and activities of volunteers;
5. Develop, implement and maintain materials for training and distribution purposes;
6. Provide information and referral on current issues and trends under the SHIP and SMP pro-

grams;

7. Participate on the state Elder Rights Team (see 408 Elder Rights Teams) and the state ADRC Advisory Council;
8. Identify a liaison or contact person for referral and assistance in key agencies and organizations, such as CMS, AoA, Quality Improvement Organization (QIO), Office of State Insurance Commissioner (OIC) and Social Security Administration (SSA);
9. Develop and maintain relationships with statewide partner organizations;
10. Maintain the Aging Information Management System (AIMS), in collaboration with the Division of Aging Services (DAS) and the Office of Information Technology (OIT);
11. Review, comment and approve Georgia SHIP components of the annual Area Plan submitted by the AAAs;
12. Prepare Georgia SHIP components of the annual Just the Facts report and other requested reports;
13. Conduct certifications, re-certifications and ongoing training for Georgia SHIP Coordinators;
14. Assist the AAAs with arrangement for temporary provision of Georgia SHIP services during transition to a new Coordinator or provider agency;
15. Participate in interviews for applicants as a member of an interviewing team and/or assist in job performance review at the provider agency's request;
16. Develop and maintain a Georgia SHIP website including basic program information and updates (see 607 Electronic Access);
17. Participate in relevant trainings, conferences and meetings and share information appropriately (see 410 Coordination of Information); and
18. File grant applications and ensure all grant requirements and reports are completed in a timely manner.

403 Area Agency on Aging Responsibilities

The AAA is responsible for assuring the provision of Georgia SHIP services in its PSA as per the DHS/DAS contract, either through subcontracts(s) with a provider agency or by serving as the provider agency. The AAA shall:

1. Maintain a full-time equivalent Georgia SHIP Coordinator that is not assigned any duties outside of the scope of the Georgia SHIP Program;
2. Inform DAS Georgia SHIP of all local staff changes and interruptions in staffing within five (5) business days of notice and/or change;
3. Provide a transition plan to minimize disruption in Georgia SHIP services when the Coordinator position is vacant or when the contract for the program is terminated or not renewed;
4. Evaluate the effectiveness of the local Georgia SHIP program at least annually and make adjustments in activities and/or budget items to meet the needs of the program;
5. Ensure that the local Georgia SHIP program maintains a sufficient supply of office supplies and equipment (e.g., electronic equipment, toner, paper, postage, etc.) to meet the needs of the clients served;

6. Provide opportunities for the local Georgia SHIP program and other aging and social service organizations to collaborate to promote the health, safety and well being of people with Medicare;
7. Ensure translation services are available via a translations line contract;
8. Assure that each Georgia SHIP office has, at a minimum, a high-speed internet connection and a sufficient voicemail system for incoming messages;
9. Promote awareness of Georgia SHIP services to consumers and the general public within the service area;
10. Ensure data and reports are provided to DAS in a timely manner and in the format required;
11. Work with DAS Georgia SHIP to remedy any program deficiencies within the PSA within 30-120 days, or sooner depending on the severity of the deficiency;
12. Submit an annual Area Plan reflecting the overall goals and/or focus of Georgia SHIP and SMP;
13. Generate and maintain all required records, reports and documentation of Georgia SHIP activities and volunteers;
14. If applicable, maintain a copy of volunteer's valid driver's license, driver's record check and proof of insurance or a signed waiver form verifying proof of insurance (see 405 Vehicle Insurance Liability); and
15. Conduct federal level criminal records checks for volunteers in a position of trust (see 305 Volunteer Application, Documentation and Files).

404 Advocacy

Identifying advocacy issues is an important program activity for Georgia SHIP Coordinators, staff and volunteers. Issues identified should be communicated to the DAS Georgia SHIP staff immediately through oral or written communication.

Coordinators, staff and volunteers are free to express their individual opinions to their elected officials, but are prohibited from speaking for, or on behalf of, the Georgia SHIP Program without prior approval from the AAA Director or DAS Georgia SHIP Program staff. Coordinators, staff and volunteers should not use the name or logo of Georgia SHIP, SMP, DHS and/or DAS when expressing their personal opinions to their elected officials.

405 Vehicle Insurance Liability

Georgia SHIP Coordinators, staff and volunteers shall not transport client(s) in any vehicle regardless of its ownership. Administering agencies are required to obtain, (if necessary), proof of a valid driver's license, driver's record check and/or proof of insurance for all drivers using their own or a company vehicle for Georgia SHIP activities.

Georgia SHIP Coordinators, staff and volunteers are covered by the state law, including O.C.G.A. § 49-6-63(g) and the DOAS Employee Liability Agreement, for actions within the scope of Georgia SHIP activities.

406 Privacy and Confidentiality

Georgia SHIP Coordinators, staff and volunteers shall maintain the privacy and confidentiality of

information disclosed to them in the course of carrying out Georgia SHIP activities pursuant to state and federal laws, regulations and DHS and DAS policies, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996. All Georgia SHIP volunteers are subject to the Georgia Department of Human Services policies on HIPAA. Volunteers may share information on counseling activities with only DAS Georgia SHIP staff and designated staff at the local AAA, as appropriate. Volunteers shall inform clients regarding confidentiality and privacy practices. Oral and/or signed consent is required to disclose information to outside sources and clients must authorize Georgia SHIP to discuss their information with others, unless otherwise required by law.

407 Conflict of Interest

All DAS Georgia SHIP and local staff, including volunteers, in accordance with state and federal laws, regulations and DHS/DAS policies, will refrain from engaging in any activities that could cause a conflict of interest or the appearance of a conflict of interest. Volunteers and staff may not sell or endorse, directly or indirectly, any related products or services, including those related to insurance. Any situation appearing to have a conflict of interest should be evaluated by DAS and/or AAA legal staff to ensure compliance with state and federal law.

408 Elder Rights Teams

The DAS Georgia SHIP staff and local Georgia SHIP Coordinators shall participate in the state and local Elder Rights Team and coordinate with the AAA, Long-Term Care Ombudsman (LTCO) Program, the Elderly Legal Assistance Program (ELAP), the Elder Abuse Prevention Program, Adult Protective Services and other pertinent entities (see also 203 Georgia SHIP Coordinator Responsibilities and 402 Division of Aging Services Responsibilities).

409 Partnership and Resource Development

DAS Georgia SHIP will develop statewide resources for the program through grant funds and public-private partnerships. The DAS Georgia SHIP will develop collaborations with organizations that will enhance the statewide Georgia SHIP. Participant updates and activities will be disseminated to local Coordinators and AAAs. Each local program will support DAS partnership efforts and develop cooperative relationships within their regions with participating agencies. The local Coordinator will report any issues and concerns of all significant local partnership activities or local development activities directly to DAS Georgia SHIP.

410 Coordination of Information

The DAS Georgia SHIP shall provide for the coordination of information between federal, state, local and other agencies and local programs on Medicare, health care fraud and other related topics.

DAS shall act as the conduit for programmatic, contract, complaint and other program related information between the local Coordinators and DAS funders (i.e., CMS and AoA) in accordance with applicable DAS Program Instructions or Memorandums.

411 Records Retention

Local Georgia SHIP programs shall maintain all original client and volunteer records at their site or designated location. Records will be maintained for the length of time required by the fund sources,

generally for six (6) years. Coordinators will also maintain copies of training agendas, curriculum and sign-in sheets. Files should be maintained in accordance with HIPAA (i.e., out of plain sight when in use or under lock and key).

412 Credit and Logo Policy

To ensure statewide consistency and program recognition, all materials developed for Georgia SHIP must display the Georgia SHIP logo and, if possible, the logo of DHS and/or DAS. Printed Georgia SHIP materials should also include the DAS statewide phone number, 1-866-55AGING or 1-866-552-446. Additional logos or tag lines may be needed as required by funding sources including, but not limited to, CMS and AoA. Georgia SHIP must follow the logo policy of the Georgia Department of Human Services, Office of Legislative Affairs and Communications.

To ensure adherence to grant requirements and quality standards, DAS Georgia SHIP retains the right to review and approve or deny public education and training materials produced by AAAs and provider agencies. Locally developed materials must be submitted to DAS Georgia SHIP for approval or denial prior to printing and distribution. Allow a minimum of two (2) business days for review and response.

Local programs may add the logo of the AAA or Regional Commission (RC) to give printed materials a local identity. It is not appropriate to add the logo of a for-profit partner to any materials bearing the DHS or DAS logo without written approval from DAS.

Coordinators should display the Georgia SHIP logo on presentation tables, exhibits and booths at events.

500 Training and Technical Assistance

501 General

The DAS Georgia SHIP will provide training to Coordinators. Included in the training will be materials that Coordinators will use to ensure that up-to-date, accurate information concerning health insurance issues is provided to volunteers, Medicare beneficiaries, their caregivers, partners and the general public. Additionally, DAS Georgia SHIP will assure that local Coordinators receive information and training to assist them in the program management process. Local Coordinators may have volunteers or other staff to participate in DAS Georgia SHIP trainings with prior approval.

DAS Georgia SHIP will also provide appropriate training to volunteers, Medicare beneficiaries, their caregivers, partners and the general public.

502 New Coordinator Training

The DAS Georgia SHIP will begin training all new Coordinators within the first fifteen (15) working days of employment. Methods may include classroom, self-study, web-based conferencing, teleconferencing and/or other appropriate methods. Mandatory training will be provided on the following topics:

1. Georgia SHIP Program Overview, including DAS, SHIP and SMP;
2. Original Medicare (Medicare Parts A and B);
3. Medicare Supplement Insurance (Medigap policies);

4. Medicare Advantage Plans (Medicare Part C);
5. Medicare Prescription Drug Plans (Medicare Part D);
6. Medicare Assistance Programs;
7. Medicare Appeals and Grievances;
8. Health Care Fraud, Error and Abuse;
9. Consumer Protection;
10. Long-Term Care Insurance;
11. Georgia Long-Term Care Partnership;
12. Counseling and presentation skills;
13. Data Management, including Performance Measures and AIMS;
14. Volunteer Management; and
15. Program Management.

503 Georgia SHIP Certification Process

Three (3) months after employment, DAS Georgia SHIP staff will provide to the Coordinator a written or online examination developed to assess their ability to apply SHIP and SMP information appropriately.

The Coordinator must complete and return the written or online examination within one (1) month of its receipt. The written or online examination will be evaluated on a pass/fail basis by DAS Georgia SHIP staff within thirty (30) calendar days. If the Coordinator does not receive a pass rating (80% or greater), DAS Georgia SHIP will provide technical assistance as needed for preparation of retesting.

Coordinators may not submit the written or online examination more than two (2) times within ninety (90) days of the receipt of the initial testing. If the Coordinator fails to receive a pass rating after two (2) attempts, the AAA must appoint a new Coordinator.

When the written or online exam is given a pass rating, DAS Georgia SHIP will administer an oral examination. If the oral exam is not passed upon the initial attempt, one (1) additional attempt will be given. If a pass rating is not obtained after the second (2^{nd}) attempt, the AAA must appoint a new Coordinator.

Coordinators are required to obtain a pass rating from both the written and oral examinations.

504 Georgia SHIP Recertification Process

Eighteen (18) hours of training is required each year to receive Georgia SHIP Recertification. To fulfill the requirement, each Coordinator must complete a minimum combination of 6 hours of SHIP-related training, 6 hours of SMP-related training and 6 hours of other program related training (e.g., volunteer management, additional SHIP and SMP and other program-related topics). The training must be provided from sources approved by DAS Georgia SHIP. Recertification is not required during the initial SFY of certification.

505 Refusal to Certify/Recertify an Individual as a Georgia SHIP Coordinator

DAS Georgia SHIP may refuse to certify/recertify any Georgia SHIP Coordinator for reasons including, but not limited to, the following:

1. Failure of the Coordinator to meet and/or maintain minimum qualifications for certification or recertification;
2. Existence of any conflict of interest or appearance of a conflict of interest (see 407 Conflict of Interest);
3. Deliberate failure of the individual to disclose any conflict or interest or appearance of a conflict of interest (see 407 Conflict of Interest);
4. Giving or having the appearance of giving an endorsement or preference for any product or specific service provided to Georgia SHIP clients;
5. Violation of confidentiality or HIPAA requirements;
6. Failure to provide adequate and appropriate services to Georgia SHIP clients;
7. Falsifying records or consistently misrepresenting or having errors in reporting and data;
8. Failure to follow the standards, policies and procedures of the DAS Georgia SHIP Program;
9. A change in employment duties which is inconsistent with Georgia SHIP duties;
10. Separation from the Georgia SHIP Program due to, but not limited to, termination of employment with the provider agency, an extended absence from the program preventing fulfillment of job responsibilities, termination or non-renewal of a provider agency's contract;
11. Providing counseling on a topic which the Coordinator did not successfully complete Georgia SHIP training;
12. Expressing opinions, either positive or negative, to beneficiaries, clients or others that damage the reputation of Georgia SHIP as an unbiased source of information;
13. Creating a discriminatory environment based on gender, race, nationality, age, disability, religion or sexual orientation;
14. Representing Georgia SHIP in an unfavorable or unprofessional manner;
15. Profiting, in any way, from providing Georgia SHIP services;
16. Acting inappropriately based on substantiated reports of misconduct by beneficiaries, clients or others involved in Georgia SHIP activities;
17. Failing to attend required in-service meetings and other mandatory training sessions without reasonable cause (e.g., illness, family crisis);
18. Knowingly providing inaccurate or outdated information consistently to beneficiaries, clients or others;
19. Failing to document activities and/or file necessary reports by the established deadline;
20. Providing medical, legal or financial advice to Georgia SHIP beneficiaries, clients or others; and
21. Failing to adhere to policies and standards in place by administering agencies (i.e., the AAA, DAS, and DHS).

506 Process for Refusal to Certify/Recertify an Individual as a Georgia SHIP Coordinator

Prior to refusing to certify or recertify, DAS Georgia SHIP shall conduct one or more of the following actions:

1. Consult with the contracting AAA to consider remedial actions to avoid the refusal to certify or to recertify;
2. Provide written notice of such refusal to the contracting AAA agency and/or provider agency. Such notice shall:
    a. Specify the reasons for the refusal to certify or recertify, and
    b. Set forth the effective date of such refusal;

If the refusal to certify or recertify an individual as a Georgia SHIP Coordinator results in the absence of Georgia SHIP services in the relevant service area, the AAA and/or provider agency and DAS Georgia SHIP shall arrange for the provision of Georgia SHIP services until a Georgia SHIP Coordinator is designated.

600 Access to Georgia SHIP Services

601 General

The Georgia SHIP provides information statewide, and occasionally nationally, on Medicare and other related issues. Community and beneficiary education is provided through, but not limited to, in-person, telephone, email, mail, fax, website and public forums.

602 Standard of Promptness

Each method of contact will maintain a maximum standard of promptness of two (2) working days.

If a caller cannot be reached on the first callback of a telephone inquiry, a second attempt is required.

603 Telephone Access

Each local program will provide a local telephone number where client calls will be received. The greeting message must clearly identify the Georgia SHIP Program.

To assure that the statewide system remains fully functional, all changes affecting the toll-free hot-line should be relayed to DAS Georgia SHIP prior to the change. This includes changing the local telephone routing number or location of the telephone (e.g., new site or new office). Financial charges may be incurred on these change requests and are not the responsibility of DAS Georgia SHIP.

604 Business-Hours Coverage

The Georgia SHIP hotline at local levels will be answered live, six hours a day on days of regular business operations with a minimum of thirty (30) hours a week. A voicemail answering system must be provided on each line that has a capacity of collecting at least 30 messages or up to 60 minutes to ensure calls are intercepted while assisting other clients.

605 After-Hours Coverage

Each local program must provide a voicemail system that will collect at least 30 messages or up to 60 minutes for messages received after normal business hours.

606 In-person Counseling Sessions

Clients may request in-person counseling sessions. Staff and volunteers, with the guidance and approval from the local Coordinator, shall make reasonable efforts to accommodate these requests and meet with clients in public locations. The agreed upon location should be in a safe, accessible site that affords some protection of privacy [i.e. office, off-site counseling station (see 608 Off-site Counseling Stations), library, health clinic, etc.].

607 Electronic Access

The DAS Georgia SHIP will maintain basic Medicare information on the DAS website (www.aging.dhr.georgia.gov/portal/site) and the Georgia SHIP website (www.mygeorgiacares.org). When possible, reciprocal links will be added to DAS, Georgia SHIP, local offices and partner websites.

608 Off-site Counseling Stations

An off-site counseling station is a location, other than the local Georgia SHIP office, where clients receive one-on-one counseling and/or enrollment assistance. Off-site counseling stations are locally accessible to all beneficiaries in the PSA, including low-income, rural and hard-to-reach populations.

Georgia SHIP will establish and maintain off-site counseling stations in every county throughout Georgia.

700 Community Education and Outreach

701 General

Group sessions and presentations are an opportunity to provide free, unbiased and factual health insurance information to people with Medicare and others in a group setting. Community education and outreach events (i.e., health fairs or booths) are efforts to inform individuals about the available services offered through Georgia SHIP. These events may be arranged by the local Georgia SHIP program or conducted in response to a request from an organization.

Each local Georgia SHIP program will assess, plan and provide community outreach and education to ensure that people with Medicare, their caregivers and others are able to make informed health coverage decisions and understand related rights and protections. Local Georgia SHIP programs will conduct community education and outreach events throughout the year (see 203 Georgia SHIP Coordinator Responsibilities).

702 Materials for Distribution

Each local Georgia SHIP program will have up-to-date literature and promotional materials available at outreach and education events and be able to fill requests for materials. The local Georgia SHIP program will distribute materials from national, state and local partners.

Information and outreach materials disseminated at outreach and community education events are at the discretion of the Coordinator; however, materials should be relevant to the subject matter of the event. Ideally, materials should include information about SHIP, SMP and a variety of Medicare and consumer protection information.

Due to the limited availability of materials, it is recommended that no more than two (2) promotional items be distributed at each event. However, this restriction does not include brochures or informational handouts.

703 Locations

Events may be conducted in a variety of settings including, but not limited to, outdoor parks, senior centers, service organizations, religious organizations, businesses and libraries. All events locations should be handicap accessible and provide reasonable accommodations to those with disabilities.

800 Program Management

801 General

Data collection is mandatory and required at all levels (i.e., Coordinators, staff, volunteers, partners). The Aging Information Management System (AIMS) is the official reporting system for the Georgia SHIP. Entering data into AIMS or any DAS-designated system is required. Reporting and tracking this information accurately and timely is required by state and federal fund sources. Data management must be inputted and validated on a monthly basis.

802 Reports

Reporting requirements are stipulated in the contracts between DAS and the AAA (i.e., Annex R, S, Y and Y1). Additional reports may be requested. Each local program will submit reports to DAS Georgia SHIP in accordance with the contract or request and in the required format.

803 Due Dates

All due dates for data required by DAS are stipulated in the contract with the AAA. Due dates are the 15th working day of the month and are submitted monthly, quarterly or semi-annually as required unless otherwise indicated in writing.

804 Data Collection

Data collection is required for counseling services and community outreach and education (e.g., public and media forms or client registration forms). The data collected must be entered into AIMS or any DAS-designated system and submitted in a timely and accurate manner.

805 Grant Funding Expenditures

CMS SHIP funds are to be obligated by March 31 of each calendar year and are to be liquidated by May 15 of each calendar year.

AoA SMP funds are to be obligated by May 31 of each calendar year and are to be liquidated by July 15 of the same calendar year.

Grants outside of basic SHIP and SMP awards will be specified accordingly.

Effective Date: January 2013

Approved:

_____

Dr. James J. Bulot, Director
Georgia Department of Human Services Division of Aging Services

3030 GeorgiaCares Brochure

3060 Georgia SHIP Writing Toolkit

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	3000 Georgia State Health Insurance Assistance (SHIP) Program	**Effective Date:**	
	Section Title:	Georgia SHIP Writing Toolkit	**Reviewed or Updated in:**	
	Section Number:	3060	**Previous Update:**	

What is a Writing Toolkit?

The Georgia SHIP Program provides services to Medicare beneficiaries throughout the state of Georgia. It is important that Georgia SHIP communicates with the Medicare population efficiently and effectively. This writing toolkit is designed to assist Georgia SHIP Program Coordinators, volun-

teers, and staff with written material guidelines.

Writing toolkits are designed to help improve material written for family members of people with Medicare, outreach workers, agency staff, community organizations, and care providers.

A writing toolkit can assist in making written materials easier for people with low literacy skills to understand written information that is sent to their homes regarding Medicare and health related changes.

What are Written Materials?

Written materials come in different shapes and sizes and are used for different purposes. Written materials in a printed format are brochures, pamphlets, booklets, flyers, fact sheets, posters, bookmarks, application forms, comparison charts, postcards, instruction sheets, and questionnaires.

The Georgia SHIP Program assists Medicare beneficiaries, caregivers, and health care providers with understanding Medicare benefits, applying for Medicare assistance programs and comparing Medicare plan options. The ability to understand coverage is important to the Medicare population.

Written materials can ask the reader to supply program-related or health-related information. Examples include enrollment forms for services, health history questionnaires, and satisfaction surveys.

Helping Older Readers

When developing written material for Medicare beneficiaries including older adults, it is important to be aware of the aging process.

Medicare beneficiaries in the older adults' category experience changes in vision, declines in cognitive processes and less flexibility in thought processes. The loss of cognitive skills can make it difficult for older adults to understand and use written material.

It takes older adults longer to recall information and longer to complete tasks that require locating and using information. Slower processing of information can make it harder for older adults to do things such as locate specific types of information in a document or make comparisons.

Older adults show less ability to make decisions when they are given additional information that

might otherwise alter their opinion. Moreover, older adults are less able to engage in "divergent thinking," which is the ability to generate alternative explanations or solutions to a problem.

Make Reading Easier

Consider content, organization, writing, and design that help make the material less taxing on the reader's working memory and speed of information processing.

Anticipate possible problem areas and avoid writing materials that might slow, confuse, or mislead older readers.

Focus on what matters most to your readers and assure that it is culturally appropriate. Limit the amount of information and emphasize the main points that readers really need to know.

If materials are condensed, do not exclude explanations, examples, and summaries that help readers understand the information.

Sample Letters

The DAS Georgia SHIP team has developed sample letters that will provide standard language. These letters, shown in the appendices, provide examples of letters that are easy for beneficiaries to read and understand. Letters should be formatted according to your Area Agencies on Aging (AAAs), i.e. including logos, contact information, signature, etc.

More Information

You can find additional information on how to write materials by visiting the CMS website that is listed below.

www.cms.gov/WrittenMaterialsToolkit

Appendix A

Dear Medicare Beneficiary:

Thank you for contacting the Georgia SHIP Program. Per your request, the following information is included:

- ▢ Original Medicare (Part A/B)
- ▢ Medicare Advantage Plans (Part C)
- ▢ Medicare & You Handbook
- ▢ Medicare Prescription Drug Plan (Part D)
- ▢ Medicare Savings Programs (MSP)
- ▢ Low Income Subsidy/ Extra Help (LIS)
- ▢ Medicare Supplement Insurance (Medigap)
- ▢ Medicare Fraud, Error and Abuse
- ▢ Volunteer Opportunities

▢ Other: _____

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Georgia SHIP helps people with Medicare understand their choices and enroll in a Medicare plan to meet their needs. Our program can help you understand Medicare and get the most out of your healthcare benefits. We also provide individual counseling, community education, and outreach.

If you would like to know more about the Georgia SHIP program and to see if you are eligible for the Medicare Saving Programs, please contact Georgia SHIP at 1-866-552-4464, option 4.

Sincerely,

Appendix B

[DATE]

[NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear [NAME]:

Thank you for calling the Georgia SHIP Program regarding the Low Income Subsidy (LIS/Extra Help) Program. Based on the information obtained during the phone screening process it appears that you are eligible for the Extra Help program. The eligibility limits follow the program guidelines set by the Social Security Administration (SSA).

An application has been submitted to the SSA on your behalf. It may take up to eight weeks to receive a determination letter explaining your benefits. The determination letter will come from the SSA.

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Georgia SHIP helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. Our program can help you understand Medicare and get the most out of your healthcare benefits. We also provide individual counseling, community education, and outreach.

If you have questions, please contact the Georgia SHIP Program at 1-866-552-4464, option 4.

Sincerely,

Appendix C

[DATE]

[NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear [NAME]:

Recently, you called the Georgia SHIP program regarding Medicare Advantage Plans (Part C) and/or the Medicare Part D Prescription Drug benefit. It was a pleasure working with you to find a drug plan that is appropriate for your needs.

Please find enclosed plan comparisons for your review to make the best decision concerning your prescription drug plan. After careful review of the plans you may call the Georgia SHIP program or Medicare to assist you in the enrollment process.

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Our program helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. We also can help you understand Medicare and get the most out of your healthcare benefits. Georgia SHIP provides individual counseling, community education, and outreach.

After you have reviewed the plans, please do not hesitate to call the Georgia SHIP Program with any questions or concerns at 1-866-552-4464, option 4.

Sincerely,

Appendix D

[DATE]

[NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear [NAME]:

Thank you for calling the Georgia SHIP Program about the Medicare Savings Programs. Based on the results of your phone screening and according to program guidelines by the Division of Family and Children Services (DFCS) you appear to be eligible for the program.

I have completed the Medicare Savings Program application on your behalf. Please sign and submit the application along with a front and back copy of your insurance cards to the Division of Family and Children Services (DFCS) listed on top of the application. It may take up to 45 days to receive a determination letter in the mail explaining your benefits. The determination letter will come from Division of Family and Children Services (DFCS).

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Our program helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. We also can help you understand Medicare and get the most out of your healthcare benefits. Georgia SHIP provides individual counseling, community education, and outreach.

If you have additional questions, please contact the Georgia SHIP Program at 1-866-552-4464, option 4.

Sincerely,

Appendix E

[DATE]

[NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear [NAME]:

Thank you for calling the Georgia SHIP Program regarding the Low Income Subsidy (LIS/Extra Help) Program. You may be eligible for Extra Help based on the results of your phone screening and the program guidelines from Social Security Administration (SSA). I have enclosed an application for you to complete and submit to the SSA. You may also visit www.ssa.gov/ and apply online. It may take up to eight weeks to receive a determination letter explaining your benefits. The determination letter will come from the SSA.

Enclosed is a SSA publication for the Extra Help program. The "Getting Extra Help with Medicare Prescription Drug Plan Costs Resource and Income Limits" publication provides helpful information about the program.

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Our program helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. We also can help you understand Medicare to get the most out of your healthcare benefits. Georgia SHIP provides individual counseling, community education, and outreach.

If you have additional questions, please contact the Georgia SHIP Program at 1-866-552-4464, option 4.

Sincerely,

Appendix F

[DATE]

[NAME]
[ADDRESS]
[CITY, STATE, ZIP CODE]

Dear [NAME]:

The Georgia SHIP Program is contacting you because you may be eligible for the Medicare Savings Programs (MSPs). The Medicare Savings Programs (MSPs) can help you save on your Medicare costs. The Georgia SHIP program can screen Medicare beneficiaries to see if they are eligible for the Medicare Savings Program. We can also assist you with the application process.

Georgia SHIP is the State Health Insurance Assistance Program (SHIP) and SMP (Senior Medicare Patrol) project. Our program helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. We also can help you understand Medicare and get the most out of your healthcare benefits. Georgia SHIP provides individual counseling, community educa-

tion, and outreach.

If you would like to know more about the Georgia SHIP program and to see if you are eligible for the Medicare Saving Programs, please contact Georgia SHIP at 1-866-552-4464, option 4.

Sincerely,

5000 Aging and Disability Resource Connection (ADRC)

5021 Purpose and Goals

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Purpose and Goals	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5021	**Previous Update:**	

Purpose

The overarching goal of access system services is to be able to deliver the information, assistance, awareness, access to services and the support consumers need to link with available and appropriate resources that will allow them to maximize independence and live in the setting of their choice.

The access system currently is referred to as the Aging & Disability Resource Connection (ADRC). The ADRC initially began as a “one-stop-shop” concept and has evolved into the current No Wrong Door (NWD) model where individuals of all ages, disabilities and incomes are served. This model reaches across multiple funding streams and allows individuals to select the most appropriate mix of services and supports to meet their individual needs. To view the NWD model as described by the Administration for Community Living (ACL) Center for Medicare/Medicaid Services (CMS) and the Veterans Health Administration (VHA) follow this link: www.acl.gov/node/413.

All Area Agencies use a telephone greeting that is inclusive of both aging and disability.

This section establishes the requirements for implementation and operation by Area Agencies on Aging of an access system which incorporates necessary strategies and activities to achieve the following related goals:

a. To provide older persons (age 60+) and persons of any age living with Alzheimer’s Disease and related disorders, persons with disabilities, and/or their family members or other caregivers, and professionals serving these individuals information about and access to needed services and supports, regardless of their income status;

b. To offer options counseling to all individuals contacting the ADRC who are identified as high priority based on targeting criteria identified using the Triage assessment;

c. To provide information, referral and assistance based upon individuals’ needs and preferences and establish eligibility for services provided either through the area agency’s contracted providers or other agencies.

d. To establish a strong local role and clear identity of the ADRC as the primary no wrong door and source of information and assistance, including public and private resources, for older persons, persons with disabilities and/or their family members or other caregivers and professionals serving these individuals.

Scope

This chapter describes activities/services which ensure the public's access to information about community resources and services available through the aging and long-term care system provided through an Area Agency on Aging (AAA) or its subcontractor(s), regardless of fund source(s) supporting the services, and to other publicly and privately funded community resources and benefits. The guidelines and standards encompass performance, accessibility and accountability.

a. Older persons and persons with disabilities and/or their family members/caregivers and professionals serving these individuals are aware of existing services and supports and are empowered to make informed choices and decisions regarding services and supports.

b. Individuals are connected with existing benefits and services in the community.

c. The ADRC network collects and uses accurate data about frail elderly persons and individuals with disabilities, their caregivers (if present) and their service needs in community-wide and area-wide service planning, priority setting, and program development.

d. Older persons, persons with disabilities and their family members can expect to receive high quality services at reasonable cost as a result of the use of quality improvement methods by the ADRC network.

e. The Area Agency demonstrates the ability to effectively manage service resources by ensuring that applicants for services are referred to the most appropriate, timely, and cost-effective services and supports to meet their needs and preferences to the extent possible.

f. The Area Agency develops, implements and communicates to service provider agencies procedures to be used to ensure that all providers route requests for information, assistance and services to the Area Agency utilizing the web intake form located at hssgaprod.wellsky.com/assessments/?WebIntake=2CBCF6CD-9412-4839-8EF8-5864FA6BA0F9

g. The Area Agency maintains and manages the waiting list for services for the planning and service area in the form and manner established or accepted by the Division and establishes procedures for transmitting client information to service providers to assess for services using the DAS Data System (DDS).

h. The Area Agency provides leadership in carrying out the Elder Rights Advocacy functions as provided by the Older Americans Act, Titles III and VII and assures their integration and coordination with the access system.

i. Area Agency Directors will assure that all ADRC staff, and other staff of the agency, or of provider agencies, as appropriate, receives a copy of these Guidelines and Requirements (and any subsequent revisions) before or during their orientation to their duties, and thereafter as a part of ongoing training.

5022 Program Characteristics

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Program Characteristics	**Reviewed or Updated in:**	MT 2019-02
	Section Number:	5022	**Previous Update:**	

Summary Statement

Services and activities which foster access to the aging/disability/long-term care system consist of intake and applicant screening; provision of information, assistance and referral services, at a minimum. A comprehensive access system extends to the provision of advocacy, outreach, ombudsman services, eligibility determination, assignment of levels of care, service authorization, participant assessment, options and benefits counseling, care planning and care coordination.

Goal

The goal of the statewide aging network is to build, using the no wrong door (NWD) system description, the component services which are identified by the following characteristics:

a. *Flexibility*: The services/activities are flexible; they can meet individual client requirements and preferences to the extent possible - provide brief information for some, assistance and service authorization for others, and Options Counseling to targeted individuals.

b. *Readily accessible*: Individuals have ready access to a widely-advertised system of assistance.

c. *Neutrality*: The services/activities are conducted independently and separately from the direct delivery of other services, to assure better coordination and avoid potential for conflicts of interest.

d. *Diversity*: The services/assistance provided are responsive to racially, culturally, ethnically and socially diverse groups dwelling in the communities including the hard-to-reach populations.

e. *Knowledgeably administered*: Staff is knowledgeable of community services, including publicly funded, privately funded and non-traditional service options and is creative in arranging individuals' access to them.

f. *Variety*: Clients have choices about which, if any, of the available services they will use.

g. *Promote self-determination*: Staff assists elderly persons, persons with disabilities, and/or their family caregivers to act on their own behalf.

h. *Promote independence*: Staff provides information and assistance which support individuals' highest level of functioning in the least restrictive environments.

i. *Provide assistance*: Staff provides/offers additional assistance to individuals including long-term support options counseling to any consumer who requests or agrees to the counseling after staff identifies the possible need for counseling.

j. *Person centered planning*: Staff asks questions of individuals in an effort to learn wants, needs, preferences and values in the planning process.

5023 System Structure

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	System Structure	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5023	**Previous Update:**	

Summary Statement

The Area Agency shall assure that the services and activities undertaken in the service area are performed in an integrated, seamless manner.

Procedures

a. The Area Agency is required to provide information and assistance services directly, including intake and assessment for all services provided through the Area Agencies' contracts with service providers.

b. The Area Agency may, through the negotiation of subcontracts, delegate any and all components of client assessment and care coordination but must be able to document that the subcontract arrangement is the more efficient and effective model of service delivery.

c. Case management/care coordination are terms used interchangeably and refer to the more extensive assistance component of an access system. (See §5024(g) for guidance on the duration of information and assistance services.]) The Area Agency may elect to phase in the provision of case management assistance, including client assessment and service planning, and may use any and all allowable fund sources in support of the delivery of these services. Guidelines and standards for case management are addressed in a separate policy issuance. See Chapter 210 in the Non-Medicaid Home and Community Based Services manual.

d. The Area Agency will provide documentation in a format specified or approved by the Division that demonstrates that the integration of the services has occurred or will occur as a result of the agency's leadership and strategic planning. The required documentation shall be submitted at the time of submission of a proposed area plan, area plan amendment or update; and at the time of program review by the Division; or upon request of the Division.

e. Ideally inquirers will have their needs for information, referral and assistance services and assessment for potential admission to services, if indicated, met by a single trained staff person, who will manage all aspects of service provision at the ADRC level. Inquirers will know the name of the person assisting them and how to contact them for additional assistance and follow up.

f. All initial call data will be recorded in the DAS Data System, regardless of whether the call results in assessment for admission to services. Staff will enter basic inquirer identifying information and other pertinent call data into DAS Data System as calls are received. Unless the caller refuses to provide information, staff will complete all data elements on the Basic Client Screen in DAS Data System. (See 5032 Accountability and Quality Improvement for guidance on data entry.)

g. All access system staff shall have a working knowledge of programs and services provided through their regional aging networks, as well as basic knowledge of other public and privately funded community resources.

h. Waiting list management: Staff shall manage the HCBS waiting list using the DAS Data System application and/or any other applications which may be developed in the future for this purpose. Data to be considered for waiting list management and admission criteria are discussed in 5038 Waiting List Management and Criteria for Admission to Services.

i. Interaction with the ADRC will provide all callers a seamless, "no wrong door" experience, characterized by prompt handling of all correspondence and verbal communications and by interactions by inquirers with as few staff as possible. The preferred operational model is depicted in Appendix 5060-C. The Division may consider alternatives from this model, which the AAA can address through the Area Plan development and approval processes.

5024 Primary Duties

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Primary Duties	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5024	**Previous Update:**	

Summary Statement

The comprehensive, streamlined access system provides the following services. The components are inter-related and require that current and future staff be cross-trained on all aspects of the access service system.

Standards

a. **Information Provision**: Staff shall provide information to inquirers in response to direct requests for information.

   1. Staff shall request the name and telephone number at the beginning of a telephone call, in case the caller is disconnected.
   2. Staff shall encourage the inquirer to re-contact the agency if information provided proves to be incorrect, inappropriate or insufficient for needed services/resources.
   3. Information provided shall be accurate and pertinent to the request.
   4. Information provided may range from limited responses (organization names, addresses, telephone numbers) to detailed information about community service systems (explanations of application processes, agency policies, etc).
   5. Staff shall enter basic client information into the DAS Data System for all inquiries (telephone, email, fax, walk-ins).
   6. Faxes, email, and other correspondence sent to the ADRC from home health agencies or hospitals for the discharge planning process do not require telephone contact except when

requested by a potential client. A letter mailed to the client explaining the AAA/ADRC and services offered is sufficient. Basic client information must be entered in the DAS Data System.

7. Counselors must explain to all callers that individual clients will not be placed on a waiting list without their knowledge and consent except in cases where the individual cannot give consent, allowing the Counselor to provide Information and referral and to complete the assessment with the caller or other representative without first speaking with the individual in need of services.

b. **Referral Provision**: Staff shall provide referrals that address needs communicated by the inquirer, as openly and non-obtrusively as possible and allow inquirer to choose from a variety of service options. ..The referral process consists of:

   A. Identifying the needs of the inquirer;

   B. Identifying appropriate resources to meet the stated need;

   C. Providing enough information about each resource to help inquirers make an informed choice;

   D. Helping inquirers for whom services are not available identify alternative resources; and,

   E. Actively participating in linking the inquirer to needed services, including warm transfers when necessary.

c. **Assistance**: The Area Agency shall ensure information is provided through a variety of formats and media, accommodating language barriers and literacy issues, including supported access through an access system staff member or case manager, also including access to staff in other organizations, and additional options for independent access by inquirers.

d. **Advocacy/Intervention**[1]: The Area Agency shall offer advocacy to ensure people receive the benefits and services to which they are entitled and organizations within the established service delivery system meet the collective needs of the community.

   1. The AAA will develop guidelines for staff providing advocacy on behalf of individual inquirers, including obtaining permission from the inquirer to proceed with making contacts on his/her behalf.

   2. Individual/Client Advocacy: Staff shall intervene on behalf of an individual to help establish eligibility and obtain appropriate services; when the individual needs assistance communicating their needs to a service provider or otherwise effectively representing themselves; or when they have a complaint about a service delivered through the ADRC network.

   3. System Advocacy: The agency shall advocate for changes in community conditions, structures, or institutions when modifications in the service delivery system are required to ensure the adequacy and availability of essential community services. Such advocacy may be based upon the collection, analysis and dissemination of data on human service needs.

e. **Follow-up**: The Area Agency will develop protocols for ADRC or other administrative staff for follow-up contacts with inquirers on a routine basis, under the following circumstances:

   1. Mandatory follow-up in situations when endangerment is suspected and when ADRC staff believe that an inquirer may not have the necessary capacity to follow through and resolve his/her own problem.

   2. Staff will conduct follow-up only with the permission of the inquirer and only in situations

in which the inquirer will clearly benefit from such actions (except for sampling for program evaluation purposes). Follow-up contacts shall also establish the consumer's satisfaction with the information provided, as a measure of program effectiveness.

3. Follow-up also may entail contacting the inquirer and/or an organization to which a referral was made to determine whether services are being provided, inquirer needs are being met, and when services are not provided.
4. Staff will verify information gathered through follow-up contacts; information shall be used to correct any errors or outdated information in the resource database.
5. If the inquirer has not received appropriate services or the need has not been met, staff will reevaluate remaining needs and make additional appropriate referrals. Staff shall document follow-up contacts and results in the DAS Data System.
6. Information obtained through the follow-up process shall be considered when evaluating the effectiveness of existing community service providers and when identifying gaps and duplications or overlaps in community services. Also see 5032 Accountability and Quality Improvement.

f. **Intake and Assessment** is the component of the access system related to contact with applicants to determine their priority and eligibility for appropriate service options available through all aging network programs and services, excluding the Long-Term Care Ombudsman Program and the GeorgiaCares programs. Staff shall be knowledgeable of and coordinate their activities with these programs when consumers would benefit from being referred to them. Access system staff will direct callers requesting services to appropriate agency staff and/or provider agencies and document the transactions in the DAS Data System. For all consumers, except those noted above, staff will evaluate clients' service needs and preferences. After determining that client meets criteria for assessment, agency staff shall identify the client's service needs and preferences with the following assessment tools.

1. Assessment Instruments: Staff will establish an individual record in the DAS Data System for each client assessed.

   A. Staff shall use the Triage Tool to gather baseline information from applicants (or their representative) surrounding basic prioritization criteria for Older American's Act (OAA) Home and Community-based Services (HCBS) services. See 5038 Waiting List Management and Criteria for Admission to Services. If client is determined to meet high priority targeting criteria, the following additional assessments must be completed for Tier 1 waiting list placement:

      i. The Determination of Need–Revised (DON-R) to determine level of functional impairment and unmet need for care in activities of daily living and instrumental activities of daily living. Refer to Chapter 114 Client Assessments in non-Medicaid Home and Community Based Services manual.

      ii. For individuals requesting nutrition services only:

         - The Nutrition Screening Initiative "DETERMINE" (NSI-D) Checklist to assess applicants' potential for nutritional risk and need for further assessment and nutrition interventions. Refer to Chapter 114 for the NSI-D Checklist and instructions on its use.
         - Staff shall use the Food Security Survey to assess applicants' food security.

iii. Staff will use the HCBS Income Worksheet assessment to determine and discuss any non-Medicaid cost share obligations for services for clients being placed on a Tier 1 Waiting List.

iv. Caregivers being assessed for services only require a Bakas Caregiver Outcomes Scale (BCOS) assessment. Triage and other care receiver assessments are not required.

v. Staff will use DAS Data System to assess and record applicants' assessment scores.

B. See 5038 Waiting List Management and Criteria for Admission to Services for reassessment guidelines.

C. Interim Assistance: Staff shall make reasonable efforts to identify other appropriate community resources for persons placed on waiting lists. Staff will provide information to applicants about their option to pay the full cost of the service for immediate admission.

D. Notifications: Staff will notify applicants for AAA-funded services of their eligibility or ineligibility for service, placement on waiting lists, or other disposition, by sending or providing a completed Applicant Notification form upon completing the initial assessments. See 5070 for a copy of the form (English & Spanish).

2. Duration of Information and Assistance: Information and Assistance (I & A) is a social service intervention, generally of a limited duration, during which any number of contacts with and on behalf of consumers may occur, over a limited period of time. Generally, the parameter for the duration of the involvement of primary I&A staff in the intervention is thirty days. If consumers' situations require considerably longer to address or resolve, the Area Agency shall make provision for case management or community options counseling assistance to be provided at either the Area Agency level or by a care coordination agency. See § 210 Case Management Service Requirements.

5025 Service Availability and Access

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Service Availability and Access	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5025	**Previous Update:**	

Availability

Hours of service shall be appropriate to community needs. Area Agencies shall make comprehensive access system services available during normal business hours. In addition, Area Agencies shall develop a process to meet the needs of callers outside of normal operating hours. Services shall be available:

1. During established working hours, at a minimum, by telephone, without a long distance charge to the caller;

2. And through a physically accessible walk-in center;
3. And by other electronic means such as access by Internet to web sites;
4. And shall be accessible to persons who are deaf, hearing impaired (through use of TTD equipment) and/or visually impaired (low vision or legally blind);
5. And shall be accessible to inquirers for whom English is not their first language.

Access

a. During hours of agency operation, the AAA shall assure that inquirers have timely contact with access system staff. Contacts are to be handled as they are received. Also see 5031 Standards of Promptness.

b. For calls received outside of established working hours (evenings, weekends, holidays), services shall be provided through a telephone answering service, call forwarding and/or other appropriate resources. Content of messaging services will provide information to callers about regular office hours, access to information via the Georgia ADRC website and the telephone number and office hours of organizations that offer crisis or emergency services. Calls will be returned within the next business day.

    1. Each Area Agency on Aging shall have a written policy for retrieving and assigning calls, emails and faxes after hours and when all counselors are on the telephone and calls go to voice mail.

c. Services shall be made available through paid staff or volunteers with language skills and other special capabilities to relate to any special needs of the population(s) served.[2] Also see 5027 Staffing regarding the use of volunteers.

d. The Area Agency will either utilize the DHS DAS call center solution or budget for and implement a dedicated, direct telephone line into the access service system, and sufficient numbers of incoming and outgoing lines for the ADRC offices, so that all staff actively engaged in receiving calls, responding inquiries, rescreening waiting lists, and conducting follow-up contacts will have an individual line available.

e. The AAA will:

    1. Establish a regularly scheduled presence at community facilities where consumers are helped face-to-face.
    2. Participate in local case management, options and benefits counseling, and elder rights collaboratives;
    3. Make all or a portion of its resource database available on an Internet Webpage, including information of interest to people with disabilities;
    4. Provide email access to Access Service staff.

f. 29 U.S.C. 794d provides for the implementation of Section 508 of the Rehabilitation Act of 1973, as amended, which establishes the standards for accessibility for the use of electronic and information technology, including telecommunications products, by persons with disabilities. For more information, refer to: www.access-board.gov/sec508/standards.htm

5026 Crisis Intervention and Emergency Services

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Crisis Intervention and Emergency Services	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5026	**Previous Update:**	

Purpose

Due to situations or health diagnoses, callers may be faced with a stressful situation where assistance beyond the expertise of ADRC staff is needed. These types of calls must be handled immediately by providing callers with information, providing a “warm transfer” and following mandated reporting guidance.

Standard

a. Mental Health or Addictive Disease crisis or access referrals are made to the Behavioral Health Link Service, Georgia’s Crisis and Access Line (1-800-715-4225, GCAL). Staff will use the “warm transfer” method of transferring callers to the Behavioral Health Link call center. See §5020.8(e).

b. **Suspected cases of abuse, neglect and/or exploitation** of community-dwelling adults, age 18 and above, **are to be referred** to the Division’s Adult Protective Services Centralized Intake Call Center during regular business hours (**1-866-55AGING or 866-552-4464 option 3**). **Alternatively, a fax referral form and instructions are available on the Division’s web page**. Any situations in which abuse of minor child/children is suspected are to be reported to the appropriate County Department of Family and Children Services (DFCS) at 1-855-GACHILD or 1-855-422-4453.

    1. AAAs shall establish linkages with emergency response organizations, such as local law enforcement agencies, or other existing agencies/entities, as appropriate to provide necessary coverage and to assure the proper disposition and reporting of suspected abuse, neglect or exploitation of older adults, when information suggesting such abuse, neglect or exploitation is received by ADRC staff, and the urgency of the situation indicates a need for immediate intervention.

c. **Medical emergencies**, or situations in which law enforcement intervention is indicated, **are referred** directly to the 9-1-1 system. If any county within the planning and service area does not have 9-1-1 emergency services available, the AAA Director/ADRC Program Manager will establish medical emergency/law enforcement referral procedures with the appropriate authorities for that county.

d. The Area Agency will assure that staff will have the technical capability through the telephone system to make direct telephone transfers for all callers, but particularly those in crisis or emergency situations, and the ability to maintain contact with the caller during the transfer.

5027 Staffing

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Staffing	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	5027	**Previous Update:**	

Purpose

The Area Agency will recruit and hire ADRC staff, who are competent, ethical, and sufficient in number to implement service policies.[3]

Standards

a. Minimum Education and Experience Required are:
    1. Bachelor's Degree in social work, sociology, psychology, human services, or a related field, or
    2. Registered, professional nurse currently licensed to practice in the state of Georgia AND two years' experience in the human services or health related fields, or
    3. Associate's degree in human services or health related field AND a minimum of two years' experience in working directly with aging or disability populations.

b. Staff shall be qualified by training and/or experience in the following areas:
    1. Ability to use assessment tools and technology;
    2. Specialized knowledge of older persons, the aging process, and long-term care issues; persons with disabilities and disability etiquette;
    3. Knowledge of the service structure of the service area;
    4. Compilation, maintenance and/or use of a resource file and/or database; and
    5. Skill in coordinating with and communicating with people making inquiries and with service providers in relaying referral information.

c. The Area Agency will provide written job descriptions for all staff, outlining responsibilities, essential job functions, and lines of accountability. Agencies will review job descriptions at least once during every planning cycle and update as indicated.

d. The Area Agency will provide for ongoing supervision and annual performance evaluation of paid employees (and volunteers, if present) by qualified management-level staff. Annual evaluations will address specific duties and functions specified in job descriptions.

e. Agencies may use trained volunteers to provide components of access services. Within the access system, the agencies will designate a staff person responsible for volunteer coordination. Volunteers are treated as unpaid staff.

f. The Area Agency will designate at least a 0.5 FTE to the role of ADRC Resource Specialist whose first priority is dedicated to new resource identification and development and database management and maintenance. The Resource Specialist shall prioritize identifying and adding pri-

vate pay resources to the database and build expertise on resources availability and unmet need throughout the planning area. Responsibilities include ensuring that resources are updated at least annually.

1. Other responsibilities will include collaboration with Minimum Data Set Section Q Options Counselors (MDSQ OCs) and Money Follows the Person Transitions Coordinators (MFP TC) regarding community resource needs for individuals who are transitioning. This can be through individual case review or through a collaborative “solution circle” process.
2. When the above responsibilities are fulfilled this person may assist in call rotation in any capacity deemed appropriate by the AAA Director and ADRC Program Manager. The Resource Specialist must meet required qualifications for the additional role (i.e. if serving as an Options Counselor must be certified).

5028 Staff Training and Certification

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Staff Training and Certification	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5028	**Previous Update:**	

Overview

The Area Agency will make appropriate training available to paid staff and volunteers. Staff whose primary function is to assist inquirers by providing information, assistance and referrals, and screening to determine program eligibility shall be cross-trained in the provision of all components of the access service system. Staff whose primary responsibilities are related to resource development and/or administrative in nature are encouraged, but not required, to be cross-trained. Staff whose primary responsibility is the provision of options counseling will be required to complete the options counseling certification process. See 5036 MDSQ Options Counseling, 5037 Community Options Counseling, and 5060-B Training Requirements.

Requirements

a. Staff will be knowledgeable of and comply with HIPAA guidelines, as applicable, in providing Information, Referral and Assistance services.

b. All staff persons for the Access service system will attain the Certified Information and Referral Resource Specialist – Aging/Disabilities (CRS – A/D), or Certified Resource Specialist (CRS) status, through the Alliance of Information and Referral Systems (AIRS) Certification Program, when eligible to do so. Staff may pursue additional, specific certifications in other programs recognized at the state, regional or national level, if desired.

c. Each AAA will have a designated staff person serving as the ADRC Program Manager. This individual will attain the Certified Resource Specialist – Aging/Disabilities (CRS – A/D), or Certified Resource Specialist (CRS) status through the Alliance of Information and Referral Systems (AIRS) Certification Program, when eligible to do so. The Program Manager (or another staff designated to represent the Program Manager) will attend all regularly scheduled Program Managers

meetings as scheduled by DAS. The Program Manager will attend an annual DAS Program Managers training either virtually or in person.

d. All Options Counselors are required to obtain Options Counseling Certification by the Division of Aging Services. This includes both Community Options Counselors and Minimum Data Set Section Q (MDS-Q) Options Counselors. See 5060-B Training Requirements for more information.

e. **Skills Set**: Staff providing access services shall have the skills to:

   1. Meet the needs of people who are in crisis. If the AAA's policy is to transfer crisis calls to another agency, staff must be able to establish meaningful contact with the individual and stabilize the situation before initiating the transfer
   2. Refer and assist difficult callers (people who are angry hostile, manipulative, or who call frequently with the same problem.)
   3. Assist all populations served by the ADRC, including person with developmental, intellectual, physical disabilities and persons with behavioral health needs.
   4. Determine through the interviewing and screening processes the most appropriate services and resources for applicants, independent of the actual request for service.
   5. Establish and sustain interpersonal relationships.
   6. Engage in team building, through knowledge of group dynamics.
   7. Use problem solving skills and techniques.

> **NOTE** See also Section 5027 footnote 1, regarding professional qualifications for registered nurses and social services staff.

5029 Protection and Disclosure of Information

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Protection and Disclosure of Information	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5029	**Previous Update:**	

Overview

AAAs will develop and implement policies that assure that staff will not disclose information by name about a consumer without the informed consent, either written or verbal, of the older person, or by his/her authorized representative.

Requirements

a. If a consumer gives verbal consent for information to be shared, staff shall maintain documentation of same in the DAS Data System, showing date and specific purpose for consent being given.

b. Staff shall discuss each instance of disclosure with the consumer and document each in the prescribed manner.

c. Staff shall discuss each instance of disclosure with the consumer and document each in the prescribed manner.

d. Staff shall not communicate to others the identity of inquirers, their requests and the information provided to others, unless:

    1. A report of information is required by law (reporting suspected incidents of abuse, neglect or exploitation of an adult or child);

    2. Careful consideration indicates the presence of risk or serious harm to the inquirer or another person, and then communication may only be to those who must be informed in order to reduce harm or risk (reports to DAS Adult Protective Services Central Intake); or

    3. The inquirer has given explicit permission for the information to be disclosed to another person or entity. The consumer must specify what information may be given and to whom.

e. Staff will protect inquirers' privacy and dignity by avoiding non-essential discussion of the individuals' circumstances and situations. This does not restrict professional discussion about services provided or planned for the individual or on-site observation and monitoring of ADRC staff activities conducted by Division staff.

f. Area Agencies will develop and use agreement forms that staff, volunteers, and others with access to confidential information will sign to document their intent to comply. ADRC staff who have not received HIPAA training and signed an agreement form will not be permitted access to the DAS Data System. Signed copies are maintained in individual staff personnel records.

g. Staff will use the DAS Data System Alert Notes to communicate with DAS regarding constituency issues to minimize HIPAA protected information disclosure.

HIPAA

The DHS Division of Aging Services is a covered entity under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), and subject to its regulations, including the Privacy Rule. The following definitions are used:

a. **Protected Health Information**. The Area Agencies, as contractors of the Division, also are regulated by the Act and Privacy Rule, which protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)."

b. **Individually identifiable health information is information**, including demographic data, that relates to:

    1. The individual's past, present or future physical or mental health or condition,

    2. The provision of health care to the individual, or

    3. The past, present, or future payment for the provision of health care to the individual,

    4. And that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

c. Area Agencies shall develop any necessary policies, procedures and protocols to guide staff in the proper handling, storage, data entry and sharing of protected health information and individually identifiable health information with which they come into contact through the intake and screening process, to assure HIPAA compliance.

5030 Technology

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Technology	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5030	**Previous Update:**	

Overview

Area Agencies shall employ technology that improves access to services and enhances their ability to serve consumers efficiently and effectively. The role of technology is to enhance or strengthen person-to-person contact, not to reduce or eliminate such contact or make it more difficult.

Requirements

a. The Agency shall either utilize the Division of Aging Services call center solution or plan and budget for, implement and use state-of-the art technology to meet the needs of end users (both staff and consumers) and to provide tools for managing the program, including during extended periods of remote work or teleworking. Specifically, the Agency shall implement telephone technology that permits remote access to incoming calls, the ability to place outgoing calls from a remote location, the tracking of call volume, number of abandoned calls, average response time (answering), and average call length. The Division of Aging Services must be notified immediately when the AAA's published ADRC telephone number is changed. Remote access solutions may include call-forwarding or VOIP solutions.

b. Technology shall not reduce nor replace supported access provided by a qualified staff person.

c. The agency shall develop strategies and procedures to assure that all consumers receive comparable benefit, either directly or indirectly, from the use of technology, and shall evaluate the benefits and deficits of any particular technical approach prior to implementation to assure that one or more groups of consumers does not receive benefits disproportionately to others.

d. Each staff person providing integrated access services shall have an available line for call handling during the core business hours of the Area Agency on Aging, both for active duty receiving and making calls, and for administrative duties, such as follow-up and re-screening of applicants on waiting lists.

e. Agencies shall either utilize the DAS call center solution or budget for and implement telephone systems which permit three-way calling, to assure greater efficiency and effectiveness in assisting callers with making needed contacts and to assist with making transfers to other staff or agencies.

f. The agency shall advise callers if telephone conversations with staff may be randomly moni-

tored by supervisors for quality assurance purposes.

g. If the agency provides resource information through an automated attendant or other menu-driven telephone system, it shall develop procedures and messaging that will allow for the transfer to a staff person if immediate consultation and guidance are desired. Callers are to be able to make the transfer from the automated attendant system to a staff person without having to make another call.

h. The agency shall provide staff with Internet access for researching information and providing other assistance to consumers, when needed.

i. Where applicable, agencies will comport with DHS information technology standards for hardware, software, and connectivity.

5031 Standards of Promptness

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Standards of Promptness	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5031	**Previous Update:**	

Overview

Access services staff will respond to inquiries and requests for information, assistance and screening for admission to services as they receive the requests, in whatever form the request is made (telephone, fax, mail, email, walk-in contacts, website inquiries).

Requirements

Staff will handle requests in order of receipt, making every effort to initiate contact with inquirers within one business day of the referral date.

a. The referral date is defined as the date a request is received by the ADRC staff and is the date entered into the DAS Data System when initiating the record of ADRC transactions. The referral date for online web intake is the date the call record was created, not the date it was assigned to an ADRC or ADRC staff.

b. Staff shall schedule all screenings within five (5) business days of the referral date unless the caller's availability has prevented this.

c. Eligibility assessments must be completed, when required, within ten (10) business days of the referral date unless the client and caller's availability has prevented this.

    1. The Area Agency shall arrange availability of ADRC Counselors to meet the needs of callers who are not available during normal operating hours.

    2. ADRC Counselors should complete eligibility assessments during the initial call if possible.

    3. ADRC Counselors shall schedule appointments to complete assessments if required information is not available during the initial call. Individual callers who do not keep appointments

and fail to notify the ADRC staff will be notified by mail that the appointment was missed and therefore cancelled, and that it is the caller's responsibility to schedule a new appointment.

4. All attempts to reach caller shall be documented in the case record.

d. Staff shall enter all documentation in DDS within 1 business day after speaking with client.

5032 Accountability and Quality Improvement

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Accountability and Quality Improvement	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5032	**Previous Update:**	

Requirements

a. Area Agencies will report to the Division in the DAS Data System the total, aggregated number of service units[4] provided (contacts / transactions handled) and corresponding expenditures each month. This includes screenings and re-screenings conducted.

b. Area Agencies will develop/improve their capacity to collect and analyze access service data and statistics regarding types of calls (to include information, referral, crisis and advocacy), follow-up results, characteristics of callers, call topics, service use, unmet needs, community assets and gaps and duplications in services. Sources of data include, but are not limited to the DAS Data System.

c. AAAs will demonstrate that these data are considered in the strategic planning process and are provided to community decision makers involved in the assessment and planning of service delivery and advocacy.

d. Staff shall document in the DAS Data System all call topics discussed with callers for services not funded by the AAA within their PSA. Staff will document first-time and new call topics. A call topic discussed multiple times with the same caller during a short time span (the same work week) will not be documented more than once[5]. This information is to be compiled and reported to the AAA leadership at least annually to be used in the strategic planning and Area Plan development processes.

e. Area Agencies will assure that access service data are accurate, complete and entered into the appropriate databases / systems in a timely manner.

f. Specifically, staff shall ensure that for each new client, in addition to basic demographic information, the following data points are entered: Date of Birth, Veteran Status, Disability Type and Sensory Impairment (if indicated in Disability Type).[6]

1. For calls where information is requested for a specific resource and the caller does not want/need anything else, staff will, at a minimum request name, age or date of birth and county of residence.[6]

g. It is the primary responsibility of the ADRC Program Manager to ensure continued quality

improvement by regularly reviewing the waiting lists and all available reports, and addressing concerns with staff.

h. Area Agencies will have a process in place to receive complaints from anyone contacting the ADRC. The process shall include the complainants name, any ADRC staff involved, a description of the complaint and the outcome of the AAA investigation. The complaint procedure shall be provided to anyone requesting it. Copies of complaints shall be maintained electronically at the AAA and shall be available to the Division of Aging upon request.

5033 Collaboration with Community Partners

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Collaboration with Community Partners	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5033	**Previous Update:**	

Overview

In communities in which there are other comprehensive and specialized agencies providing information and assistance, the Area Agency will develop cooperative working relationships to build a coordinated access system, with a particular focus on coordination with 2-1-1 call systems when present. The Area Agency will provide leadership in representing the needs of individuals who are aging and/or living with disabilities. Access services also should extend to address disaster and emergency planning, preparedness, and access system operations during such events.

Requirements

The AAA will:

1. Establish a “no wrong door” approach, through meaningful involvement of consumers and other stakeholders, to provide awareness, information, assistance and access to resources for older adults, individuals with disabilities, their caregivers and professionals working with these individuals.
2. Partner with appropriate organizations to develop written cross-referral protocols for streamlining client access to long term services and supports across agencies. This includes encouraging all partner organizations to place a link to the statewide ADRC website (www.georgiaadrc.com) on their organizations websites.
3. Sustain an Aging and Disabilities Advisory Council. Meet a minimum of three times per year for:
   A. Membership review of ADRC planning, marketing, and data and information sharing between members of the Council;
   B. Finding ways to identify and address the unmet needs of consumers; and
   C. Identifying collaborations that will enhance service delivery to individuals who are aging and individuals who have a disability.
4. Meeting minutes will be provided to the DAS upon request and during onsite monitoring.

5. A teleconference option shall be offered. At a minimum, individuals representing the following populations/organizations shall be included:
    1. Developmental Disabilities
    2. Brain & Spinal Cord Injuries
    3. Alzheimer's disease
    4. DFCS - preferably Medicaid eligibility staff
    5. APS
    6. LTCO
    7. Hospital discharge planner
    8. Nursing home discharge planner and/or admissions staff,
    9. Center for Independent Living
    10. GeorgiaCares
    11. Behavioral Health
    12. AAA ADRC Program Manager
    13. Public Guardian Office
6. For any organizations not represented AAA staff will provide evidence of attempts to involve them in Council activities.
7. Work with ADRC partners to identify and update disability related resources in the DAS Data System.
8. Provide limited training and technical assistance to disability partner agencies on the use of the DAS Data System.
9. Work with appropriate partner organizations to provide and receive staff cross-training on aging and disability issues, services and supports.
10. Participate actively in data collection and related evaluation activities.

5034 Outreach and Marketing

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Outreach and Marketing	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5034	**Previous Update:**	

Overview

The Area Agency will establish and maintain efforts to promote public awareness of the availability of access services, aging and disability services and other community resources through its single entry point.

Requirements

a. The Area Agency will develop a written outreach and marketing plan that uses a systematic methodology for publicizing its services, including options counseling, to targeted populations[7], including private pay individuals, and to other community resources.

b. The agency will use various methods[8] tailored to the needs of diverse populations to publicize the access service system.

c. Periodically the agency will evaluate the effectiveness of the outreach plan, using consumer demographic data and other referral source data, among others.

d. The Area Agency may incorporate the plan into the Area Plan document, in addressing goals and objectives.

e. The Area Agency will incorporate the ADRC logo on all written materials distributed by the Contractor. Along with logo include the statewide ADRC website www.georgiaadrc.com on all written materials used for marketing and outreach.

f. The Agency will identify resources and **strategies for** handling increases in contact volume when external activities indicate the potential for increases in call volume. Disaster / emergency planning also should address this issue.

g. The Agency will assure that outreach efforts and methods are culturally appropriate and are used to reach people with limited knowledge or use of English; people residing in rural and other isolated or underserved areas; minorities; LGBT populations; people with disabilities and people with resources to pay privately for services.

h. Designated Area Agency staff, both paid and volunteer, will communicate regularly with other community services providers and participate in various community activities that will enhance the public's knowledge and awareness of the agency's access service system.

i. The Area Agency will promote the statewide ADRC website (www.georgiaadrc.com) as the official website representing the ADRC. This includes listing the link in a prominent location on the AAA website and including the link along with the ADRC logo on all printed materials used for marketing and outreach.

j. The voice message on the ADRC telephone line will include the message "you may also learn about resources by visiting the ADRC website at: https://www.georgiaadrc.com." This message should be heard by after-hours callers, and callers who do not reach a live person during business hours. The intent of this message is not to discourage callers from requesting a return call, but to divert callers who may prefer self-service prior to or instead of speaking to a live person.

5035 Records Management

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Records Management	**Reviewed or Updated in:**	MT 2019-02
	Section Number:	5035	**Previous Update:**	

Requirements

Area Agencies will maintain any required paper documents and records pertaining to the provision of access system services, according to state records retention requirements. However, the Division encourages agencies to reduce to a minimum the amount of paper documents and records retained, and implement, to the extent possible, a paperless system. Management of electronic documents and systems is addressed in DAS MAN 5600 1060 Division Reports, Overview.

5036 MDSQ Options Counseling

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Minimum Data Set Section Q (MDSQ) Options Counseling	**Reviewed or Updated in:**	MT 2020-01
	Section Number:	5036	**Previous Update:**	

Summary

This chapter establishes the requirements to be followed when Area Agencies on Aging (AAA) directly provide or contract for the delivery of MDSQ Options Counseling.

Scope

Aging and Disability Resource Connections (ADRCs), designated as the local contact agencies (LCA) for Minimum Data Set Section Q (MDSQ) referrals from skilled nursing facilities, will respond to MDSQ referrals by providing individuals, families, and caregivers information about community living services and supports.

Definitions

Action Plan

a plan outlining the steps identified in the options counseling process that are needed by the individual and/or options counselor to attain the supports that meet the goals and preferences of the individual. This plan is time bound and is directed and developed by the individual with support from the options counselor as needed.

Decision Support

a process of examining the pros and cons of various options. It may include information and education but goes beyond both of these both to support an individual as he/she weighs options.

Dignity of Risk

refers to respecting each individual's autonomy and self-determination to make choices for him or herself. The concept means that all adults have the right to make their own choices about their health and care, even if healthcare and other professionals believe these choices endanger the person's health or longevity.

MDS 3.0

Minimum Data Set is a tool for implementing standardized assessment and for facilitating care management in nursing homes. MDS 3.0 has been designed to improve reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols.

Motivational Interviewing

is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.

Options Counseling (OC)

an independent decision-support process whereby individuals, families, and caregivers are supported in their deliberations to determine care choices based on the individual's needs, strengths, preferences, values, and individual circumstances.

Person-Centered Planning (PCP)

a process to develop an individual support plan that is driven by an individual's own preferences, strengths, and personal goals, as well as directed by the individual and/or their representative.

Core Components

The core components of Options Counseling are:

- Personal Interview
- Assisting with identification of available choices
- Facilitating the decision-support process
- Assisting in the development of an action plan
- Connecting to service
- Follow-up

Goals of Options Counseling

The goals of MDSQ Options Counseling are:

a. To provide individuals with the information he or she needs to make informed choices about returning to the community
b. To provide appropriate guidance to proactively match individual's needs, strengths, preferences, and values with available services
c. To help individuals plan for the future and avoid crisis planning
d. To help improve the quality of life of individuals receiving Long-Term Services and Supports

Staffing

Area Agencies will identify, at a minimum, one Full Time Equivalent to conduct MDSQ options counseling. See Manual 5200, 5027 Staffing for minimum education and experience requirements

and equivalencies.

MDSQ Options Counseling staff will:

a. Utilize a person-centered approach in providing options counseling services to individuals identified on the MDS assessment as wanting to speak with the LCA about community living options.
b. Be supervised by the ADRC Program Manager or by another staff person who supervises the ADRC Program Manager.
c. Become AIRS certified when eligible. This is based on the AIRS criteria. AIRS certification shall be completed within eighteen months of employment as an options counselor.
d. Attend all training events required by DAS.
e. Become certified in Options Counseling through DAS. New staff shall enroll in the next available class after employment as an options counselor .and successfully pass all components of certification.

Options Counseling Activities and Standards of Promptness

At a minimum, MDSQ options counselors will perform the following activities:

a. Handle referrals in order of receipt.
b. Make initial telephone contact or contact attempt within one business day with identified individual to schedule an appointment to conduct a face-to-face options counseling session.
c. Conduct face-to-face options counseling session with individual within ten business days of receiving referral. This may include persons the individual has identified as wanting to be present during the face-to-face options counseling meeting.
d. An MDSQ Options counseling referral that requires one telephone call only will be entered in to the DAS Data System as I&R.
e. If APS involvement is identified, the OC will follow up with the APS investigator to avoid a potential transition back into a previously dangerous environment.
f. During face-to-face options counseling session and all follow up, options counselors will use a person-centered approach to explore options for the individual based upon their needs, strengths, preferences, and values. Options explored will be:
    1. Accurate – options counselors will ensure information is to the best of their knowledge, up to date, and complete in nature.
    2. Timely – information will be provided to individuals in a manner consistent with ADRC Standards of Promptness.
    3. Culturally Appropriate – individuals and the system respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families, and communities and protects and preserves the dignity of each.
    4. Useful and helpful-options counselors will be mindful of options that could possibly be of benefit to the individual based upon their needs, strengths, preferences, and values. Options counselors will be careful not to overwhelm a person with options for which they would not qualify or that would fail to meet a self-identified need.

5. Complete – options counselors will explore public and private pay options with individual based on individual's identified needs, strengths, preferences, and values. Options counselors will help individuals explore the pros and cons of options in assisting the individual in making an informed decision.

g. Information provided will be given in a language appropriate to the individual's comprehension level. Options counselors will be mindful of professional jargon and minute details that can overwhelm an individual.

h. Provide a minimum of three follow ups to individuals who are not immediately referred to MFP, unless fewer follow ups are requested by the participant. The dates will be based on the individual's need and preference. If three follow up contacts are not provided, the reason must be noted in the DAS data system.

i. Establish collaborative working relationships with skilled nursing facility staff including social workers and discharge staff.

j. Complete and enter into the DAS Data System all required documentation for individuals who receive MDSQ Options Counseling within five (5) business days of options counseling activities.

    1. Required documentation:

        i. Nursing Home Transition Screening Form

        ii. DON-R (required for MFP Eligible individuals)

        iii. Action Plan (Appendix 5060 – F)

        iv. Case Notes and follow up

        v. Risk Assessment Tool (required for NHT Eligible individuals

        vi. Additional documentation as needed

k. If an individual qualifies for the Money Follows the Person Program (MFP) the options counselor will refer the case to the Transition Coordinator (TC) within five (5) business days using the following process:

    1. Individuals who are eligible for MFP will be referred to either the Center for Independent Living (CIL) or the AAA using a rotation method between organizations when both areas serve the same geographic area. If the CIL does not serve the area, the referral will remain with the AAA.

    2. If the AAA and the CIL develop an alternate arrangement for referrals that is satisfactory to both parties the AAA will submit this process in writing to the DAS Transitions Specialist for approval. If approved, this alternate method may be used.

    3. If the individual is then deemed ineligible for the MFP program, the TC will refer the case back to the MDSQ options counselor for continued follow-up and exploration of public and private pay options to assist the individual in transitioning into the community.

    4. If an individual is deemed eligible for MFP the MDSQ Options Counselor will submit a waiver application on behalf of the individual, but a waiver is not required prior to the referral.

    5. Housing options and applications must be reviewed prior to referral to Money Follows the Person (MFP) Transition Coordinator, but housing does not have to be finalized.

    6. If the MFP TC is also the Nursing Home Transitions (NHT) TC, the case does not have to be

referred back to the MDSQ options counselor for continued follow-up.

l. If an individual qualifies for the Nursing Home Transition Program (NHT), the options counselor will refer the case to the NHT Transition Coordinator (TC) within five (5) business days using the following process:

    1. Individuals who are eligible for NHT and are 66 years old and older will be referred to the Transitions Individuals who are eligible for NHT and are 66 years old and older will be referred to the Transitions Specialist at the AAA.
    2. Individuals who are eligible for NHT and are 65 years old and younger will be referred to the Center for Independent Living. The CIL retains the right to refuse the referral if the distance presents a hardship due to designated service area.
    3. If the individual is deemed ineligible for both programs, the TC will refer back to the MDSQ options counselor for continued follow-up and exploration of public and private pay options to assist the individual in transitioning into the community.

m. All referrals will be documented in the DAS Data System by using the Provider enrollment and Alert Note to the receiving Transition agency. If the CIL is unable to transition an individual, they should also return the referral to the MDSQ Options Counselor via Alert Notes documenting the reason for their inability to accept the transition. If a referral is not accepted by the CIL and/or the alert note remains unread, the MDSQ options counselor can take the referral back after 5 days to be rebrokered to another Transition Coordination agency. The OC must note the reason for rebrokering in the DAS Data System.

n. If necessary, DAS may re-designate staff to assist in other areas or with other roles relating to options counseling and transition services.

o. The organization providing the delivery of MDSQ Options Counseling is required to establish a formal referral process to all organizations within the service area who provide MFP and/or NHT Transition Coordination.

Short Term Rehabilitation Referrals

Referrals from individuals who are receiving short-term rehabilitation services:

a. If an individual has a discharge plan/date, the ADRC can choose to have the options counselor:

    1. Send a community resource packet to the individual at their home address omitting a visit to the facility. This will be entered as Information & Assistance Type of Case, not options counseling in the DAS Data System, or
    2. Provide nursing homes and other institutions information packets for distribution to individuals admitted to the nursing facility for **short-term rehabilitation** who answer 'yes' on Section Q questions and MDSQ referrals made.

b. All MDSQ referrals received at the ADRC will be entered into the DAS Data System as directed in the ADRC standards.

Additional follow-up for individuals for short term rehabilitation is not required, unless in the professional opinion of the MDSQ options counselor it is determined that additional follow-up is needed or the individual requests follow-up appointments involving a referral to either MFP or NHT.

The Action Plan

The action plan is required in all options counseling. The action plan incorporates the next steps to be completed by the individual as well as the next steps to be completed by the options counselor. A written copy of the action plan will be left with the individual and will include follow-up date and contact information for the Options Counselor. The action plan will be entered into the DAS Data System. See Appendix 5060-F.

MDSQ Options Counseling in MFP Transitions

MDSQ options counselors may take responsibility for MFP transitions consisting of, with approval from the TC or TC Supervisor:

a. Transition to Personal Care Home
b. Transition home with family or other member of support circle (no major conflict noted), can include family legal guardians in agreement with transition
c. The MDSQ options counselor must follow all MFP program guidelines, including documentation. After 90 days, the options counselor may transfer the individual to the TC for monthly follow up calls.

MDSQ options counselors will **not** take responsibility for transitions consisting of:

a. Area to area transitions
b. Independent living transitions
c. DHS wards

Client Records

a. MDSQ options counselors will enter MDSQ referral client information in the DAS Data System using established procedure. Basic client information will be entered within one business day of referral receipt. Detailed information and information from activities will be entered into case notes within 3 business days of completion of tasks. All data will be entered by the 3rd of the month following the month the referral was received to coincide with submission of the MDSQ monthly report.
b. MDSQ options counselors will enter case notes identifying activities conducted and description of individual's self-identified needs, the options discussed, and the action plan.
c. The MDSQ monthly Outreach Report is due the 3rd of each month. Must be submitted on the form provided by DAS.
d. Each ADRC Program Manager will develop and implement a quality assurance process to review data entry and documentation for options counseling.
e. MFP field personnel (OCs and TCs) are responsible for the following regarding MFP denial and terminations: issue denial notices to participants including administrative hearing rights available for denial of eligibility or termination of service. Maintain appropriate documentation of decision-making for administrative review and appeal See Department of Community Healthy Policy 605.5.
f. Options counselors will provide individuals with a copy of the booklet, HCBS, A Guide to Medic-

aid Waivers in Georgia. Requests for booklets can be faxed directly to Georgia Health Partnership (GHP) using the request form (DMA 292 – Request for Forms or Handbooks). See Appendix 5060-J.

Outreach

a. MDSQ options counselors will provide outreach to all potential sources of referrals to MFP, NHT, and ADRCs to include skilled nursing facilities, hospitals, and other community organizations. Outreach must be completed in a face-to-face setting and includes, but is not limited to presentations, community education events, and resident council meetings. With prior approval from DAS, non-face-to-face outreach can be counted towards the minimum monthly requirement. Outreach must include the provision of information related to transitions and community options. Meetings with nursing home social workers may be considered outreach when the social worker is new or is unfamiliar with options counseling and transition services.
b. MDSQ options counselors will complete a minimum of four outreach events per month and record outreach events in the approved DAS Data System. Outreach activities will be reported to DAS, using the required form, by the 3rd of each month.
c. MDSQ outreach events will be entered into the DAS Data System (DDS) within three (3) calendar days of the event date.
d. MDSQ options counselors will serve as active members of the ADRC Advisory Council in their region.
e. MDSQ options counselors will provide skilled nursing facilities with copies of the MDSQ referral forms, using those provided by DAS or those provided by the AAA, using the ADRC logo.
f. MDSQ options counselors will try to provide outreach/education to each nursing home's Resident Council members or Council President at least one time annually to explain transitions and options counseling services.
    1. The request for an invitation to present at a meeting shall go to the Resident Council President, or, in the absence of a resident serving as President, to the designated nursing home staff.
    2. In the event the request is refused, the MDSQ OC will request assistance from the Long-Term Care Ombudsman serving the facility residents. Presentation at a Resident Council meeting counts as one outreach event.
    3. This requirement may be satisfied by meeting with the President of the Council, explaining the service and leaving contact information.

Mandatory Reporting

All staff must be familiar with and able to recognize situations of possible abuse, neglect, or exploitation or likelihood of serious physical harm to persons receiving services. Providers shall develop procedures for reporting suspected abuse, neglect, or exploitation.

Suspected cases of abuse, neglect and/or exploitation of older adults and adults age 18 and older with a disability residing in a long-term care facility, are to be referred to the Department of Community Health, Healthcare Facility Regulation by contacting 800.878.6442 or visiting dch.georgia.gov.

References

DAS Manual 5200, Section 5027
DAS Manual 5200, Section 5060-B
DAS Manual 5200, Section 5060-F
DAS Manual 5200, Section 5060-J
DAS Manual 5200, Section 5060-K
DAS Manual 5600, Section 2025-2028
Department of Community Healthy Policy 605

5037 Community Options Counseling

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Community Options Counseling	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	5037	**Previous Update:**	

Summary Statement

This chapter establishes the requirements when Area Agencies on Aging (AAA) directly provide or contract for the delivery of Community Options Counseling.

Scope

Options counseling supports informed decision-making about Long-Term Services and Supports (LTSS) and represents a core function of Aging and Disability Resource Connection (ADRC). Many individuals need options counseling for the following reasons:

a. An abundance of information is available about LTSS but the information can be complex, contradictory, and confusing
b. Individuals and/or families may want or need additional support interpreting information and weighing the pros and cons of their different options related to LTSS
c. Few people plan ahead for LTSS needs institutional placement often occurs without consideration of available community-based options

Definitions

Action Plan

a plan outlining the steps identified in the options counseling process that are needed by the individual and/or options counselor to attain the supports that meet the goals and preferences of the individual. This plan is time bound and is directed and developed by the individual with support from the options counselor as needed.

Caregiver

a family member, partner, friend, or neighbor who supports an individual. Caregivers may also

be the individual seeking options counseling for their own support needs.

Decision Support

a process of examining the pros and cons of various options. It may include information and education but goes beyond both of these to support an individual as he/she weighs options.

Dignity of Risk

refers to respecting each individual's autonomy and self-determination to make choices for him or herself. The concept means that all adults have the right to make their own choices about their health and care, even if healthcare and other professionals believe these choices endanger the person's health or longevity.

Motivational Interviewing

is a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.

Options Counseling (OC)

an independent decision-support process whereby individuals, families, and caregivers are supported in their deliberations to determine care choices based on the individual's needs, preferences, values, and individual circumstances.

Person-Centered Planning

a process to develop an individual support plan that is driven by an individual's own preferences, strengths and personal goals, as well as directed by the individual and/or their representative.

Core Components

The core components of options counseling are:

1. Personal interview
2. Assisting with identification of available choices
3. Facilitating the decision-support process
4. Assisting in the development of an action plan
5. Connecting to service
6. Follow-up

Eligibility

Options counseling will be available to anyone contacting the ADRC. Situations and triggers that may indicate the need for options counseling include:

a. Individual requests information or advice concerning LTSS
b. Individual is referred to ADRC through a critical pathway provider (hospital, assisted living, or other agencies)
c. Individual has had a recent significant change in life situation and is looking for assistance

d. Individual has LTSS needs, but is unsure on how to access services or what services may be available to best meet their needs and preferences
e. Individual is requesting assistance transferring from one living situation to another
f. Individual might be eligible for new benefits and is unsure what will best meet his/her needs and what he/she may be eligible for
g. Individual is interested in consumer-directed service options
h. Individual has been admitted to a hospital and needs help planning once discharged
i. Individual lacks awareness of potential LTSS options for remaining in the community
j. individual has multiple needs across many services or systems
k. Individual has been denied Medicaid and needs decision support around non-Medicaid options
l. Individual is at a Risk Level 2 as indicated by the Risk Assessment Tool
m. Individual does not meet qualifications for wait list placement but is in need

Staffing

Area Agencies will identify, at a minimum, one FTE to conduct community options counseling. Minimum education and experience requirements and equivalencies are located in MAN 5200, Section 5027.

Options counseling is, to the extent possible, provided by one options counselor who supports the individual through the entire decision-making process and follows-up with the individual during scheduled follow-up contacts.

ADRCs can choose to have specific staff designated as options counselors and options counseling is their primary job responsibility or to organize their staff with blended roles based on organizational capacity. Options counselors will be supervised by the ADRC Program Manager.

Options Counseling Activities

At a minimum, options counselors will perform the following activities:

a. Deliver options counseling in the setting and by the method desired by the individual, resources permitting. Settings may include: over the phone, individual's place of residence, hospital, medical practice, Agency, etc.
b. Provide options counseling in a manner without personal bias of the options counselor and without a vested interest in the decisions made by the individual.
c. Include discussion of publicly and privately funded LTSS.
d. Assist in making appropriate connections to services (i.e. SHIP, financial, employment, mobility assistance, peer support).
e. Facilitate future planning by talking with individuals about options for services and supports that might be needed in the future.
f. Provide decision support. Assist individuals in evaluating various pathways, including the pros/cons of specific options of interest to the individual.

g. Relay information with language appropriate to an individual's comprehension level, being mindful of professional jargon and minute details that can overwhelm and confuse an individual.

h. Provide connections to community supports that provide or coordinate eligibility determination.

i. Complete a written action plan with individuals during the options counseling session.

j. Provide follow up 30 days after completion of action plan if applicable or, 30 days after completion of options counseling session, or when indicated by the action plan.

Action Plan

The action plan is required in all options counseling. If an action is **not** completed, the session is entered into the DAS Data System as Information & Assistance **only**. The action plan incorporates the next steps to be completed by the individual as well as the next steps to be completed by the options counselor. A written copy of the action plan will be left with the individual and will include the follow-up date to be as agreed upon by the individual and options counselor and the options counselor's contact information. If options counseling is being completed via the telephone, a copy of the action plan can be mailed, emailed, or faxed to the client. The action plan will be entered into the DAS Data System. Refer to Appendix 5060-F.

Follow Up

The 30 day follow up has the goals of:

1. Clarifying questions and or concerns of the individual
2. Providing assistance regarding applications and eligibility process, if requested
3. Providing assistance regarding implementation of LTSS
4. Evaluating the usefulness of the options counseling service and identifying barriers encountered in assisting an individual in achieving his or her goals

Staff Training

All persons performing options counseling will receive initial training. Each ADRC will have staff development program in place including the following areas:

a. Physical and emotional aspects of aging and disability

b. Understanding the dignity of risk and an individual's right to fail

c. Decision support strategies (person-centered planning, motivational interviewing, etc.)

d. Communication techniques, including the use of adaptive and interpretive communication devices

e. Cultural competence

f. Information and resource program, both publicly and privately funded

g. Documentation and follow-up protocol

Partnerships

Options counseling is at the center of streamlined eligibility, a core component of a fully-functioning No Wrong Door. Partnerships are the foundation of this component and must include key partners in the process, including, but not limited to, the following:

a. State and local representatives of the aging network
b. State and local representatives of the disability network
c. State and local representatives of the Medicaid agency
d. SHIP representatives
e. State and local providers for other long-term services and supports programs

Client Records

Options counselors will enter client information into the approved DAS data system. Case notes will be entered under Formal Case Notes in the data system following DAS policy on case note entry located in MAN 5020 Appendix I. This will include a completed action plan created by the individual with the assistance of the options counselor.

Fee for Service

Each AAA/provider is encouraged to offer options counseling services as a fee for-service enterprise to enhance the sustainability of the Aging network. The AAA must follow all requirements of MAN 5600, Sections 2025-2028.

Mandatory Reporting

All staff must be familiar with and be able to recognize situations of possible abuse, neglect, or exploitation or likelihood of serious physical harm to persons receiving services. Providers shall develop procedures for reporting suspected abuse, neglect, or exploitation.

Suspected cases of abuse, neglect and/or exploitation of community dwelling adults, age 18 and above, are to be referred to the Division's Adult Protective Services Centralized Intake (1-866-552-4464). A voicemail may be left after hours. Alternatively, a fax referral form and instructions and a web reporting form are available on DAS's web page, aging.georgia.gov/.

Any situations in which abuse of minor child/children is suspected are to be reported to the appropriate County Department of Family and Children services (DFCS) at 1-855-GACHILD.

References

DAS Manual 5200, Section 5027
DAS Manual 5200, Section 5060, Appendix F
DAS Manual 5200, Section 5060, Appendix I
DAS Manual 5600, Section 2025-2028

5038 Waiting List Management and Criteria for Admission to Services

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Waiting List Management and Criteria for Admission to Services	**Reviewed or Updated in:**	MT 2021-01
	Section Number:	5038	**Previous Update:**	

Summary Statement

The access system adheres to the following guidelines for managing the non-Medicaid, HCBS Waiting List(s). These policies and guidelines do not apply to EDWP referrals, intake, screening and/or eligibility. ADRC Counselors must be knowledgeable of all requirements.

Requirements

Triage

a. In an effort to prevent unnecessary assessments, individuals will not be assessed for services unless they meet the criteria for assessment, as indicated by the Triage Assessment (Forms 5070). In cases where there is no waiting list for a service, the triage may be omitted.

b. Individuals who are requesting Caregiver Services are not subject to Triage and are only required to be screened using the Bakas Caregiver Outcomes (BCOS) assessment in DDS.

   Instructions for using the Triage score are as follows:

   1. Individuals who do not meet basic eligibility criteria (e.g. 60+ with a demonstrated need for services) do not require Triage assessment. They should be treated as simple I&R calls.
   2. Level One (Score of 7.0 +) (High Priority) – These individuals should be fully assessed at the ADRC Counselor level using the DON-R and placed on Tier 1 Waiting List(s) as applicable For individuals requesting nutrition services, FSS and NSI assessments should also be completed.
   3. Level Two (Score of 0 – 6.99) (Not High Priority) – These individuals do not require full assessment but should be placed on a Tier 2 Waiting List for requested services and offered Community Options Counseling to develop an action plan to immediately address stated needs.

Waiting List Placement

c. The Tier 1 Waiting List is for individuals who will most likely receive services within 12 months of being placed on the list. Individuals will be rescreened every six months. For individuals receiving other non-Medicaid services, the provider's most recent assessment may be used in lieu of a rescreen, if it has been completed within the last six months. Private pay resources and assistive technology must be discussed and documented as options for meeting the needs while the client remains on the waiting list(s).

d. The Tier 2 Waiting List is for individuals who are requesting services and are not anticipated to

receive services within 12 months of being placed on the list. Requirements include:

1. Individuals will be contacted annually by mail to request a status update. Suggested wording for this letter can be found in Appendix 5060-A.
2. The Tier 2 list will be used if additional funding is available and for AAA advocacy purposes.
3. Individuals on the Tier 2 waiting list are prioritized by the Triage Score
4. Assistive technology and private pay services must be discussed and documented as options to meet stated needs while the client remains on the waiting list(s).

e. During the initial triage assessment and each time an individual on a waiting list has a status update, ADRC staff shall discuss the waiting list process and the estimated wait time based on waiting list Tier placement. Below is an example script. Each area may modify this as needed:

> "Ms. Doe, we have a lengthy waiting list for homemaker services. We have about [insert estimated number] individuals waiting for services whose needs are greater than yours. This means that most likely you will not receive the service within the next twelve months unless there is a change in your situation (admitted to the hospital, falls, etc.). We have added you to our list showing that you have requested the service. This documents the need for additional funding and services; however, we will not place you on the priority waiting list. We have a record of your request and will contact you if additional funding becomes available. Please call us if your condition changes. You will receive a letter from us reminding you of this."

f. Documentation of this discussion about waiting list process and estimated wait time will be entered in DAS Data System at the time of the telephone call. The AAA will use the HCBS Notification Form (English/Spanish) to provide a record to the individual regarding the outcome of the assessment for services.

Frequency and Coordination of Rescreening

g. Individuals on either waiting list will also be reassessed when there is notification of a significant change in status that may impact need for service, including but not limited to: hospitalization or emergency room visit(s), change in diagnosis, change in support system, fall, self-care etc.

h. Each AAA will integrate rescreening activities for persons on the Tier 1 Waiting List with the reassessment activities for persons who are also receiving other HCBS services.

1. The face to face reassessment shall receive priority and may count as the rescreening if the reassessment date is within the corresponding time frame for frequency of rescreening. For example, if the period for rescreening is 6 months, but a face-to-face assessment of that client has occurred within those 6 months, the assessment will take the place of the telephonic rescreening.
2. The AAA may identify a hierarchy of service delivery providers to maximize coordination

for clients who are on the waiting list and who receive HCBS services from multiple providers (see CH 114.8, “Guidelines for Client Assessment”).

Admission to Services

i. When funding becomes available to add persons to service from the Tier 1 Waiting List, AAA staff shall contact priority client(s) on the list to determine interest in service.

j. Staff will inform interested clients they are being referred for assessment and that the outcome of the face to face assessment will determine whether services are offered and the potential amount of service.

k. Variations in DON-R scores between screenings and face to face assessments that exceed 10 or more points will be sent to the ADRC program manager of that region. ADRC program managers will coordinate with persons responsible for reviewing the client’s record and for adjusting service plans. Adjustments will be made to waiting list if warranted.

Referrals to Case Management

l. The AAA, through established referral protocols, may refer clients identified through ADRC to case management services. Each AAA may determine who in the ADRC is responsible for making a referral based on recommendation of ADRC Counselor. Reasons for appropriate case management referrals include, but are not limited to:

   1. Screening cannot be completed by telephone (sensory impairments, cognitive impairments, etc.).
   2. Needs identified are beyond the capacity of ADRC Counselors to assess or address by telephone.
   3. Clients who are in crisis and need a face-to-face assessment.

m. Case management should not be used to replace effective ADRC Counseling or Community Options Counseling activities (which including developing an Action Plan to address unmet needs for Tier 2 waiting list clients).

Removal from the Waiting List

n. Tier 1 - At the time of rescreening, if the individual does not respond to a message left via the telephone and a letter mailed to the address on record, the client will be removed from the waiting list. The letter sent as a reminder for rescreening will clearly state that failure to contact the AAA within 14 calendar days of the date of the letter will result in being removed from the list. Each AAA will have a written process for identifying these individuals and removing names from waiting list.

o. Tier 2 - Individuals will be contacted by mail one time annually. If they do not respond within 14 days, they will be removed from Tier 2 list. If the letter is returned to AAA as undeliverable, the AAA will contact the individual by telephone. If the individual is unavailable, the AAA will leave a message. If this is not possible, the AAA will attempt to contact again at another time of day. No more than 2 attempted contacts are required. If the telephone number is disconnected, the AAA will remove the individual from the Tier 2 list. Suggested wording for the letter is in Appendix 5060-A.

When a Client Moves to Another Region

If a client who is active on the waiting list in one of Georgia's PSAs moves to another PSA, the AAA which placed the client on the waiting list should coordinate the transfer of the client to the waiting list of the new PSA as needed. Once notified of the relocation, the original PSA ADRC staff will contact the client to determine if services will be needed in the new area. If so, the original PSA will add the new client address, then create an Alert Note in DDS using Note Type "Referral" and setting the ADRC program manager in the receiving region as a Note Recipient. If services are no longer needed, client should be removed from WL, but the new address should be added to the DDS record.

The Alert Note should notify the receiving ADRC Program Manager that the client has moved into their PSA with an open service request. The receiving PSA should follow-up with the transferred client within 30 days to update assessments and waiting list status based upon the new living arrangements and services provided in the new PSA. A new client notification form should be sent to inform the client of the new waiting list status and expected wait time.

5060 Appendices

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Appendices	**Reviewed or Updated in:**	MT 2016-04
	Section Number:	5060	**Previous Update:**	

5060-A Triage Tool

5060-B Training Requirements

Training Content

The following topical areas should be covered at a minimum in training for all access service staff. Recruitment of staff may focus on identifying individuals who have already had training and experience in areas of practice, including, but not limited to:

- Interviewing skills, techniques and attitudes
- Person-centered planning
- Listening skills
- Communication skills and theories
- Proper telephone usage
- Screening and assessment tools and techniques, specifically the DON-R, NSI and Food Security Survey
- Information and referral procedures
- Follow-up procedures
- Data recording in the DAS Data System
- Records maintenance
- Use of the resource database
- Job related tools and equipment, including telephone and computer systems
- Working with the elderly; individuals with disabilities; multicultural populations/ethnic minorities; other special populations, including learning Person First Language for individuals with disabilities and use of language access services
- Techniques for handling calls from persons in crisis, including people who are despondent, suicidal or angry and people whose primary reason for calling is for social contact to alleviate loneliness or isolation, including the ability to complete warm transfers to crisis lines as appropriate
- Overview of the region's service delivery system for aging and disability services, agency operations, policies and procedures
- DAS policies and procedures, including eligibility criteria for home and community-based services
- Understanding of APS criteria, which types of cases are referred to APS Central Intake and which ones are referred to the Department of Community Health Healthcare Facility Regulation and/or the Long-Term Care Ombudsman - when abuse, neglect or exploitation is alleged.

- Handling calls by inquirers who are non-English speaking or for whom English is not their primary language
- Use of language access services and Georgia Relay or Teletypewriter (TTY) equipment

Desired Learning Outcomes

As a result of initial and ongoing training, staff will be able to:

- Establish rapport with inquirer and use active listening skills to determine the presenting problem;
- Respond to each inquirer in a professional, non-judgmental and culturally appropriate manner;
- Recognize and encourage the inquirer's right to make his or her own choice;
- Make an accurate assessment of the inquirer's problems and needs asking relevant questions to elicit information necessary to make an accurate referral;
- Present the inquirer with various approaches to address the problem;
- Explore the inquirer's own resources (examples: family, friends, faith community)
- Effectively use the resource database to identify resources appropriate to meet the inquirer's needs;
- Where possible and desirable, provide more than one referral to give the inquirer a choice and to avoid the perception that staff are making recommendations;
- Provide accurate and necessary information so that the inquirer can choose the most appropriate resources;
- Pursue the problem until both the inquirer and the staff member are assured that all appropriate options have been exhausted;
- Suggest ways the inquirer can advocate on his/her own behalf, when appropriate;
- When warranted and with the inquirer's permission, make direct contact and communicate effectively with other agency staff through three-way calling; notification of the inquirer's forthcoming contact or scheduling of appointments;
- Refer to an advocacy organization or negotiate on behalf of inquirers to assist them in obtaining a needed service when they cannot effectively represent themselves or when they have a complaint about a service;
- Encourage inquirers to call back if the information provided proves incorrect, inappropriate or insufficient to link them with needed services;
- Follow up when appropriate; and
- Accurately record transaction information in DAS Data System.

Options Counseling Certification

All individuals serving as Options Counselors are required to obtain Options Counseling Certification by the Division of Aging Services. This includes both Community Options Counselors and MDS-Q Options Counselors.

Certification includes, but is not limited to:

- an online training course through Boston University's Center for Aging and Disability Education Research (CADER) program,
- a one day in-person training,
- a written exam, and
- an oral review administered by the DASADRC Options Counseling Specialist.

Individuals who need to enroll in the certification process should contact the DAS ADRC Options Counseling Specialist.

Individuals may have up to two attempts to pass the written exam with an 80% achieved grade. The exam is Pass/Fail.

ADRC Staff Duties

General Description

Serves as point of first contact for individuals requesting information or service assistance for themselves or others. Under general supervision, performs work of moderate difficulty by providing skilled casework, intake, screening and information and assistance services to the elderly, individuals with disabilities, their caregivers, professionals, the general public, and other populations.

Screening Activities / Duties

- Completes referrals within ten business days of receipt: Determines applicant priority for full assessment, conducts telephone assessment, completes the DON-R, Food Security Survey and NSI, and other assessments as needed/required
- Preliminarily determines Medicaid status
- Identifies applicant needs and service requests as indicated by referral source (statement of presenting problems)
- Determines priority and eligibility for publicly funded services and makes referrals to other appropriate resources, including private pay and cost share options
- Explains thoroughly the scope and purpose of publicly funded services
- Informs applicants determined to be ineligible for publicly funded services of appeal rights
- Balances active listening with caller's desire to "vent" or share information not relevant to purpose of call. It is not the ADRC Counselor's role to fulfill the need of lonely or isolated callers. This is a function for telephone reassurance staff/volunteers.

5060-C Operational Model

5060-D Professional Documentation

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Professional Documentation	**Reviewed or Updated in:**	MT 2015-04
	Section Number:	5060 Appendix D	**Previous Update:**	

ADRC Documentation Module

Purpose of Module:

1. Explain how documentation helps staff with supporting informed decision making of individuals.
2. Provide guidance regarding what to document; and
3. Provide guidance regarding how to document.

Purpose of Documentation:

1. Documentation is the 'glue' that holds together all of the steps involving your work as counselors.
2. Documentation is very important.
3. Each case note in the DAS Data System is the narrative describing the background/ history:
    - Presence of a Legal Guardian
    - Past involvement of Adult Protective Services (APS)
    - Needs, preference and values of the individual
    - Cultural awareness
    - All options discussed with individual to include public and private pay resources
    - Development of an action plan working to empower the individual to move forward with their desired goal.
    - Referrals made to appropriate programs on behalf of individual
    - Communication with NH staff, other family members and community partners as agreed to by individual
    - OC specific: Follow-up contacts at 14, 90 and 180 days. Answer questions, revise action plan as needed, make any necessary referrals, research and provide additional information to the individual
    - Need to involve the Long Term Care Ombudsman (LTCO)
    - It is a working instrument to record the individual process
    - It will serve as a record of what the OC has completed and what needs to be completed.
    - It is a formal record of the agency's work. As such, it is the documentation to your supervisor, DAS Options Counseling Specialist, Individuals, and, potentially the courts that the Options Counseling Program has done an adequate job of its work.

    - It is a formal record for funding sources that the ADRCs as the Local Contact Agencies and the MDSQ Options Counseling Program OCs are handling MDS Section Q referrals and meeting set obligations
    - Documentation helps

State facts in a clear format:

- Documenting your interactions and observations forces you to be clear and factual about the situation. Your impressions, emotions, and preconceived ideas are removed from capturing the facts. Also, when handling referrals for multiple individuals residing at multiple nursing homes, the documentation will remind you of important details on each referral.
- Clear documentation enables someone else to pick up, if necessary, where you left off. This is extremely important with moving a referral forward without losing valuable time or increasing an individual's stress level.
- Being able to read 'just the facts' can help to organize thoughts around supporting an individual with their decisions.

Organize thoughts:

- Throughout the steps in the options counseling process, OCs need to stop and analyze what they know, what else they need to understand and to strategically plan with the individual the next steps. Having key elements in writing enhances your ability to effectively move through the options counseling process with the individual.

Track Progress:

- You can review documentation to see the status of the work being conducted with the individual, time frames for OCs actions, time frames for other facility's actions and to determine what else needs to be done.
- Identify barriers to transitioning to the community
- Over time, documentation provides a picture of barriers for individuals to transition to the community by identifying patterns.
- Documentation demonstrates options counseling impact on individuals transitioning to the community and on relationships/ partnerships with nursing facilities.
- Review of documentation from across the state may reveal the need for a change in policy or regulation to correct widespread problems preventing transitions.

Provide a 'safety net':

- Documentation is more reliable than memory of events and actions in responding to MDSQ and non-MDSQ referrals. Sometimes it reassures an individual that you took their concerns seriously and did everything possible to assist the individual with meeting their goals related to returning to the community to live.
- Documentation is sources of specific information of questions arise later on down the road as to how a referral was handled. It is the indicator of the quality of OCs work and compliance with standards and procedures. If necessary, it can assist the DAS Options Counseling Specialist in

supporting OC actions as well as maintaining credibility of a statewide program.

Establish credibility:

- Maintaining good documentation adds credibility to decisions that are reached. It will demonstrate referral sources, active listening and discovery, assistance to individual with informed decision making process, referrals to other agencies, creation of action plans and meeting requires follow-up contacts.
- Clear statements of the person's needs, preferences and values
- Individual's involvement in their transition to the community
- Individual's permission to receive options counseling

How to Document: Fact versus Opinion

- Use objective language in your documentation. It is a natural tendency to want to add personal opinions and perceptions with the facts. As an Options Counselor, your documentation must be factual and objective.
- Avoiding recording subjective information in the history notes unless you substantiate this with facts and/or record it as a direct quote from an individual and identify who the individual is related to the quote.

  FACTS - are client activities, agency actions and/or information from official records or documents. In addition, facts may be straightforward descriptions of circumstances.

  Example - Ms Smith stated she would need assistance with a utility deposit in order to transition out of the nursing home.

  Examples - Ms Smith stated it is important to her to return to her family home to care for her pet cat.

  OBSERVATIONS - are recorded notes about the client, condition of a home, physical injury and/or seen by the Options Counselor. **When recording observations, the source of the information must be clear.**

  Example - The Options Counselor observed Ms Smith crying and clenching her fists.

Notes should include:

- Date-When documenting dates, enter the month, day and year, **not 'by next week'**
- Options Counselor's name
- Type of Activity (face to face, telephone call, email, fax, etc.)
- Who was contacted
- Purpose of contact
- Significant information or observations

The narrative should be written in such a manner that any person will understand exactly what transpired during the case, from beginning (when the referral was received) to end (180 day follow-up) whether they were involved or not.

The narrative 'paints a picture' for the reader to see. It begins with the MDSQ or non-MDSQ referral as received by the ADRC and documented in the DAS Data System.

Judgment terms should not be used in history notes. If used, they must be clarified with clear descriptions.

> I.e. - Instead of recording "Ms. Smith will obtain adequate housing", state- "Ms Smith will obtain adequate housing that at a minimum has running water, electricity, one bedroom, bathroom and kitchen."
>
> I.e. - instead of stating, "Ms Smith's family is dysfunctional", state "I observed Ms Smith, her husband and her daughter screaming at one another during the face to face meeting."

Avoid words/phrases such as 'appeared', 'seems to be'; 'apparently', which may indicate the observation is uncertain. Labels such as 'alcoholic', 'schizophrenic', 'incompetent', 'incapacitated', and 'mentally retarded' shall not be used in isolation and will **ONLY** be used when a certified or licensed professional has made such a diagnosis or when quoting someone.

> I.e. - Instead of saying, "Ms Smith is an alcoholic," it is better to state, "Options counselor observed Ms Smith to have slurred speech, staggered walk and her breath smelled of alcohol."
>
> I.e. - Ms Smith's daughter said, "It is embarrassing to have an alcoholic for a mother."

Differences in objective and subjective examples:

Use Objective Language	Avoid Subjective Language
Can be measured, counted, and seen by more than one person. Two people would have the same understanding of the situation.	Is open to different interpretations. Two people can describe or understand the meaning in different ways.
Word examples: Hit, run, cried, slept, does not speak, laughs, talks to other people	Word examples: depressed, dumb, confused, unable to relate, violent temper, stubborn, lack of respect, an alcoholic, inconsiderate, typical, filthy, friendly
Describe behaviors: I.e. - "Client stated he had no comment when I asked him about wanting to move home with his adult child. After I asked more questions about wanting to return to the community the client asked me to leave his room and not bother him."	Labels Behavior: I.e. - "Client was rude and unresponsive during my interview."
Describe observations: I.e. - "I saw the client struggle to pull herself to a sitting position for the meeting."	Interjects opinion/offers as interpretation: I.e. - "The client could not sit up and obviously needs 24/7 care."

In the DAS Data System, it is best to indicate and acknowledge an error with phrasing such as "CORRECTION to entry dated 00/00/0000 and proceed to document the correction.

Don't document "He/She refused services." Do document, "He/She said "Leave me alone." Document editorial comments - "He/She never returns my phone calls/emails." Instead document specific dates/times calls/emails placed to a specific person or agency.

Subjective, Vague and Judgmental Terms

The following list gives examples of subjective, vague and judgmental terms. (It is not an all-inclusive list) Subjective, vague and judgmental terms are not to be used in isolation. If used, clarify by using descriptive works. Judgmental terms are used ONLY when quoting someone.

Subjective, Vague Terms

Abusive	Messy
Adequate	Neat
Angry	Neglectful
Apparently	Nervous
Appeared	Nurturing
Appropriate	Obviously
As soon as possible	Offensive
Clean/dirty	Physical
Cluttered	Proper
Good/poor housekeeping	Quality
Happy/sad	Regular
Healthy	Seems to be
Hostile	Suitable
Hyper	Stable
Hysterical	Unmotivated
Immediately	Upset
Loud	Verbal/non-verbal
Incompetent	Tidy
Incapable	Well cared for

Judgemental Terms

Dysfunctional	Filthy
Junky	Lazy/sorry
Nasty	Obnoxious
Druggie	Unfit
Slob	

5 “W”s and a “H”: Information Gathering and Reporting

Who

Is the primary reader?

Else will read this case note?

Are you to the reader?

Should perform these actions?

What

Do you hope to accomplish?

Criteria are you using?

Is fact, what is opinion?

Is the solution?

Are the alternatives?

Questions might the reader ask?

Does the reader already know about the subject?

Why

Are you writing?

Are you writing now?

Where

Does the communication lead?

Are the reader's biases?

Is the reader's resistance?

Did event/actions occur?

When

Will additional information be available?

Will actions/events/resolutions occur?

Are deadlines? (i.e. eligibility requirements, face to face visits, follow-up contacts, etc.)

How

Did this happen?

Have the conclusions been reached?

Will this be handled?

Will this be avoided in the future?

Case Notes: At a minimum the formal case note must include the type of contact, staff person who made the contact, time spent on the contact (time spent box) and detailed information as to the items discussed and concerns presented, any given information and unmet needs in a factual manner. Formal case notes need to be written in such a way to avoid the use of personal opinion, judgment calls and biases toward the individual transitions.

5060-E Accepted Documentation Abbreviations

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Accepted Documentation Abbreviations	**Reviewed or Updated in:**	MT 2015-04
	Section Number:	5060 Appendix E	**Previous Update:**	

Avg	Average
b/c	Because
BKA	Below the knee amputation
CL	Client
CCSP	Community Care Service Program
c/g	caregiver
CHF	Congestive heart failure
COPD	Chronic obstructive pulmonary disease
DD	Developmental disability
DFCS	Department of Family and Children Services
DOB	Date of birth
DON-R	Determination of need
DTR	Daughter
Dx	Diagnosis
ER	Emergency room
F/u	Follow-up
HCBS	Home and Community Based Services
HIPAA	Health Insurance Portability Accountability Act
HTN	hypertension
Hx	History
Info	information
Msg	Message
MFP	Money Follows the person
MD	Medical doctor
MDSQ	Minimum Data Set Section Q
MH	Mental health
NH	Nursing home
OC	Options Counselor
PCH	Personal care home
PSS	Personal support services
SOURCE	Service Options Utilizing Resource in the Community Environment
SSI	Social Security Income
SSDI	Social Security Disability Insurance
TBI	Traumatic Brain Injury
TC	Transition Coordinator
TCF	Telephone call from
TCT	Telephone call to
UTI	Urinary Tract Infection
VA	Veterans Administration
VM	voicemail
w/	with

WL	Wait List
w/o	without
yr	Year

5060-F Options Counseling Action Plan

5060-G Questions to Foster Rapport

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	Questions to Foster Rapport	**Reviewed or Updated in:**	MT 2015-04
	Section Number:	5060 Appendix G	**Previous Update:**	

Community Options Counseling Questions to Foster Rapport and Begin Discussion

To start the meeting:

- Confirm how much time is available to talk and is client comfortable (in person)
- Introduce yourself and provide a **brief** background/history of the work of options counseling and the agency
- Review any previously received data for accuracy (address, phone, email, preferred contact method, etc)
- Assure individual of confidentiality of any of the personal information shared (HIPAA)
- Describe the purpose of this meeting
- Get to know individual better
- Answer their questions about options counseling and ADRC
- Identify client's goals (as it relates to long term services and supports)
- Describe the process and about the creation of an action plan to use as a guide in moving forward.

Questions:

- What good things are happening in your life right now?
- If struggling, prompt with a follow-up question of can you tell me one thing that you feel good about right now?
- What do you enjoy doing?
- Hobbies, interests, skills, talents
- Something you like to do or used to like to do that brings you happiness.
- What are your challenges at this time?
- Things that are causing you to worry.

- What do you need the most help with right now?
- Prompts: do you need help with things like cooking or cleaning your house, managing your money, remembering to take medication, paying for medication, etc.
- If you could have anything you want (not material goods or money), what would be three things about your life you would change right now?
- Ok, more specifically, what are your hopes and goals for the future?
- Prompt: where you want to live, what you would like to be doing, who you would like to be with
- Are there things you have tried to do yourself to resolve a challenge you are facing?
- Did any of those things work out as you would like?
- What gets in the way of achieving your goals?
- Have you had any hospitalizations in the past year?
- Have you fallen in the past 6 months?
- Who else have you worked with before?
- Prompt: other professionals, family members, friends, co-workers, neighbors, church peers, physician, etc.
- Get names and contact info of people who have helped in the past.

Caregiver specific questions only: (ask as applicable)

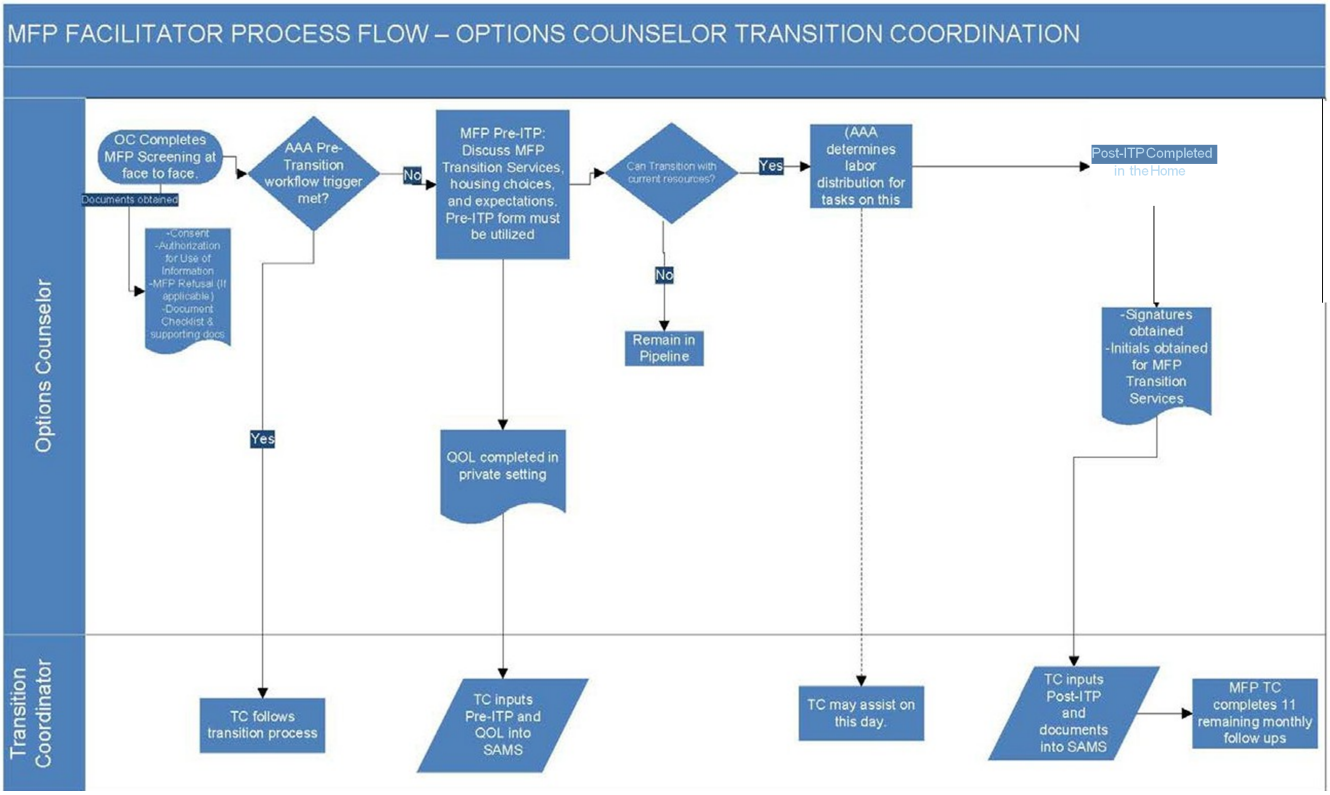
- How many hours a week do you spend helping your loved one(s)?
- On a scale from 1 to 10 with 1 being no stress and 10 being extremely stressed, how would you rate your current stress level?
- Are you considering placing your loved one in a nursing home or other facility?
- On a scale of 1 to 10 with 1 being unlikely to place in NH and 10 being going to place in NH within the next 3 months, how would you score your likelihood to place in a NH?
- Are you satisfied with support you are receiving from other family members (if applicable)
- Do you feel that other people understand what you are going through?
- Who has been most helpful? Why/ how were they helpful?
- Who else is involved with your life now?
- Family members, friends, neighbors, church group, co-workers
- Is there someone in particular you would consider that could be helpful in meeting your goals? (Name contact info) and may I have your permission to speak with them?
- Do you have a health care POA? Financial POA?
- Yes? Name and contact info
- Is there anything we haven't discussed that you want to include right now?
- Let's review what we discussed today to make sure we are on the same page about next steps:
- We talked about… (Recap…aka active listening)
- Here are some of the next steps that I will follow-up with to help you explore your options

towards making an informed decision.

- Now let's make a list of things you can work on in the next two weeks to move forward
- Add to action plan to leave/ send a hard copy to the individual
- I would like to follow-up with you in approximately 30 days to see how things are going. Would that be ok with you? Is _____ date at say _____ time sound good?
- Add confirmed date and time to action plan sheet
- I really enjoyed talking with you and look forward to follow-up with you to see how things are going.

5060-H MFP Facilitator Process Flow

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	5000 Aging and Disability Resource Connection (ADRC)	**Effective Date:**	
	Section Title:	MFP Facilitator Process Flow	**Reviewed or Updated in:**	MT 2015-03
	Section Number:	5060 Appendix H	**Previous Update:**	



5060-I Secret Shopper Toolkit

5060-J Waiver Booklet Order Form

5060-K Nursing Home Transition Screening Form

5070 Forms

Options Counseling Action Plan

ADRC Sample Collaboration Agreement

ADRC Sample Participation Statement

HCBS Notification Form

HCBS Notification Form (Spanish)

HCBS Waiver Booklet Order Form

Understanding Georgia's Waiting List Policy Letter

Assessment Triage Form

5080 ADRC Monitoring Guide

6000 Community Transitions

6100 Money Follows the Person

6111 Overview

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Overview	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6111	**Previous Update:**	

Summary Statement

The Money Follows the Person Program is a grant-funded program designed to assist Medicaid beneficiaries in transitioning from institutional settings into community settings using person-centered practices.

Authorization

The Money Follows the Person Program (MFP) was created and authorized by the Deficit Reduction Act of 2005. The law authorized the Centers for Medicare and Medicaid Services (CMS) to provide competitive grants to 13 states. Georgia was awarded the grant in 2007.

The MFP program was re-authorized, expanded, and extended by the Affordable Care Act of 2010. Funding was approved through the year 2020 and 42 states (including Washington, DC) participate as of 2014.

Georgia's lead agency on Medicaid, the Department of Community Health (DCH) was awarded the grant in 2007. DCH operates the grant through an Operational Protocol submitted to CMS each calendar year.

As grantee, DCH contracts with other state agencies, including the Department of Human Services to administer the grant. Rules for administration of the program are kept in a Medicaid manual entitled: *Policies and Procedures for Money Follows the Person*, published by DCH.

References

1. Deficit Reduction Act of 2005: www.gpo.gov/fdsys/pkg/PLAW-109publ171/html/PLAW-109publ171.htm
2. Affordable Care Act of 2010: www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html
3. DCH Operational Protocol & Manual: dch.georgia.gov/georgia-money-follows-person-ga-mfp

6113 Monitoring

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Monitoring	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6113	**Previous Update:**	

Summary Statement

DAS Money Follows the Person (MFP) staff monitor Transition Coordination (TC) activities described in DAS Standards, as published on ODIS, and described in the Department of Community Health (DCH) Policies and Procedures for the Money Follows the Person Program (Manual).

Basic Considerations

DAS MFP staff monitor program compliance using the following Tools:

- MFP Monitoring Tool
- Harmony for MFP User Guide as published on ODIS
- Serious Incident Review Team reviews
- Harmony Advanced Reporting Tools:
  - Program Participation Report
  - Program Enrollment Status Report for Semi-Annual
  - SER Validation Report
  - Screening Validation Report
  - DC Checklist Validation Report
  - New Transition Validation Report
  - Case Note Validation Report

DAS Procedures

DAS MFP staff monitor Transition Coordination activities in the following manner:

- Review up to 3 Completed records that have the highest MFP Transition Service expenditures according to Harmony for MFP
- Review up to 3 Completed records that have the lowest MFP Transition Service expenditures according to Harmony for MFP
- Review up to 3 Reinstitutionalized records
- Review up to 3 Deceased records
- Review up to 3 Terminated records
- Review up to 3 Active records
- Review up to 3 Pre-Transition records

DAS MFP staff review the selected records and complete the Desk Review portion of the monitoring. Should significant deficiencies become apparent in the Desk Review process, DAS staff may pull additional records to determine patterns. DAS may complete Desk Reviews at any time.

DAS MFP staff may select to schedule a site visit and complete the On-Site portion of the monitoring. On-Site monitoring includes a scheduled visit to willing, Active MFP Participants. The interview portion of the On-Site monitoring is completed during the visit.

DAS MFP staff reserve the right to schedule the on-site interview directly.

DAS MFP Staff schedule a discussion of the Monitoring via a Monitoring Review Meeting no more than thirty calendar days after the Monitoring is completed.

Monitoring Review Meetings may be face to face or via electronic means (i.e. web conference).

If an Action Plan is necessary:

- DAS MFP staff approve or deny the steps within the Action Plan.
- Denied steps are returned with comments.
- Field Staff review comments and resubmit Denied Action Steps.
- Only Action Plans in which all steps have been approved are considered acceptable.

AAA Procedures

MFP Field staff (led by the AAA) will complete an Action Plan in response to any Monitoring Findings. Action Plans are due 30 calendar days from the date of the DAS-led Monitoring Review Meeting. Monitoring Findings are identified in the completed Monitoring Tool.

An Action Plan must include the following:

- Reference to the Monitoring Finding(s) from the Monitoring Tool
- Specific tasks/actions to be taken
- Measurable outcomes from the tasks/actions

- Timeframe for which the tasks/actions are to be completed

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6121 Communication

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Communication	**Reviewed or Updated in:**	MT 2015-02
	Section Number:	6121	**Previous Update:**	

Summary Statement

The Department of Community Health (DCH) contracts with Division of Aging Services (DAS) to administer the Money Follows the Person (MFP) program. In order to maintain statewide consistency in policy and procedures, communication between DCH and the AAAs will be through DAS.

Basic Considerations

DCH staff are to communicate with AAA employees through DAS staff. DCH should not communicate with AAA staff directly (in regard to MFP). If DCH provides guidance directly to AAA staff, AAA staff is to confirm guidance with DAS prior to responding to DCH.

AAA Procedures

DAS staff will deliver all official guidance to Transition Coordinators in writing, generally by email or email attachment.

- Guidance that results in exceptions or waivers to the use of MFP Transition Services are delivered by DAS staff via the Technical Assistance function in SAMS Journals.
- DAS staff will copy TCs and the AAA-designated TC supervisors on emails related to guidance, policy clarification, and technical assistance.
- Technical assistance via telephone will not be considered official guidance unless followed up with a written document.

The above guidance will apply to Transition Coordinators who are AAA employees, contract employees/temporary staff, and independent contractors, or any other status.

It is the responsibility of the AAA to assure Transition Coordinators keep the AAA staff informed when the TC generates electronic communication. DAS staff will assure all email/written replies are copied to the designated MFP supervisor at the AAA.

Requests for guidance or policy clarification are to come in writing, rather than verbal or other

informal avenues.

6122 Area to Area Transitions

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Area to Area Transitions	**Reviewed or Updated in:**	MT 2015-02
	Section Number:	6122	**Previous Update:**	

Summary Statement

Transition Coordinators will cooperate to assist one another in the transition of an MFP Participant from one PSA to another PSA.

Basic Considerations

Transition Coordinators are called upon to assist MFP Participants in a person-centered process. This will require both TCs to communicate consistently. Information, including relevant documentation, must be communicated between TCs as soon as possible.

An official handoff of the case should occur on day of transition or shortly thereafter. This can be accomplished by a conference call. DAS staff must be invited to this call.

Definitions

Sending AAA

The Sending AAA or Sending TC refers to the PSA or staff in which the nursing home resides.

Receiving AAA

The Receiving AAA, or Receiving TC refers to the PSA or staff in which the Participant will eventually reside.

EXCEPTION No exceptions at this time.

AAA Procedures

Pre-Transition

1. **Screening**:
   - Sending AAA conducts MFP Screening as part of the Options Counseling process.
2. **Waiver Process**:
   - Waiver referral is made through Options Counseling Process.
   - Sending TC assures appropriate waiver case managers and providers are selected. Make sure the providers operate in the geographic location in which the Participant wishes to move.

3. **Notification**:
    - Sending TC assures the Receiving AAA is aware of the impending transition within ten (10) business days of screening. Sending TC assures DAS and Receiving TC obtain MFP screening once completed.
    - Sending TC sends separate communication to DAS identifying the Participant as a potential Area to Area transition at the time of screening submission.
4. **Housing Search**:
    - Once the waiver determination is made, Sending and Receiving TCs partner on local housing search.
    - Receiving TC is responsible for assuring applications are submitted and housing application fees/security deposits are paid.
    - Receiving TC assists with establishment of utilities and payment of utility deposits.
5. **Individual Transition Plan**:
    - Sending TC facilitates ITP in facility or location of Participant's choice.
    - Sending TC notifies Receiving TC and DAS staff no less than ten (10) business days in advance of an ITP date.
    - Both TCs must work together to assure they participate in the ITP process.
    - Section 20 of each Area to Area ITP will be distributed to relevant partners (including DAS staff) within three (3) business days of the ITP.

> **NOTE** *During the ITP, Section 20: Transition Plan Assignments, is thoroughly utilized. Section 20 delineates each task, person responsible, and due dates. Sending TC takes responsibility for updating the task list. If a responsible party delegates a task to someone else, the responsible party listed on the ITP will be held accountable for task completion in the appropriate timeframe.*

6. **Medical**:
    - Receiving TC assures a local physician, pharmacy, dialysis clinic, etc. are established prior to date of transition. It is imperative that an MFP Participant's medical assurances are seamless throughout a transition.
    - Sending TC assures the nursing facility has ordered proper Durable Medical Equipment (DME), Assistive Technology (AT), etc. and items will be delivered to the agreed-upon address on or before date of transition.
7. **Final Notification**:
    - Sending TC notifies all relevant parties (use ITP Item 20 distribution list as a reference) within seven (7) business days of the final transition date.

Day of Transition

1. **Transportation**:
    - Sending TC coordinates transportation from the nursing facility to the Participant's new res-

idence.

2. **Documentation**:
   - Sending TC obtains DMA-59 from the nursing facility and submits to DAS and the Receiving TC within three (3) business days of transition.
   - Receiving TC submits Discharge Day Checklist and waiver documents within the standards of promptness.
3. **Transition Services**:
   - Receiving TC assures delivery of Household Goods and Supplies (HGS), Household Furnishings (HHF), and all MFP Transition Services identified at the ITP not attributed to the Sending TC.
4. **Social Security**:
   - Receiving TC assures the Participant goes to the Social Security office with a copy of their executed lease (or other proof of address) and the DMA-59. Both documents will be required to assure the Participant receives their funds.

Post-Transition

1. **Face to Face Visit**:
   - Receiving TC conducts face to face visit within seven (7) business days of transition.
2. **Contacts**:
   - Receiving TC completes monthly contacts per MFP Policy & Procedure guide and delivers necessary Transition Services through the Participant's MFP enrollment period.
   - At this point, Receiving TC takes full responsibility for MFP services and process.
3. **ITP Execution**:
   - Receiving TC assures actions documented in ITP are executed in a timely fashion.

Transition Credit

Under the procedures above, the Sending AAA receives 0.25 transition credits and the Receiving AAA receives 0.75 transition credits.

References

1. Policies and Procedures for Money Follows the Person, as published by Georgia Department of Community Health, Medicaid Division; dch.georgia.gov/georgia-money-follows-person-ga-mfp

6123 Transition Coordinators Qualifications and Training

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Transition Coordinators Qualifications and Training	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6123	**Previous Update:**	

Summary Statement

In order to assure Transition Coordinators (TCs) for the Money Follows the Person Program (MFP) have the training and experience necessary to effectively discharge the transition coordination activities.

Basic Considerations

MFP Transition Coordination contains activities related to Information and Referral, Case Management, Project Management/Coordination, and Options Counseling, among others. As such, Transition Coordinators can come from varied backgrounds with different skillsets. The TC position may be a Full Time Equivalent, Contractor, or part time worker.

Definitions

Transition Coordinator

A Transition Coordinator with a minimum of one year's experience as an ATC or with a Nursing Home Transition program, either as a TC, Options Counselor, or in a transition position with a Center for Independent Living.

Associate Transition Coordinator or TC Support (ATC)

An ATC position works to support TCs through activities such as administrative support (follow up calls, data entry, etc.), TC activities as overseen by the TC, or other support activities that contribute to transitions.

AAA Procedures

Item 1 AAAs follow DAS standards for Transition Coordination unless expressly approved by DAS MFP staff through the existing waiver process on ODIS.

Item 2 AAAs or their subcontractors will have a minimum of one TC who meets the qualifications above available to provide transition services.

Item 3 AAAs notify DAS MFP program staff regarding TC staffing changes as follows:

- Within two (2) business days of the change.
- In writing (email is acceptable)
- How MFP activities will be supported in absence of TC
- Approximate time TC position will be open

DAS Procedures

DAS maintains and updates the standards for Transition Coordination and may update qualifications and standards at any time following the appropriate process.

Training Requirements

Transition Coordinators will attend all training required by the Division of Aging Services.

Transition Coordinators will attend all training required by the Department of Community Health.

Required Training for Transition Coordinators within one (1) year of taking position:

- Adult Crime Tactics training (provided by the Forensic Special Investigation Unit, administered by DAS).
- HIPAA

Suggested Competencies:

- Medicaid Waivers
- Information & Referral
- Nursing Home operations

TC Qualifications

Education: Bachelor's Degree, Associate's Degree, or Registered Nurse

Experience: A minimum of one year in a Human Services position required. Refer to Basic Considerations of this policy for additional experience requirements.

> **NOTE** Any TC in place at the initial implementation of these standards are not subject to the qualifications section of these standards.

Preferred Skillsets:

- Comfortable with technology such as mobile platforms and data systems.
- Knowledgeable in Nursing Home operations.
- Experience with managing case loads and/or projects of a similar size and scope.
- Knowledgeable of Community Medicaid resources (Waivers).
- Understanding of Person-Centered philosophy.
- Understanding of Person Directed planning and/or case management.

Qualification Waiver Process

Should a AAA believe the best candidate for a Transition Coordination position does not meet the requirements listed above, they may apply to DAS for a waiver of the TC Qualifications.

The Waiver request must include the applicant's curriculum vitae and any other experience, qualifications, and/or education that may influence the decision to waive TC qualifications. Additional rationale may be included.

The Waiver must be submitted by the AAA, in writing, and approved by DAS staff. If approved, the TC Qualifications for that individual are waived and the individual may take the position.

The AAA may not request a 'standing' Waiver, a waiver of the qualifications that applies to the AAA as a whole. Only Waiver requests for individual Transition Coordinators are considered.

Associate TC Qualifications

Education: Completed High School or GED

Experience: None necessary. Field agencies may wish to hire ATCs based on a skill set for a specific support role, such as vendor management, database administration, information & assistance, etc.

Preferred Skillsets: Same as for TC

6131 Money Follows the Person and Chronic Disease Self-Management Education

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Money Follows the Person and Chronic Disease Self-Management Education	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6131	**Previous Update:**	

Summary Statement

Chronic Disease Self-Management Education (CDSME) is used to support Money Follows the Person (MFP) Participants using the Life Skills Coaching Transition Service.

Basic Considerations

MFP Field staff must work with the Participant and CDSME leader to enroll the Participant in the CDSME program of their choice.

MFP Participants may participate in either the in-person or online CDSME activities.

MFP Transition Service Taxonomy must be observed. CDSME Action Plan: The Action Plan(s), will be submitted as the Individualized Training Needs Assessment (ITNA) required by the MFP Transition Service Taxonomy (Appendix B of the Policies and Procedures for Money Follows the Person).

MFP Transition Services cannot pay for any 'ongoing' service unless expressly approved in the MFP Polices & Procedures.

AAA Procedures

Step 1 Transition Coordinator (TC) identifies in the Individual Transition Plan (ITP) that the Participant is diagnosed with a chronic disease and has expressed a desire to participate in an education program.

Step 2 TC refers the Participant to the local CDSME group leader and assures the Participant is enrolled. MFP Transition Services may not be used to transport the Participant to CDSME activities.

Step 3 MFP Field staff will ensure the ITNA documents are obtained and submitted with the Vendor Request for Payment document. CDSME vendors will not be reimbursed without copies of the ITNA.

Step 4 MFP Transition Services may be used to support the Participant's use of the online CDSME resources. The Equipment, Vision, Dental, & Hearing Services Transition Service category can be used to purchase a baseline computer or tablet. The Utility Deposit Transition Service may be used to pay for set-up and installation of internet access.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Living a Healthy Life with Chronic Conditions, Bull Publishing, 4th Ed., p.26

6132 Home Care Ombudsman

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Home Care Ombudsman	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6132	**Previous Update:**	

Summary Statement

Home Care Ombudsman is an available service for Money Follows the Person (MFP) Participants during their 365-day participation period.

Basic Considerations

Georgia Home Care Ombudsmen (HCOs) provide services including (but not limited to) advocacy, rights education, and complaint resolution to MFP participants.

HCOs provide their service(s) according to the policies/procedures/processes developed by the State Long Term Care Ombudsman's office.

HCOs are reimbursed for their services in accordance with the Policies and Procedures for Money Follows the Person (Manual), Appendix B, published by the Department of Community Health.

HCOs may recommend expenditure of MFP Transition Services in the course of their work.

Only Transition Coordinators may authorize MFP Transition Service expenditures. MFP Transition Services are requested by the MFP Participant and justified in the Individual Transition Plan.

Definitions

Home Care Ombudsman (HCO)

An individual, trained and certified by the Georgia State Long Term Care Ombudsman's office, who provides Ombudsman services to MFP participants during their 365-day participation period.

AAA Procedures

1. Authorizing Home Care Ombudsman Services

    Step 1 MFP Field Staff explain the HCO service during the ITP meeting.

    Step 2 MFP Participants authorize HCO services by initialing the service description on the ITP document. Participants may or may not choose to authorize the service, at their discretion.

2. Referring Home Care Ombudsman Services

    Step 1 MFP Field staff refer clients to HCO within 30 days of transition.

    Step 2 TCs do not refer MFP Participants who reside in Personal Care Homes. These participants benefit from LTCO services.

    Step 3 TCs submit a copy of the ITP to the HCO upon request (only for Participants who have chosen the HCO service).

3. Responding to Home Care Ombudsman Recommendations

    Step 1 TCs receive written recommendations from HCO.

    Step 2 TCs verify recommendations with MFP Participant.

    Step 3 TC responds to HCO within fourteen (14) calendar days as to next steps.

    Step 4 TC apprises HCO of recommendation status upon request.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6134 Transition Services Vendor Management

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Transition Services Vendor Management	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6134	**Previous Update:**	

Summary Statement

Division of Aging Services (DAS) Money Follows the Person (MFP) staff will vet all MFP Transition Service Vendors that are to be reimbursed by the MFP Fiscal Intermediary (FI).

Basic Considerations

MFP Field staff will develop and maintain professional, legal, and ethical relationships with MFP Vendors.

MFP Field staff ensure MFP Transition Services are delivered within the scope of the Policies and Procedures for the Money Follows the Person Program (MFP Manual), specifically Appendix B: Taxonomy of Services.

Expenditures made outside of the Taxonomy of Services may not be reimbursed by the Fiscal Intermediary or may be recouped upon audit.

Social Service Block Grant (SSBG) funds may be used for any MFP Transition Services.

Definitions

MFP Transition Service Vendor

The entity, identified on the MFP Vendor Import File, that is reimbursed by the Fiscal Intermediary for MFP Transition Services rendered. The MFP Transition Service Vendor may not necessarily be the entity that engaged in the direct service.

Third Party Vendor

The entity not identified on the MFP Vendor Import File but contracted to complete the MFP Transition Service directly.

AAA Procedures

MFP Field staff must provide to DAS the following minimum documentation to enroll an MFP Transition Service Vendor:

- W-9
- Copy of Current Business License
- Contact information for billing office
- Services to be enrolled

MFP Field staff will provide, upon request by DAS staff, the following minimum documentation for MFP Third Party Vendors:

- W-9
- Copy of Current Business License
- Copy of current Licensure (if required to deliver service)
- Copy of Bond documentation (if providing Environmental Modification or Vehicle Adaptation services)
- Copy of current Insurance documentation (if required to deliver service)
- Contact information for billing office

Vendor documentation is provided through normal communication channels such as email, fax, or mail.

If an MFP Transition Service (which would appear on the VIF) is delivered by AAA staff, the following criteria must be observed:

- Service is authorized by DAS
- AAA staff delivering service are not managed by the designated MFP Program Manager
- AAA staff delivering the service may not be paid by MFP Administration dollars sent to the AAA through DAS
- Service delivery must follow the MFP Taxonomy of Services

DAS Procedures

1. DAS MFP Fiscal Staff:
    - Pulls Vendor Import File (VIF) Reports from Harmony for MFP per schedule published to AAAs. A new schedule is published each fiscal year.

      NOTE *If all required data is not entered into Harmony for MFP, the expenditures will not appear on the VIF.*

    - Checks VIF records against physical records uploaded to Harmony for MFP.
    - Marks approved Records as 'DAS Approved,' marks incomplete or inaccurate records as 'Returned to AAA'.
    - Records marked 'Returned to AAA' are not reimbursed until appropriate documentation is provided.
2. DAS Program Staff:
    - Enters Vendor into Harmony provider system within 10 calendar days of receipt of complete information.
    - Answer Technical Assistance questions as it pertains to policy or procedure of the Vendor Import File.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6141 Harmony for MFP

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Harmony for MFP	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6141	**Previous Update:**	

Summary Statement

The Harmony Framework Database, developed by Harmony Information Systems (Harmony) and administered by Division of Aging Services (DAS), is the database of record for all Money Follows the Person (MFP) activities. Area Agencies on Aging (AAAs), their staff, and contractors utilize the Harmony system as proscribed by DAS policy, procedure, and guidance.

Basic Considerations

DAS creates policy and procedure for the use of the Harmony for MFP module based on the Policies and Procedures for Money Follows the Person (MFP Manual), DAS MFP Standards, and guidance from the Department of Community Health (DCH).

Utilization of Harmony for MFP is required. Data entered into Harmony is the only source from which mandatory program reports are generated.

DAS staff will use the Harmony database to assess situations and deliver and document technical assistance. If information is not available in the database for DAS staff to make a determination, a decision will not be communicated until all necessary information is available in the system.

AAA Procedures

AAA staff will utilize the Harmony for MFP User Guide, published by DAS, as the official reference to document MFP activities within the database.

The User Guide is updated on a regular basis, no less than annually, and distributed to all staff who use the system.

DAS reserves the right to send guidance via other means to clarify the User Guide prior to an official update. This may be done through formal letters, email communication, or other written formats.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6142 Money Follows the Person Vendor Import File

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Money Follows the Person Vendor Import File	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6142	**Previous Update:**	

Summary Statement

The Money Follows the Person (MFP) Vendor Import File (VIF) documentation is automated using

the Harmony for MFP database and Harmony Advanced Reporting (HAR) tools.

Basic Considerations

The MFP VIF is the official documentation standard by which MFP Transition Service expenditures are communicated to the Department of Community Health (DCH) for reimbursement by the Fiscal Intermediary (FI).

DAS Fiscal staff are responsible for transmittal of the VIF to the FI/DCH.

DAS staff run the VIF on a regularly scheduled basis. A schedule, referred to as the MFP VIF Calendar, is published by DAS and distributed to MFP field staff annually.

The VIF Report in HAR is designed to pull Service Deliveries by 'Create Date', or the date they are physically entered into the database, not the date of Service entered into the Service Delivery Calendar.

MFP field staff use HAR and native Harmony reporting tools to perform quality assurance and financial tracking functions to assure accuracy of the VIF generated by DAS (see MFP VIF Calendar for dates).

MFP field staff are responsible for ensuring data entry into Harmony for MFP is timely and accurate. Inaccurate data entry can result in a delay of payment.

AAA Procedures

MFP Field staff follow the steps below to ensure an accurate Vendor Import File.

Step 1 MFP field staff provide required documentation for MFP Transition Service expenditures to DAS via the Harmony File Attachment feature. Required documentation is outlined in the MFP Manual produced by DCH, section 604.5.

Step 2 MFP field staff enter Service Deliveries per the Harmony for MFP User Guide developed and published by DAS. Inaccurate data entry can result in a delay of payment.

Step 3 MFP Field staff with access to HAR (Report Runners) run the VIF prior to the date on the VIF Calendar. Field staff correct any errors to their portion of the report prior to the date DAS runs the final VIF. Failure to correct errors in a timely fashion will delay reimbursement.

Step 4 MFP field staff with access to Harmony for MFP run the 'Service Delivery QA' report in Harmony and Report Runners run a preliminary VIF for quality assurance purposes. DAS highly recommends running both these reports no less than monthly to maintain the quality of the VIF data.

Step 5 MFP field staff follow internal procedures to reconcile VIF data with actual expenditures.

Step 6 MFP field staff are required to respond to DAS requests for data entry or quality assurances by the timelines established in the DAS Vendor Import Calendar.

DAS Procedures

DAS fiscal staff run the final VIF report according to the published schedule. The final VIF and supporting documentation are submitted to DCH/FI.

DAS fiscal staff supply a copy of each final VIF to MFP field staff for quality assurance and reference purposes.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6143 Documenting a MFP Sentinel Event Report

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Documenting a MFP Sentinel Event Report	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6143	**Previous Update:**	

Summary Statement

Money Follows the Person Field staff uses the Sentinel Event Report (SER) to communicate critical incidents to Division of Aging Services, Department of Community Health, and the Centers for Medicaid and Medicare Services.

Basic Considerations

A sentinel event is defined as one of the following:

Definitions

Abuse

As defined by OCGA 30-5-3 (1); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Neglect

As defined by OCGA 30-5-3 (9); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Exploitation

As defined by OCGA 30-5-3 (8); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Hospital/Nursing Facility/ICF Admit

Participant is admitted to a hospital, nursing (or skilled nursing) facility, long-term acute care, in-patient hospice, or similar facility for more than twenty-four (24) hours.

Emergency Room Visit

The MFP Participant visits an emergency room seeking treatment, prescriptions, or other medical care. The Participant need not receive services for a SER to be completed.

Death

An MFP Participant is confirmed as deceased by a local medical authority.

Involvement with the Criminal Justice System

An MFP Participant encounters law enforcement, accesses criminal legal services, violates probation or parole, or becomes involved in any other incident that involves the criminal justice system not to include misdemeanor traffic violations.

Medication Administration

An MFP Participant encounters difficulty with the administration of their medication or abuses their medication. This includes when insufficient medication is sent on day of transition.

Other

The TC believes a critical incident has occurred but cannot explain it with one of the categories above. TCs may also use 'Other' to notify DAS and DCH as to Medicaid conversion issues that prevent Participants from receiving scheduled services.

Standards of Promptness

All MFP Sentinel Event Reports are submitted to DAS within three (3) business days of the time the sentinel event becomes known to the TC. The date of the incident and the date of the report are listed separately on the MFP Sentinel Event Report.

Reporting Standards

All MFP Sentinel Event Reports will be logged into Harmony for MFP. DAS will not accept scans of paper copies of a Sentinel Event Report.

The original SER document should be updated as often as necessary to capture updates to the initial event described. Additional SERs are not required unless information becomes available that would trigger a second SER category.

AAA Procedures

The procedures below are formatted to follow the flow of the official SER report document. The standards are the guide by which the document is completed.

Process By Category

Abuse/Neglect/Exploitation

As mandated reporters, MFP Field staff are required to report any instances of abuse, neglect, or exploitation to Adult Protective Services and law enforcement in addition to the programmatic reporting done through the SER. If an MFP Participant is a victim, or the TC suspects they are a victim, of abuse, neglect, or exploitation a SER must be completed.

Hospital / Nursing Facility / ICF Admission

If the MFP TC discovers the Participant has been admitted to a facility, for any reason, a SER is completed.

If the admittance to an inpatient facility exceeds thirty (30) calendar days, the TC submits a Participant Status Change.

Emergency Room Visit

If the MFP Participant visits an emergency room seeking treatment, prescriptions, or other medical care, the TC submits a SER for the incident.

If the Participant is released without treatment, a SER must still be completed.

If the Participant is admitted to the hospital through the ER, report the incident under Hospital/Nursing Facility/ICF Admit, not Emergency Room Visit.

Death

If an MFP Participant dies, for any reason, a SER must be completed.

TC submits a preliminary SER within the standards of promptness, even if all information is unavailable. An update to the record may be submitted once additional information has been obtained.

Involvement with the Criminal Justice System

If an MFP Participant encounters law enforcement, accesses criminal legal services, violates probation or parole, or becomes involved in any other incident that involves the criminal justice system, the TC must complete a SER.

TC submits a preliminary SER within the standards of promptness, even if all information is unavailable. An update to the record may be submitted once all information has been obtained.

Medication Administration

If an MFP Participant encounters difficulty with the administration of their medication or abuses their medication, submit a SER under this category.

If the issue with medication administration results in an immediate ER visit or hospitalization, report the incident under the most appropriate category.

Other

If the TC believes a critical incident has occurred but cannot utilize one of the categories above, use the ‘Other’ category and write a short topic header in the line provided.

Summary / Participant Reporting / Adverse Outcomes

Step 1 The MFP TC makes contact with the principal individuals associated with the Sentinel Event to determine the facts of the incident. Principal individuals may include the

related physician, personal support aide, case manager, facility staff, family, friends, or other members of the circle of support. TCs are expected to investigate the incident thoroughly to provide complete and informative documentation related to the event.

Step 2 If the TC is unable to make contact with the principals prior to the standards of promptness, this is noted on the report, and the report submitted. An update to the report is then submitted once additional information is obtained.

Witnesses

List individuals who witnessed the event or originally discovered the status of the Participant.

Discovery

Document the action(s) the TC took at the time of discovery.

Action Plan

Step 1 An action plan must be developed to address the root cause of the sentinel event. The action plan is documented on the MFP Sentinel Event Report.

Step 2 If it is determined that an MFP Transition Service could be utilized to help address the root cause, the TC then:

a. Work with the Participant to address the root cause and determine the good/service that can be utilized.
b. Procure the goods/services that could assist the Participant to reduce the likelihood of similar events in the future in a reasonable timeframe.
c. Review the effectiveness of the solution at each subsequent monthly contact until the TC is assured the best solution was identified.

Process Improvement

Document if there are processes that could be improved based on the results of the SER investigation. Recommendations need not be limited to MFP.

MFP Field Staff receive Serious Incident Review Team recommendations from DAS staff. Field Staff respond to SIRT recommendations as though they were a Corrective Action Plan request.

Follow Up

Define Follow-up timeframes if they are necessary prior to the next scheduled monthly contact.

DAS Procedures

The following are the process and procedures by which DAS MFP Program staff will evaluate SERs as delivered in the data system.

SER Review

MFP Program Specialist reviews SER documentation monthly. SER reviews answer the following questions:

Q 1 Is data reportable to Department of Community Health (DCH) accurate?

Q 2 Were standards of promptness observed?

Q 3 Did the Transition Coordinator (TC) adhere to policy and procedure in response to the event?

Q 4 If an action plan was required, was it conducted using a person centered approach using independent living philosophy?

Q 5 Are Journal notes surrounding the event informative and written according to standards and/or training?

If deficits are noted, a Plan For Improvement (PFI) is drafted based on the elements above. A PFI is a statement from DAS informing the AAA that deficits exist. The PFI is an informative tool only. The PFI refers to standards, policy, procedure, or general practice for review at the discretion of the MFP Program Specialist.

If significant deficits are present or multiple PFIs indicate more significant action is necessary, a Corrective Action Plan (CAP) is drafted. A CAP is requested of the staff at the AAA to address the deficits in the program. The CAP is a plan with specific, measurable goals to address the deficit within a reasonable timeframe.

DAS MFP staff submit SIRT recommendations to MFP Field Staff in the format of a CAP request.

MFP Program Specialist will report SER status through the SIRT process.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6144 Protection and Disclosure of Information

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Protection and Disclosure of Information	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6144	**Previous Update:**	

Summary Statement

The Division of Aging Services (DAS) complies with the Health Information Portability and Accountability Act (HIPAA) of 1996, including its rules regarding security and privacy of confidential health

information.

For complete policy refer to MAN 5600 Section 2054.

6146 Money Follows the Person Required Contacts

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Money Follows the Person Required Contacts	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6146	**Previous Update:**	

Summary Statement

Transition Coordinators (TC) document required contacts for MFP Participants using the Harmony for MFP Module.

Basic Considerations

MFP Field staff will make required contacts with MFP Participants to support their transitions. These contacts will be documented according to the following guidelines:

- Harmony Notes (case notes) use the appropriate Note Type and subtype (Harmony for MFP User Guide).
- Documentation will uses the minimum amount of abbreviations to assure full understanding of the note. Common acronyms and medical abbreviations are acceptable abbreviations. Other abbreviations should be used sparingly, if at all.
- Any Harmony Note entered in 'ALL CAPS' will not be recognized as a valid entry by DAS.

AAA Procedures

MFP Field staff make required contacts and utilize the Harmony Notes in accordance with the Policies and Procedures for Money Follows the Person (MFP Manual), published by Department of Community Health and MFP Standards published by DAS on the ODIS website, specifically Pre-Transition Workflow Management (MAN 5200, Section 6140.01).

Face-to-face visits are made by MFP Field staff in the following instances:

- MFP Screening
- ITP
- Day of Transition
- Monthly Contact at month 1
- Monthly Contact at month 9
- Administer QOL

Telephone contacts are made in the following instances:

- 90-Day Pre-Transition contacts (can be made by proxy)
- Post-Transition Monthly Contacts (excluding those listed above)

DAS Procedures

DAS staff review Journal notes as part of the following activities:

- Technical Assistance
- Monitoring activities
- Desk Audits
- Quality Assurance initiatives
- Other business needs

References

1. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I
2. MAN 5200, Section 6140.01, Pre-Transition Workflow Management

6147 Standards of Promptness

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Standards of Promptness	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6147	**Previous Update:**	

Summary Statement

Standards of promptness for delivery of Money Follows the Person (MFP)-related documentation are observed.

Basic Considerations

MFP Field staff observe the standards of promptness for form submission, as determined by the Department of Community Health (DCH); see table under AAA procedures.

AAA Procedures

All documentation for a calendar month is due in Harmony for MFP (database of record) no later than the fifth (5th) calendar day of the following month.

Document and Due Date Table for all MFP documentation is available in the Policies and Procedures for Money Follows the Person, published by the Department of Community Health.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-

money-follows-person-ga-mfp

2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6151 MFP Pre-Transition Workflow Management

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	MFP Pre-Transition Workflow Management	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6151	**Previous Update:**	

Summary Statement

Money Follows the Person (MFP) Transition Coordinators (TCs) will identify MFP Participants for transition in a consistent manner in all areas.

Basic Considerations

To create a consistent experience across Area Agencies on Aging (AAAs), the procedures below are followed to determine a Participant's Readiness to Transition. As MFP and the Aging Network partner with other regional and state-wide agencies in transitioning Participants, it is imperative these transitions occur in a recognizable pattern across all AAAs.

AAA Procedures

MFP Transition Coordinators will approach their pre-transition workflow in the following fashion:

1. Secure waiver services:

   Waiver services are considered secured when a care plan (even if provisional) is shared with the Participant and Transition Coordinator.

2. Identify housing:

   Housing is considered identified under any one of the following circumstances:

   - Family has stated to the TC they will bring the MFP Participant into their home.
   - A Personal Care Home has agreed to accept the Participant.
   - The TC has confirmed the Participant's own home is habitable (according to local code).
   - The Participant has secured rental arrangements in coordination with their TC.

Once the above tasks are completed, the TC is to conduct an ITP to facilitate transition. After the ITP is conducted, Participant moves to 'Ready' status.

TCs will transition Ready Participants in order of the original MFP Screening date.

> **NOTE** *Under the guidelines described above, Transition Coordinators are expected to con-*

tinue to assist those Participants who require assistance or do not independently show readiness to transition in a reasonable timeframe.

Confirming MFP Refusals

Some MFP Participants will refuse MFP services. They will do so at different stages of the process. Follow the procedure below to address their status in the MFP workflow.

Withdrawal

MFP Participant chooses to withdraw from the program prior to ITP.

- Obtain signature on Page 7 of the MFP Screening Form, confirming refusal.
- Send Denial/Termination letter, marked refused.

Refusal Based on Services

Some MFP Participants will wish to follow the MFP process through the transition plan. It is imperative the TC respect this wish.

Refusal Based on Services If/Then

IF	THEN
Participant refuses waiver services, is denied waiver services, or the TC believes the services available cannot support the Participant.	Conduct final ITP and discuss unmet needs, barriers, and risks the Participant will face.
Participant accepts risks as discussed at ITP.	Proceed with execution of ITP.
Participant would be at a significant risk upon Transition.	Submit completed ITP to DAS for further review (described below).
Participant does not accept risks as discussed at ITP.	Complete refusal page of MFP Screening and send Termination Letter & PSC. Mark as Denial, with reason as 'Refused.'

Pre-Transition Status Management

DAS-level ITP Review

The Participant states they wish to transition, regardless of the risks outlined in the ITP.

- TC submits ITP for review at the DAS level.
- DAS staff reviews ITP and conferences with AAA staff.
- DAS staff issue decision as to whether the AAA staff are to transition or send Denial/Termination letter.

Pre-Transition Status Management If/Then

IF	THEN
Contact is made by individual on approved list & documented.	No contact needed for another 90 days.
TC confirms Participant has transitioned without MFP.	A Denial/Termination letter may be sent, removing Participant from workflow.

IF	THEN
TC confirms Participant has moved from their PSA outside of MFP process.	TC communicates with other PSA to make contact with Participant as to next steps.

6152 Administrative Termination

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Administrative Termination	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6152	**Previous Update:**	

Summary Statement

Money Follows the Person (MFP) Transition Coordinators (TCs) may terminate MFP Participants through an administrative process provided by the Division of Aging Services (DAS) in concurrence with DCH program guidelines.

Basic Considerations

- MFP TCs' primary role is to support individuals in transitioning from nursing facilities.
- According to the MFP Informed Consent for Participation, MFP Field personnel may determine appropriateness for program participation.
- Each MFP Participant assumes the responsibility of leading their transition planning and being proactive in the transition planning and execution process. Leading their transition includes such activities as convening their circle of support and providing their own housing search options, among others.
- Should an MFP Participant not engage in their transition planning process, an MFP TC may terminate the Participant.

AAA Procedures

Pre-Transition

MFP Field staff will use motivational interviewing skills to support MFP Participants in taking the lead in planning their transition.

If MFP Field staff determines, after one year from the Participant's Screening date, that the Participant has made no significant progress in the transition planning process, they may be administratively terminated due to non-participation.

Post Transition

Participants may be administratively terminated after transition:

- If the Participant becomes ineligible for the MFP program according to the Policies and Procedure Guide for MFP

- If MFP Field Staff are unable to contact MFP Participant for ninety (90) days

> **NOTE** Staff must attempt to contact Circle of Support members during the ninety (90) day period and document results.

Policy Reminder

Field staff will follow all termination procedures as prescribed in the Policies and Procedures for Money Follows the Person (Manual), as published by DCH as well as DAS standards and Harmony for MFP User Guide procedures.

DAS Procedures

DAS MFP staff will review MFP eligibility, status changes, and terminations through the existing Quality Assurance and Monitoring practices.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I

6161 DCA 811 Procedure

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	DCA 811 Procedure	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6161	**Previous Update:**	

Summary Statement

The Department of Community Affairs (DCA) supports Money Follows the Person (MFP) transition activities by providing Housing and Urban Development (HUD) funded, Project-Based Section 811 housing units targeted to MFP Participants.

MFP Field Staff are to utilize Section 811 Housing to support MFP transition activities in the authorized municipalities to the best of their ability.

Basic Considerations

MFP Field staff will provide assistance to individuals who choose to participate in the 811 application process. Field staff will render such assistance as necessary to support the completion of the relevant applications, procuring necessary vital records, and other documentation required by DCA and/or HUD to support the Section 811 application.

DAS reserves the right to require Field Staff to update their pre-transition workflow processes to support Special Initiatives.

AAA Procedures

AAA Staff will assist in Section 811 Program Development & Steering efforts in the following way:

Step 1 Attend conference calls/webcasts and/or face to face meetings as organized or supported by DAS in the identification, evaluation, and selection of Section 811 properties in their area.

Step 2 Provide feedback as requested or required by associated deadlines to ensure MFP Participants' wants, needs, & preferences are being addressed in selection of Section 811 properties.

Step 3 AAAs will cooperate with DCH, DCA, DAS, CILs, and other stakeholders involved with the development & steering process.

MFP Field staff will facilitate utilization of Section 811 vouchers using the following procedures:

Step 1 Identify Participants who could benefit from and wish to use vouchers.

Step 2 Confirm Participant is willing to live in a municipality and complex in which 811 vouchers are supported.

Step 3 TC identifies Participant as otherwise 'Ready' according to the Pre-Transition Workflow standards.

Step 4 Ensure Participant procures necessary vital records, financial documentation, and other supporting documentation as required by DCA/HUD and/or the chosen Housing Complex.

a. Field staff assists the Participant to develop a circle of support, both formal and informal, to facilitate procurement of the 811/Housing Complex application documentation.

b. In the absence of a circle of support: Field staff provide direct assistance, as necessary, to procure application documentation (including completion of the applications themselves).

Step 5 Ensure Participant has access and ability to complete a housing search in an area supported by the 811 program.

Step 6 Ensure Participant is able to attend required meetings/inspections as required by the 811 process.

Step 7 Documents all necessary information in the Housing Subsidy Assessment in SAMS. The assessment provides mandatory reporting information as outlined in the MFP Policy & Procedure Manual.

Step 8 Ensures the Participant has necessary supports and resources to address any move-in barriers.

DAS Procedures

- DAS MFP staff maintain a Section 811 wait list on behalf of DCA.

- The 811 Wait List is organized in the following fashion:
- TC Determination of Readiness
  - Completion of Pre-Application documentation
  - MFP Screening Date
  - 811 Wait List date (using Housing Subsidy Screen in Harmony for MFP)
  - DAS staff will issue the 811 voucher upon completion of the pre-application process, the determination of the Participant's place on the wait list, and the availability of units.
  - All 811 applications will be reviewed by DCH Housing staff prior to submission to DCA for final approval.
  - Upon final approval by DCA staff, DAS will facilitate the issuance of the voucher.

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I
3. DAS MFP Standards on Special Initiatives
4. DAS MFP Standards on Pre-Transition Workflow

6162 DCA RAD Procedure

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	DCA Rental Assistance Division Procedure	**Reviewed or Updated in:**	MT 2016-02
	Section Number:	6162	**Previous Update:**	

Summary Statement

The Department of Community Affairs (DCA) supports Money Follows the Person (MFP) transition activities by providing Rental Assistance Division (RAD) Housing Choice Vouchers (HCVs) to MFP Participants.

MFP Field Staff utilize RAD-HCVs to support MFP transition activities in the authorized counties to the best of their ability.

Basic Considerations

MFP Field staff provide assistance to individuals who choose to participate in the HCV application process. Field staff render such assistance as necessary to support the completion of the relevant applications, procuring necessary vital records, and other documentation required by DCA to support the HCV application.

DAS reserves the right to require Field Staff to update their pre-transition workflow processes to

support Special Initiatives.

AAA Procedures

MFP Field staff will facilitate utilization of HCV vouchers using the following procedures:

Step 1 Identify Participants who could benefit from and wish to use vouchers.

Step 2 Confirm Participant is willing to live in a county in which HCV vouchers are supported.

Step 3 TC identifies Participant as 'Ready' according to the Pre-Transition Workflow standards.

Step 4 Ensure Participant procures necessary vital records, financial documentation, and other supporting documentation as required by DCA and/or the chosen Housing Complex.

a. Field staff assist the Participant to develop a circle of support, both formal and informal, to facilitate procurement of the HCV/Housing Complex application documentation.

b. In the absence of a circle of support: Field staff provide direct assistance, as necessary, to procure application documentation (including completion of the applications themselves).

Step 5 Ensure Participant has access and ability to complete a housing search in an area supported by the HCV program.

Step 6 Ensure Participant is able to attend required meetings/inspections as required by the HCV process.

Step 7 Documents all necessary information in the Housing Subsidy Assessment in Harmony for MFP. The assessment provides mandatory reporting information as outlined in the MFP Policy & Procedure Manual.

Step 8 Ensure the Participant has necessary supports and resources to address any move-in barriers.

DAS Procedures

DAS MFP staff maintain the HCV wait list on behalf of DCA.

The HCV Wait List is organized in the following fashion:

- TC Determination of Readiness
- Completion of Pre-Application documentation
- MFP Screening Date
- HCV Wait List date (using Housing Subsidy Assessment in Harmony for MFP)
- DAS staff will issue the HCV voucher upon completion of the pre-application process, the determination of the Participant's place on the wait list, and the availability of vouchers

- All 811 applications will be reviewed by DCH Housing staff prior to submission to DCA for final approval
- Upon final approval by DCA staff, DAS facilitates the issuance of the voucher

References

1. Policies and Procedures for Money Follows the Person (MFP Manual), dch.georgia.gov/georgia-money-follows-person-ga-mfp
2. Harmony for MFP User Guide v1.x, Section 1060 (MAN 5600), Appendix I
3. DAS MFP Standards on Special Initiatives
4. DAS MFP Standards on Pre-Transition Workflow

6200 Nursing Home Transitions

6210 NHT Eligibility Criteria

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Nursing Home Transition Eligibility Criteria	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	6210	**Previous Update:**	

Summary Statement

DAS sets eligibility criteria for the Nursing Home Transition (NHT) program. Clients are deemed eligible in an objective manner based on assessment scoring.

Basic Considerations

NHT agencies will support transition of eligible clients based on the following criteria:

- Triage Risk Assessment
- Income criteria
- Minimum 20 day stay in facility (consecutive stays in a facility, including hospital, may be used to accumulate 20-day total)
- Documented transition barriers or risks for readmission
- Citizenship or Legal Status
- DON-R

NHT agencies must be able to document why the individual must rely on NHT Transition Services to transition. Individuals transitioning home prior to a Care Plan being entered into the DAS Data System will not be considered eligible for NHT services. Transition barriers must be identified and documented prior to transition.

Should NHT agencies transition non-eligible clients, and expend NHT funds to support the transi-

tion, those funds may be recouped at audit.

Definitions

Planning List

Group of individuals who have requested assistance in Nursing Home Transition and are eligible but have not yet transitioned back into the community.

Facility

A Nursing Home, sometimes called Skilled Nursing Facility. This term can also be used to refer to the following inpatient facility types from which NHT referrals may be accepted: Intermediate Care Facilities (ICFs or ICF/MRs), Long-Term Acute Care facilities, Complex Rehabilitation facilities, and Veterans Affairs hospitals.

DAS Procedures

DAS NHT Staff may review eligibility criteria for any NHT Client as part of quality assurance activities.

DAS NHT Staff will verify citizenship and residency eligibility after receiving required documentation.

NHT Provider Procedures

Establish Eligibility

NHT agency staff are responsible for establishing or ensuring eligibility for NHT Clients. Use the following criteria for NHT eligibility:

Step 1 **Age**: Individuals who are 55 or older[9]

Step 2 **Income**: Client's gross monthly income must be less than the average cost of care for a nursing home in Georgia[10] to be eligible to utilize NHT Transition Service Funds.

Step 3 **Assets**: Assets are not currently considered in NHT eligibility decisions.

Step 4 **Length of Stay**: Client must have a length of stay of a minimum of twenty (20) consecutive days in a facility. Multiple, unbroken facility stays may be added to achieve the 20 day stay. Example: 10 days in the hospital and 10 days in the nursing facility.

Step 5 **Citizenship & Residency**: Individual must be a citizen or have proof of legal status. Complete Appendix C form

Triage Risk Assessment Tool

Each NHT Client must have an appropriate Triage Risk Assessment score to be considered eligible.

Level 1: Lowest priority. Not NHT Eligible. Appropriate for MDS-Q Options Counseling.

Level 2: Medium priority. Eligible for NHT with a clearly identified transition barrier and minimum DON-R Level of Impairment score of 15.

Level 3: High priority. Eligible for NHT with a clearly identified transition barrier. Should be evaluated for MFP and/or waiver services.

DONR must be completed.

If NHT Agency staff are unsure of a potential client's eligibility, contact DAS staff for approval.

6211 Area to Area Transitions and Transfers

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Area to Area Transitions and Transfers	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6211	**Previous Update:**	

Summary Statement

Nursing Home Transition (NHT) Field Staff will cooperate to assist one another in the transition or transfer of an NHT Client from one Division of Aging Services (DAS) Planning and Service Area (PSA) to another PSA.

Basic Considerations

NHT Field Staff are called upon to assist NHT Clients in a person-centered process. This will require both teams to communicate consistently. Information, including relevant documentation, must be communicated between teams as soon as possible using the DAS Data System.

An official handoff of the case should occur on day of transition or shortly thereafter for Area to Area Transitions. This can be accomplished by a conference call, written communication (such as email) or an Alert Note in the data system. DAS staff may be invited to this call.

Definitions

Sending Agency

The Sending NHT Agency or Sending Team refers to the PSA of the nursing facility in which the client resides.

Receiving Agency

The Receiving NHT Agency, or Receiving Team, refers to the PSA or staff in which the client will reside.

EXCEPTION No exceptions currently.

NHT Providers Procedures

Pre-Transition

a. Screening: MDSQ Options Counselors complete the NHT Screening document

b. NHT Referral Process: MDSQ OC refers to NHT Agency per regional agreements.

c. Referral(s) Process: Outside referrals are made during the Transition planning process. Referrals are documented according to DAS Data System policy/procedure. Sending Team assists client and assures appropriate providers are selected. Make sure the providers operate in the geographic location in which the Client wishes to move.

d. Notification:

    1. The Sending Team assures the Receiving PSA is aware of the impending transition within three (3) business days of NHT Screening
    2. Sending Team ensures DAS Data System is configured to allow Receiving Team access to the relevant client record.

e. Housing Search:

    1. Once internal and external referrals are made, Sending and receiving Teams partner on local housing search (if necessary).
    2. The Receiving Team is responsible for assuring applications are submitted and housing application fees/security deposits are paid.
    3. The Receiving Team assists with establishment of utilities and payment of utility deposits.

f. Care Plan:

    1. Any expenditure of NHT funds requires a Care Plan in the DAS Data System.
    2. Care Plans must be structured to justify the expenditure of NHT funds. Goal statuses must be maintained and accurate at all times.
    3. Refer to the NHT for Harmony Framework User Guide for additional instructions.
    4. For standard area to area transitions (day of transition), the Care Plan and budget should be clearly communicated between agencies, with responsibility for each line item (planned service) clearly delineated in the DAS Data System.

g. Medical:

    1. The Receiving Team assures a local physician, pharmacy, dialysis clinic, etc. are established prior to date of transition. It is imperative that an NHT Client's medical assurances are seamless throughout a transition.
    2. The sending Team assures the nursing facility has ordered proper Durable Medical Equipment (DME), Assistive Technology (AT), etc. and items will be delivered to the agreed-upon address on or before the date of transition.

h. Final Notification:

    1. The sending Team notifies all relevant parties within seven (7) business days of the final transition date.

Day of Transition

a. Transportation: The sending Team coordinates transportation from the nursing facility to the participant's new residence.

b. Documentation: The sending Team obtains DMA-59 from the nursing facility and uploads to the DAS Data System within three (3) business days.

c. Transition Services: The receiving Team assures delivery of NHT Transition Services identified by the Care Plan.

d. Social Security: If the client's income is dependent upon Social Security benefits, the receiving Team assures that the client can notify Social Security (this sometimes requires a face to face appointment at the Social Security office) of their transition.

Post Transition

a. Face to Face Visits: Receiving TC conducts face to face visit within three (3) business days of transition and makes subsequent contacts per policy.

b. Contacts:

    1. The receiving Team completes the post transition contacts per policy and delivers necessary Transition Services through the client's NHT Enrollment period.

    2. At this point, receiving Team takes full responsibility for NHT services and process.

c. Care Plan Execution: The receiving Team assures Needs/Goals documented in Care Plan are resolved in a timely fashion.

Transition Credit

Under the procedures above, the Sending PSA receives 0.25 transition credits and the Receiving PSA receives 0.75 transition credits. Shared transitions are only applicable to clients leaving a facility in one region and moving directly into another region. A client transitioning from a facility into a temporary home in the same region is not considered a shared transition, even if they eventually move to a permanent location in another region.

Post-Transition Transfer to Another Region

If a client moves to another region post-transition, the transition only counts for the original transition agency. This is not a shared transition. The original transition agency will retain budget responsibility for the client's existing Care Plan. The transition agency in the region to which the client is moving will be responsible only for the required follow-ups during the client's 365-day transition period. Any additional services requested under the NHT program must be approved by the original transition agency which maintains budget authority.

It is the responsibility of the original transition agency to communicate and facilitate the transfer of follow-up services to the new region/agency. All transfers should be documented in the DAS Data System using the Provider Enrollment and Alert Note functions.

References

1. MAN 5600 DAS/Appendix H/Data System Manuals/User Guide

6212 NHT Mandatory Documentation

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Nursing Home Transition Mandatory Documentation	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6212	**Previous Update:**	

Summary Statement

Nursing Home Transition (NHT) agencies will provide, at minimum, the mandatory documentation required by the Division of Aging Services.

Basic Considerations

The following documentation standards must be followed for Nursing Home Transitions to ensure accurate record keeping, and allow quality assurance and analysis:

DAS Data System

- NHT Screening
- Determination of Need/Revised (DON-R)
- Triage Risk Assessment (Attached in Notes)
- Monthly Contact Script (when required)
- Care Plan, Planned Services, & Authorizations
- Care Plan Activities
- Quality of Life Assessment
- Notes (when required)

DAS Procedures

DAS NHT Staff reserves the right to review all NHT documentation for monitoring and quality assurance purposes at any time, without prior notification to the NHT agency.

NHT Agency Procedures

NHT agency staff are to complete documentation at the appropriate benchmark in the transition process. Benchmarks and associated documentation are listed below:

Client Intake / Eligibility Determination

- NHT Screening
- DON-R
- Triage Risk Assessment
- Release of Information (Form 5459, Appendix D, Manual 5600)
- Legal Status Affidavit (Appendix D, Manual 5600)

Transition Planning

- Pre-Transition Contacts
- Care Plan
- Planned Services
- Authorizations
- Activities
- Quality of Life Assessment (Baseline)

Post-Transition

- Additional Planned Services, Authorizations, and/or Activities
- Monthly Contact Scripts
- Quality of Life Assessment (1-Year)

DAS may require additional documentation/information on a case-by-case basis.

6213 Harmony for NHT

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Harmony for NHT	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6213	**Previous Update:**	

Summary Statement

The Harmony Framework Database, developed by Harmony Information Systems (Harmony) and administered by Division of Aging Services (DAS), is the database of record for all Nursing Home Transition (NHT) activities. NHT Agencies, their staff, and contractors utilize the Harmony system following DAS policy, procedure, and guidance.

Basic Considerations

Utilization of Harmony for documentation of NHT is required. Data entered into Harmony is the only source from which mandatory program reports are generated.

DAS staff will use the Harmony database to assess situations and deliver and document technical assistance. If information is not available in the database for DAS staff to decide, a decision will not be communicated until all necessary information is available in the system.

NHT Agency Procedures

NHT Agency staff will utilize the Harmony for MFP/NHT User Guide, published by DAS, as the official reference to document NHT activities within the database.

The User Guide is updated on a regular basis, no less than annually, and distributed to all staff who

use the system.

DAS reserves the right to send guidance via other means to clarify the User Guide prior to an official update. This may be done through formal letters, email communication, or other written formats including the AtS Midweek Update sent to all Transition Coordination staff and AAA Directors.

References

MAN 5600/Appendix H DAS Data System Manuals/MFP User Guide

6214 NHT Required Contacts

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Nursing Home Transition Required Contacts	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6214	**Previous Update:**	

Summary Statement

Nursing Home Transition agencies document required contacts for Nursing Home Transition using the DAS Data System.

Basic Considerations

NHT agency staff make required contacts with NHT clients to support their transitions. These contacts will be documented according to the following guidelines:

- Harmony Notes (case notes) use the appropriate Note Type and sub-type (Harmony for MFP/NHT User Guide).
- Documentation uses the minimum amount of abbreviations to assure full understanding of the note. Common acronyms and medical abbreviations are acceptable abbreviations. Other abbreviations should be used sparingly, if at all.
- Monthly Contacts must be documented using the Monthly Contact Script in the DAS Data System.

DAS Procedures

DAS staff review Notes as part of the following activities:

- Case staffing
- Technical Assistance
- Monitoring activities
- Desk Audits
- Quality Assurance initiatives
- Other business needs

NHT Agency Procedures

NHT agency staff make required contacts and utilize the Harmony Notes in accordance with the following requirements:

Face to Face (FtF) Visits:

- Initial FtF is made by MDSQ Options Counselor
- 1st Home Visit, within three (3) business days of transition
- 2nd Home Visit, between thirty (30) and sixty (60) calendar days from date of transition

Remote Contacts (Phone, Video Chat, e-mail, etc):

Additional remote contacts must be made directly with the client. Remote contacts must be made monthly after the 2nd home visit through the 6th month following the transition date.

Mandated TC-initiated calls may be discontinued after the 6th month post-transition call.

TC Agencies must have a written remote contact policy identifying how many remote contacts are attempted before a home visit is required. Attempted remote contacts may include a welfare check from the client's local law enforcement agency and/or an attempt to contact letter to the client's address. If remote contact cannot be made, an unscheduled home visit must be attempted within the same calendar month.

If a client is unable to be contacted either remotely or by unscheduled home visit for two (2) consecutive months, the client should be terminated from the NHT program. See NHT Termination Policy, Chapter 6221.

TCs must remain available and responsive to client-initiated contacts for the duration of the client's 365-day participation period or until the client is terminated from the program.

6216 Documenting a NHT Sentinel Event Report

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Documenting a NHT Sentinel Event Report	**Reviewed or Updated in:**	MT 2017-01
	Section Number:	6216	**Previous Update:**	

Summary Statement

Nursing Home Transition Agencies use the Sentinel Event Report (SER) to communicate critical incidents to Division of Aging Services.

Basic Considerations

Definitions

A sentinel event is defined as one of the following:

Abuse

As defined by OCGA 30-5-3 (1); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Neglect

As defined by OCGA 30-5-3 (9); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Exploitation

As defined by OCGA 30-5-3 (8); refer to Adult Protective Services Manual, Chapter 1, Section 2001.5.

Hospital / Nursing Facility / ICF Admit

Client is admitted to a hospital, nursing (or skilled nursing) facility, long-term acute care, in-patient hospice, or similar facility for more than twenty-four (24) hours. Scheduled medical procedures/surgeries can be omitted from this report.

Repeated Use of Emergency Room

The NHT Client repeatedly visits an emergency room seeking treatment, prescriptions, or other medical care. Repeatedly is defined as more than once in a 30-day period.

Other

The TC believes a critical incident has occurred but cannot explain it with one of the categories above.

Standards of Promptness

All Sentinel Event Reports are entered into the DAS Data System within three (3) business days of the time the sentinel event becomes known to the TC. The date of the incident and the date of the report are to be listed separately on the report.

Reporting Standards

All Sentinel Event Reports will be logged into the DAS Data System. Paper copies are not accepted as reports.

The original SER should be updated as often as necessary to capture updates to the initial event described. Additional SERs are not required unless information becomes available that would trigger a second SER category.

DAS Procedures

The following are the process and procedures by which DAS NHT Program staff will evaluate SERs.

NHT Program Staff review SER documentation monthly. SER reviews answer the following questions:

1. Is information accurate?
2. Were standards of promptness observed?

3. Did the Transition Coordinator (TC) adhere to policy and procedure in response to the event?
4. If an action plan was required, was it conducted using a person centered approach using independent living philosophy?
5. Is documentation surrounding the event informative and written according to standards and/or training?

If, during review, deficits are noted, a Plan For Improvement (PFI) will be drafted based on the elements above. A plan for improvement is a statement from Division of Aging Services informing the NHT agency that deficits exist. The PFI is an informative tool only. The PFI would refer to standards, policy, procedure, or general practice that should be reviewed to assure the deficit noted is corrected in future work. It may ask for document correction and resubmission.

If significant deficits are present or multiple PFIs indicate more significant action is necessary, a Corrective Action Plan (CAP) may be drafted. A CAP requests the staff at the NHT agency to address the deficits in the program. A CAP has specific, measurable goals to address the deficit within a reasonable timeframe.

NHT Agency Procedures

The procedures below are formatted to follow the flow of the SER report document. The standards are the guide by which the document is completed.

Process By Category

Abuse / Neglect / Exploitation (ANE)

As mandated reporters, NHT agency staff are required to report any instances of abuse, neglect, or exploitation to Adult Protective Services and law enforcement in addition to the programmatic reporting done through the SER. If an NHT client is a victim, or the TC suspects they are a victim, of abuse, neglect, or exploitation a SER should be completed.

Hospital / Nursing Facility / ICF Admission

If the NHT TC discovers the client has been admitted to a facility, for any of the reasons above (ANE), an SER is to be completed.

Repeated Emergency Room Visits

Repeated use of the ER, or using the ER as a primary physician is a key precursor of nursing home placement. NHT TCs should be diligent in assisting clients in obtaining a regular primary care physician. The NHT TC does not assume transportation responsibility to physician visits.

Death

If the NHT client dies during their 365-day participation, an SER must be completed.

A preliminary SER should be entered into the DAS Data System upon TCs knowledge of the event. Additional details may be added as the TC discovers them.

Summary / Participant Reporting / Adverse Outcomes

The NHT TC makes contact with the principal individuals associated with the Sentinel Event to determine the facts of the incident. The MFP Participant is always contacted regarding an SER. Other principal individuals may include the related physician, personal support aide, case manager, facility staff, family, friends, or other members of the circle of support. TCs are expected to investigate the incident thoroughly to provide complete and informative documentation related to the event.

If the TC is unable to make contact with the principals prior to the standards of promptness, this should be noted on the report, and the report submitted. An update to the report should then be submitted once additional information is obtained.

Witnesses / Alleged Participants

List individuals who witnessed the event or originally discovered the status of the client.

Discovery

Document the action(s) the TC took at the time of Discovery.

Action Plan

An action plan must be developed to address the root cause of the sentinel event. If it is determined that an NHT Transition Service could be utilized to help address the root cause, the TC will then:

a. Work with the client to address the root cause and determine the good/service that can be utilized.
b. Procure the good/service that could assist the client to reduce the likelihood of similar events in the future in a reasonable timeframe.
c. Review the effectiveness of the solution at each subsequent monthly contact until the TC is assured the best solution was identified.

Process Improvement

Document if there are processes that could be improved based on the results of the SER investigation. Recommendations need not be limited to NHT.

Follow Up

Define Follow-up timeframes if they are necessary prior to the next scheduled contact.

6217 NHT Taxonomy of Services

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Nursing Home Transitions Taxonomy of Services	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	6217	**Previous Update:**	

Summary Statement

Nursing Home Transition (NHT) Services are delivered using a taxonomy of services that governs the types of goods and services that are allowable. Expenditures outside of the taxonomy may not utilize Nursing Home Transition Services without express approval from the Division of Aging Services (DAS).

Basic Considerations

Nursing Home Transition Clients may need goods and/or services (hereafter Transition Services, or Services) to support their transition from a facility into a community setting and to reduce the risk of readmission. These Services are delivered in a person-centered manner, using a person-centered plan.

NHT Transition Services should be provided as a payor of last resort. Client funds/assets, insurance policies, community services, and/or Home and Community-based Services/Long Term Services and Supports (HCBS/LTSS), and Medicare/Medicaid should be explored as an option prior to use of NHT funds.

Only Transition Services that are essential to remove the barriers associated with transition, to support the immediate health and welfare needs of the client upon discharge, or to mitigate readmission risks should be provided.

Careful planning must be done to ensure the planned Services will achieve the desired effect.

A client must be deemed eligible for NHT prior to receiving Services. Services may be delivered while the client is still in the facility, but a reasonable and actionable Transition date must be set prior to receipt of Services.

Any single item whose cost exceeds $1000.00 must be accompanied by two competing quotes.

NHT Services must use standard materials or readily available goods. Custom work and/or materials must be approved by DAS prior to procurement.

DAS Procedures

DAS NHT Staff maintain the Taxonomy of Services and reserve the right to amend the Taxonomy at any time. Formal notification of Taxonomy changes are submitted through standard DAS protocol for policy changes.

DAS may assign approved or “preferred” vendors for certain services.

Taxonomy of Services

Housing Loss Prevention

Loss of housing during an inpatient facility stay is a primary reason for institutionalization. This service may be used to pay basic rent and utilities for a client’s residence for a 30-day period. This Service can only make payments for dates in which the client resides at an inpatient facility.

Required Documentation:

- Lease: Must be in the name of the client
- Utility bills: Must be in the name of the client and must be for dates in which the client resided in a facility

Utility Deposits

Should the NHT client require a different housing arrangement than prior to their stay at an inpatient facility, NHT Services may be used to pay setup fees and/or deposits for new utility services.

Required Documentation:

- Receipt of payment of deposit/setup fee(s)

Security Deposits

Should the NHT client require a different housing arrangement than prior to their stay at an inpatient facility, NHT Services may be used to pay security deposits, application fees, background check fees, and first month's rent, plus any pro-rated rent for a partial month, for a new rental residence.

Required Documentation:

- Lease, must be in the name of the client
- Receipts for application fees, background check fees, and/or first month's rent amount
- Client must be able to sustain monthly rent payments from their own resources/income

Medical Equipment and Assistive Technology (AT)

Many clients who transition from nursing facilities require functional supports to remain independent. NHT Services may be used to purchase medical equipment and/or assistive technology to support the individual's independence. Should the client require assessment for specialized equipment or AT, NHT Services may assist with associated fees.

Medical Supplies/Disposables

Should the client require a start-up supply of disposable supplies, such as incontinence supplies, sterile gloves, diabetic supplies, etc. NHT Services may purchase up to a 30 day supply of each item needed. NHT Services should not be used to support the purchase of any ongoing service.

Environmental Modifications

Many NHT clients transition from an inpatient facility with changed functional needs. As such, NHT Services may assist the client with modifications to their home environment to make it more accessible to them or to increase their independence. Should the client require Environmental Modifications, the home must be inspected or assessed prior to modification. The inspection or assessment must produce a scope of work from which a quote or bid may be obtained.

EMD Inspection: Must be completed by a licensed contractor, certified home inspector, or Certified Aging in Place Specialist. Entity completing the inspection may not place a bid on the same job for which they are the inspector.

An inspection and scope must be obtained prior to use of this service. This service may not be used to modify Personal Care Homes.

Moving Expenses

NHT Services may be used to transport clients' belongings from the inpatient facility or a storage location to their community setting. Moving Expenses may also be used to cover shipping/delivery costs associated with procurement of NHT Services.

Vehicle Adaptations

Vehicle adaptations should only be funded for NHT clients when the adaptations are essential for regular transportation needs to support the participant's independence. Vehicle adaptations must be identified as a transition barrier (because the client will not be able to access ongoing health-care, etc.) and added to the Care Plan prior to discharge. Vehicle adaptations may not be added to the Care Plan post-discharge.

Personal Support Services (PSS)

Personal Support Services for NHT clients may only be used during the initial transition from the facility back and is limited to 21 dates of service in the initial 30 days post-transition. This service should be used to support safe transition back into a community setting.

Personal Support Services provides assistance such as light housekeeping, running essential errands, and basic personal care needs (feeding, dressing, bathing, toileting, and transferring).

Peer Support

Many national associations, nonprofits, and governmental entities provide peer support and/or peer counseling for individuals with disabilities. NHT clients can receive visits and/or counseling from these providers and NHT Services can cover the associated fees. It is preferred that Peer Support is delivered face to face but may be delivered remotely.

Life Skills Coaching

NHT clients may request or require training or coaching to recover, re-learn, or reinforce skills needed to maintain their independence. Life Skills Coaching may be used to provide training that would support the individual as they reorient themselves to community living. This service may include, but is not limited to:

- Household finances management
- Disease management
- Communication skills
- AT/Equipment training

Caregiver Supports

Caregivers for NHT clients may experience life changes and stresses that can jeopardize the success of a transition. NHT clients who are dependent upon a live-in, unpaid, caregiver are eligible for this service. Caregiver support services can include services similar to Life Skills Coaching and Peer

Support (but directed at the caregiver) or more traditional Caregiver Supports, such as those delivered by Area Agencies on Aging.

Household Setup

Clients returning to the community may require new or updated household items such as kitchen supplies and equipment, furniture, bathroom supplies/toiletries, etc. NHT Services may be used to assist with setup of a new residence, or re-establishment of an existing residence.

This service should be limited to items that are required to facilitate independence and the ability to execute basic living standards. Items that are purely decorative or non-functional in nature are not to be purchased. Items that are for entertainment should not be purchased; traditional "entertainment" items (such as televisions, DVD players, etc.) being purchased to function as Assistive Technology should be coded to the Assistive Technology category and should function as assistive technology by allowing direct, two-way communication with other individuals or organizations. Radios may be purchased under the Household Setup category for listening to the news and/or receiving weather alerts.

Food/Meals: The Household Setup category may be used for an initial setup supply of food. This may include standard groceries or home delivered meals services. This subservice may not exceed $250 in cost.

Transportation

This service may be used to transport NHT clients in the following ways:

- From inpatient facility to the community setting
- To meetings which require face to face interaction, such as Social Security, some Utility Services, etc.
- First primary care physician's appointment
- Housing Searches

Department of Human Services transportation vendors are a preferred vendor for this service.

6218 New Vendors Management

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	New Vendors Management	**Reviewed or Updated in:**	MT 2017-01
	Section Number:	6218	**Previous Update:**	

Summary Statement

Division of Aging Services (DAS) Nursing Home Transition (NHT) staff vet all NHT Transition Service Vendors that are to be reimbursed using state NHT funds.

Basic Considerations

NHT agency staff develop and maintain professional, legal, and ethical relationships with NHT Vendors.

NHT agency staff ensure NHT Transition Services are delivered within the Nursing Home Transition Taxonomy of Services.

Definitions

NHT Transition Service Vendor

The entity, identified on the NHT Transition Expenditures report, that is reimbursed by the Fiscal Intermediary for NHT Transition Services rendered. The NHT Transition Service Vendor may not necessarily be the entity that engaged in the direct service.

DAS Procedures

- DAS NHT staff receive communications from the field.
- Enters Vendor into DAS Data System within ten (10) calendar days of receipt of complete information.

NHT Agency Procedures

NHT agency staff provide the following minimum documentation to enroll an NHT Transition Services Vendor:

- W-9
- Copy of current Business License
- Contact information for billing office
- Services to be enrolled

NHT agency staff will provide the following, should they be required by state law, licensure, local ordinance, or other regulatory authority:

- Copy of current professional Licensure
- Copy of Bond documentation
- Copy of current Insurance documentation (if required to deliver service)

Vendor documentation is provided through normal communication channels such as email, fax, or mail.

If an NHT Transition Service is delivered by NHT agency staff and reimbursed with NHT state funds, the following criteria must be observed:

- Service is authorized by DAS
- Service is documented in Care Plan
- Service is requested by NHT Client and is integral to transition
- NHT agency staff delivering the service is not managed by agency program manager of NHT

- Service delivery must follow NHT Taxonomy of Services

6219 NHT Expenditure Tracking Process

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Nursing Home Transition Expenditure Tracking Process	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6219	**Previous Update:**	

Summary Statement

Nursing Home Transition agencies will track expenditures for NHT Services through the DAS Data System.

Basic Considerations

Nursing Home Transition Services are delivered according to the NHT Taxonomy of Services.

Required documentation must be acquired and provided to DAS through the DAS Data System within three (3) business days of activity date.

Refer to the Harmony for MFP and NHT User Guide for information and procedure specific to the use of the DAS Data System.

The NHT Services Taxonomy does not contain individual service cost caps. This is done to provide services in a person-centered fashion.

NHT agencies control costs using a per-client cost average of $5100.00.

A client is defined as an eligible NHT Client who transitions with the program.

Example 1

Client	Total NHT Service Expenditures
Client 1	$9,500
Client 2	$1,000
Client 3	$2,500
Average for all Clients	$4,333

The above example is an allowable NHT Services mix.

Example 2

Client	Total NHT Service Expenditures
Client 1	$11,500
Client 2	$500
Client 3	$5,500
Average for all Clients	$5,833

The example above is not an allowable NHT Services mix.

Example 3

Client	Total NHT Service Expenditures
Client 1	$5,000
Client 2	$1,100
Client 3 (Who does *not transition*)	$2,000
Average for all NHT Services divided by *Transitioned Clients*	$4050

The example above is an allowable NHT Services mix.

Example 4

Client	Total NHT Service Expenditures
Client 1	$9,000
Client 2	$1,100
Client 3 (Who does *not transition*)	$2,000
Average for all NHT Services divided by *Transitioned Clients*	$6050

The example above is not an allowable NHT Services mix.

NHT Allocations

NHT funds are allocated to Area Agencies on Aging and Centers for Independent Living based on transition targets and workload. AAAs will pay service vendors upon completion of service provision.

NHT agencies follow the process below to log and document expenditures related to NHT Services:

1. Document NHT Service needs in the Framework Care Plan and/or Case Notes as instructed in the Harmony User Guide.
2. Acquire invoices, receipts, etc and upload to DAS Data System
3. Add Activities in the DAS Data System using the NHT Taxonomy of Services to track expenditures. Activity Date should match Receipt Date. All Activities should be entered in to the DAS Data System within three (3) business days from the Activity Date.

DAS NHT staff will review completed Activities and associated documentation as part of the quality assurance and monitoring process.

References

MAN 5600, Appendix H (User Guide)

6220 TC Qualifications and Training

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	TC Qualifications and Training	**Reviewed or Updated in:**	MT 2017-01
	Section Number:	6220	**Previous Update:**	

Summary Statement

Transition Coordinators (TCs) for Division of Aging Services (DAS) Nursing Home Transition (NHT) must have the training and experience necessary to effectively discharge transition coordination activities.

Basic Considerations

NHT Transition Coordination includes activities related to Information and Referral, Case Management, Project Management/Coordination, and Options Counseling, among others. As such, Transition Coordinators come from varied backgrounds with different skillsets.

Definitions

Transition Coordinator

The role of Transition Coordinator has a minimum of one year's experience with the NHT, MFP, or other Nursing Home Transition program, either as a TC, Options Counselor, or in a transition position with a Center for Independent Living. Certified Care Transitions Specialists may also meet the requirements of a TC.

Associate Transition Coordinator or TC Support (ATC)

An ATC position works to support TCs through activities such as administrative support (follow up calls, data entry, etc.), TC activities as overseen by the TC, or other support activities that contribute to transitions.

NHT Agency Procedures

Item 1

NHT Agencies follow DAS standards for Transition Coordination unless expressly approved by DAS NHT staff through the existing waiver process on ODIS.

Item 2

NHT Agencies will have a minimum of one TC who meets the qualifications above available to provide transition services.

Item 3

The TC position may be a Full Time Equivalent, Contractor, or part time worker.

Item 4

NHT Agencies notify DAS NHT program staff regarding TC staffing changes as follows:

- Within two (2) business days of the change

- In writing (email is acceptable)
- Plan for NHT activities to continue in absence of TC
- Approximate time TC position will be open

DAS Procedures

DAS maintains and updates the standards for Transition Coordination and may update qualifications and standards at any time following the appropriate process.

Training Requirements

Transition Coordinators will attend all training required by the Division of Aging Services.

Required Training for Transition Coordinators within one (1) year of taking position:

- Adult Crime Tactics training (provided by the Forensic Special Investigation Unit, administered by DAS).
- HIPAA

Suggested Competencies:

- Medicaid Waivers
- Non-Medicaid Home & Community-Based Services
- Information & Referral
- Nursing Home operations

TC Qualifications

Education: Bachelor's Degree, Associate's Degree, or a Registered Nurse

Experience: A minimum of one year in a Human Services position required. DAS prefers a candidate with experience in Nursing Home Transition, Care Transitions, Information & Referral/Assistance, Options Counseling, or related fields.

Preferred Skillsets:

- Comfortable with technology such as mobile platforms and data systems.
- Knowledgeable of Nursing Home operations.
- Experience with managing caseloads and/or projects of a similar size and scope.
- Knowledgeable of Community Medicaid resources (Waivers).
- Understanding of Person-Centered philosophy.
- Understanding of Person Directed planning and/or case management.

Associate TC Qualifications

Education: Completed High School or GED

Experience: None necessary. Field agencies may wish to hire ATCs based on a skill set for a specific support role, such as vendor management, database administration, information & assistance, etc.

Preferred Skillsets: Same as for TC

6221 Terminations

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Terminations	**Reviewed or Updated in:**	MT 2018-02
	Section Number:	6221	**Previous Update:**	

Summary Statement

From time to time, it will be necessary to terminate NHT participants prior to the completion of their 365-day participation period. Terminations prior to completion should be done in alignment with DAS policy.

Basic Considerations

The provider agency will discontinue services in the following cases:

a. Upon the death of the client. It is not necessary to send a Client Notification Form in this instance.

b. When the agency has been unable to contact the client for 60 consecutive days. Documentation of attempted contacts in the Client Record, including an attempted unscheduled home visit, must be made prior to discharging a client for this reason. The final attempt must be in writing to the last known address.

c. When the client, client's family, or home environment threatens the in-home service worker or other agency staff to the extent that the staff's welfare and safety are at risk and good faith attempts at corrective action have failed.

d. Upon the request of the client or caregiver, if acting as the authorized representative, power of attorney or guardian of the client.

e. Client moves out of state. Clients moving within the state should be transferred to the appropriate Transition Coordination agency in the new region. See 6211 Area to Area Transitions and Transfers.

NHT Agency Procedures

Clients who are being terminated must be given a 30-day notice prior to termination.

After the 30th day client may be terminated by sending or providing a copy of Manual 5500, Appendix D, Client Notification Form, including Client's Rights and Responsibilities, including and the right to appeal the termination.

Once a client has been terminated, the client's file in the DDS should be closed out, along with the

reason for termination/discharge.

6400 Forms for Community and Nursing Home Transitions

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Forms for Community and Nursing Home Transitions	**Reviewed or Updated in:**	
	Section Number:	6400	**Previous Update:**	

6401 Legal Status Affidavit Form

6402 Triage Risk Assessment Form

6403 2013 Secure and Verifiable Document Listing

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	6000 Community Transitions	**Effective Date:**	
	Section Title:	Secure and Verifiable Documents Under O.C.G.A. § 50-36-2	**Reviewed or Updated in:**	
	Section Number:	6403	**Previous Update:**	

Issued July 10, 2013 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA"), as amended by Senate Bill 160, signed into law as Act No. 27, (2013), provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(g). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- An unexpired United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired passport issued by a foreign government, provided that such passport is accompanied by a United States Department of Homeland Security ("DHS") Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual's lawful immigration status or other proof of lawful presence under federal immigration law[11] [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An unexpired Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- An unexpired NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- An unexpired Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- An unexpired driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Certification of Report of Birth issued by the United States Department of State (Form DS-1350) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Certification of Birth Abroad issued by the United States Department of State (Form FS-545) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- Consular Report of Birth Abroad issued by the United States Department of State (Form FS-240) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- An original or certified copy of a birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit.

6404 MFP File Review Checklist

6405 Referral Form

6406 Services Table

6407 Vendor Payment Request

6408 Informed Consent

6409 Release of Health Information

6410 Transition Screening Form

6411 Individualized Transition Plan

6412 Discharge Day Checklist

6413 Quote Form for CT Services

6414 Authorization for Transition Services

6415 Complaint Form

6416 Right to Appeal CT Services Decision Letter

6417 CT Letter of Denial, Suspension or Termination

7000 Dementia Programs

7000 Dementia Programs Overview

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Dementia Programs Overview	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7000	**Previous Update:**	N/A

Summary Statement

The Division of Aging Services' dementia programs and initiatives include the Georgia Memory Net, the Georgia Alzheimer's and Related Dementias State Plan, Dementia Friends, and the Dementia Care Specialist Program. The goal of these programs and initiatives is to make Georgia more dementia capable.

Basic Considerations

There are thousands of Georgians living with dementia. There are thousands more caregivers of persons living with dementia in the state. As research continues, more is learned about the impact of dementia on families and communities. The legislature and other stakeholders recognize the need for interventions to help meet the needs of persons living with dementia and their families.

To address the challenges mentioned above, Georgia continues to innovate to make our state more dementia capable. We are strategically focusing on:

- increasing awareness of modifiable risk factors and the importance of early detection and diagnosis,
- targeting disproportionately impacted communities,
- collaborating within communities to ensure strong continuums of care, and
- creating the infrastructure to meet the needs of families impacted by dementia.

With the strong support of the legislature, Georgia has laid a solid foundation for dementia care and support. In 2014, Governor Deal signed the Georgia Alzheimer's and Related Dementias (GARD) state plan. State funding began in state fiscal year 2018 for the Georgia Alzheimer's Project (GAP), now known as the Georgia Memory Net (GMN).

In the 2022 legislative session, the General Assembly made a $1.25 million investment to create the Dementia Care Specialist Program to meet the unique needs of people living with dementia.

The efforts listed above are enabling Georgia to:

- build an effective infrastructure to support caregivers,
- promote the adoption of person and family centered care with the person living with dementia and their caregivers at the center of care teams, and
- offer information, education, and care coordination to those impacted by dementia.

References

OCGA 49-6-90, 91, 92 Mobilization for State Response to Alzheimer's and Dementia Patients

7002 Georgia Alzheimer's & Related Dementias (GARD) State Plan

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	07/23/2018
	Section Title:	7002 Georgia Alzheimer's & Related Dementias (GARD) State Plan	**Reviewed or Updated in:**	MT 2019-01
	Section Number:	7002	**Previous Update:**	N/A

Summary Statement

The Division of Aging Services shall maintain the Georgia Alzheimer's & Related Dementias (GARD) State Plan.

Basic Considerations

The Georgia Alzheimer's & Related Dementias (GARD) State Plan was signed by Governor Deal in 2014. The state plan creates a unique blueprint that addresses the growing challenges of dementia in Georgia. During the development of the GARD State Plan, work groups formed to collaborate on addressing the goals within the State Plan.

In 2018, Governor Deal signed legislation to establish an Advisory Council for GARD, which also includes a mandate for the GARD State Plan Coordinator position within the Department of Human Services Division of Aging Services.

The GARD State Plan serves multiple functions, including:

- Analyzing state demographics, prevalent statistics and existing resources to gauge the state's capacity to meet growing needs
- Present a roadmap for creating a more dementia-capable Georgia.

The legislation also provided for a GARD State Plan Coordinator to support the council by:

- Assisting the council with council related activities
- Coordinating the advisory council meetings
- Coordinating and serving as a liaison between the work groups and the advisory council

- Ensure the progress report is published as required by law
- Other associated duties assigned by the Department.

Advisory Council

The GARD Advisory Council serves in an advisory capacity to the Governor, General Assembly and state agencies on matters relating to the GARD State Plan.

Composition

Council members shall consist of the following:

The following individuals or their designees

- Commissioner of the Department of Human Services
- The Director of the Division of Aging Services
- The President of the Georgia Association of Area Agencies on Aging
- Commissioner of the Department of Community Health
- Commissioner of the Department of Public Health
- Commissioner of the Department of Behavioral Health and Developmental Disabilities
- Chairperson of the Senate Health and Human Services Committee
- Chairperson of the House Committee on Health and Human Services
- Chairperson of the House Committee on Human Relations and Aging

Additional members include:

- A representative of the Georgia Chapter of the Alzheimer's Association
- A representative of the Georgia Council on Aging

The Governor shall appoint one member from each of these six specific fields:

- A provider of residential, healthcare or personal care services to those living with dementia
- A social gerontologist or clinical researcher in an education or clinical setting with expertise in dementia
- An advocate with a not-for-profit or state agency whose role is to improve services for older adults or those living with dementia
- A medical professional with an active practice specializing in geriatrics, neurology, or other field closely related to dementia
- A caregiver, current or past, for a family member with dementia who as experience navigating healthcare service options
- A person who has been diagnosed with dementia

The council shall annually elect a chairperson and vice chairperson from among its membership

Duties

The Advisory Council shall review and make recommendations regarding the state plan including:

- Selecting current priorities for state plan work groups
- Examining current laws, rules and regulations, and policies of state agencies that interact with services for individuals with dementia and make recommendations to improve the navigation of and provision of care services for those with dementia and their caregivers
- Proposing legislative or administrative changes to policies and programs needed for furtherance of the state plan
- Examining state and federal funding into the areas of the state plan and reviewing how to work inter-disciplinarily to ensure the most efficient and effective use of available resources
- Locating and assisting departments or partner agencies in applying for new funding sources and new opportunities in furtherance of the goals for the state plan
- Amending the state plan at least every three years and submitting the amended state plan to the governor for authorization.

The Advisory Council shall create and vote on bylaws and policies as needed.

Council members shall serve in one or more of the GARD State Plan workgroups as described in the goals of the state plan.

Meetings

The Advisory Council shall meet as follows:

- At least quarterly
- At such additional times as it deems necessary to perform its duties.
- On call of the Chairperson, vice-chair person, DHS Commissioner, or the Governor

All meetings shall contain updates from each work group and presentations on any developed proposals for furtherance of state plan goals.

At or before the summer quarterly meeting, the advisory council shall take a formal vote on any proposals or recommendations under consideration.

Reports

Beginning January 1, 2019 and every three years thereafter the Advisory Council shall submit to the Governor for approval and make available to the General Assembly a report on the work of the council to include:

- A progress report toward implementation of the state plan
- Recommendations for amendments to the state plan

Amendments to the State Plan may be submitted for approval to the Governor at the same time as the progress report.

References

www.legis.ga.gov/Legislation/en-US/display/20172018/SB/444

O.C.G.A. §49-6-90 et seq

7100 Dementia Care Specialist Program Overview

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Dementia Care Specialist Program Overview	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7100	**Previous Update:**	N/A

Summary Statement

The mission of the Dementia Care Specialist (DCS) Program is to support people living with dementia and their care partners so they can enjoy the highest quality of life. The DCS will accomplish this by creating community partnerships through outreach, education, and building awareness for families and care partners.

Basic Considerations

In collaboration with other programs and initiatives, the DCS Program is a critical component of Georgia's efforts to become a dementia capable state. The DCS Program was developed to drive the state to become a leader supporting in its aging population, specifically individuals with brain change and their care partners. The program is led by the Dementia Care Specialist Team Lead at the Division of Aging Services (DAS) and a DCS at each of the twelve Area Agencies on Aging (AAA). The DCS Lead will support the DCS through programming, skill building, data, and resource development.

7101 Dementia Care Specialist Basic Requirements

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Dementia Care Specialist Basic Requirements	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7101	**Previous Update:**	N/A

Summary Statement

The purpose of the Dementia Care Specialist (DCS) Program is to increase dementia awareness, expand community education and partnerships, and strengthen available resources and programming for care partners and People Living with Dementia (PLWD). The DCS will accomplish these goals through brain health education, providing early detection through memory screenings, building dementia capable communities, and supporting individuals with dementia and mild cognitive

brain impairment so they can maintain a quality of life.

Objective

The objective of the DCS is to educate Area Agency on Aging (AAA) staff, provider staff, local businesses, families, health care professionals, and communities so they are dementia aware and can build more dementia capable communities. By building a strong communal network, care partners will have the resources, skills, and support to keep the individual living with dementia residing in their current environment for as long as possible.

Dementia Care Specialist Qualifications

Each AAA must employ one (1) full time equivalent (FTE) Dementia Care Specialist. The responsibilities of the DCS in the AAA include, but may not be limited to, the following:

- Train AAA staff and the aging network, local businesses, health care systems, and the community to recognize individuals with dementia and build a skill set to support people living with dementia.
- Provide education, resources, and support to care partners so they have the tools necessary to help themselves become better care partners and to take care of the person living with dementia. Through this support, the goal is that the person living with dementia can remain in their environment for as long as possible and continue to have an active, safe, and meaningful life.

Education requirements for the position of DCS:

- Bachelor's degree preferably in health or human services, social work, gerontology, sociology, psychology, or related field, OR
- Registered, professional nurse currently licensed to practice in the state of Georgia AND two years' experience in the human services or health related fields, OR
- Associate 's degree in human services or health related field AND a minimum of two years' experience in working directly with aging or disability populations.
- At least one year of full-time paid experience or internship working directly with multiple people with dementia **and** family or informal care partners (for example, providing direct care, case management, support group facilitation, residential care management, home care)

7102 Dementia Care Specialist Program Three Domains of Concentration

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Dementia Care Specialist Program Three Domains of Concentration	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7102	**Previous Update:**	N/A

Summary Statement

Three Domains of Concentration

The Dementia Care Specialist (DCS) will use an integrative approach with the help of Area Agency on Aging (AAA) staff, community professionals, care partners and people living with dementia (PLWD) to create an inclusive environment. To increase dementia awareness, build a dementia capable community, support care partners and PLWD, the DCS will focus on three domains: education and awareness, community outreach and partnerships, and supporting care partners and PLWD.

1. **Education and Awareness**

   The Dementia Care Specialist is responsible for educating staff within the AAA, community partners, care partners, and the PLWD. Through education, early detection, and skill building, the AAA staff and community partners will have the knowledge to identify and work effectively with PLWD and their care partners. The Division of Aging (DAS) will provide resources, guidance, and selection of content.

   A key element of this domain is to keep AAA staff informed, educated, and up to date on dementia training, resources, and skills. Dementia training for AAA staff must include dementia education and knowledge of resources and referral opportunities.

   DCS will also train community members at large to be dementia aware, to build dementia capable communities, and support PLWD and care partners.

   Suggested education topics include:

   Knowledge Topics:

   - Definition of dementia
   - Different types of dementia, including mild cognitive impairment
   - General stages of dementia
   - Brain changes in dementia
   - Disparities in dementia prevalence and population level information
   - Common symptoms of Alzheimer’s disease and related dementias
   - Needs of caregivers
   - Needs of persons living with dementia
   - Importance of screening and diagnosis with a focus on early detection and diagnosis
   - Normal aging versus dementia
   - Conditions that mimic dementia
   - Brain health, dementia risk factors, and prevention
   - Safety at home or in another environment

   Skill Topics:

   - How to assess for communication and challenging responses

- How to recognize someone who has dementia
- How to interact with someone who has dementia

Services and Resources:

- AAA Programs and Services
- Dementia capable communities or dementia capable business trainings
- Community resources for PLWDs and caregivers

As the program grows, it will be important for dementia education to expand into education at the college/technical level, high school health career classes, and first responder trainings.

Education and training can be delivered through a variety of methods such as but not limited to in-person and virtual training, community fairs, community memory screenings, personalized training to business specific concepts, and webinars.

2. **Community Outreach and Partnerships**

   The DCS will serve as a catalyst for developing and implementing strategies to create dementia capable communities. As the leader of the DCS Program, the DCS is responsible for building or joining a dementia-focused community coalition that will meet on a regular basis to exchange ideas, strengthen resources, and build new partnerships. The coalition will meet quarterly (at a minimum) and can be in person, virtual or a hybrid meeting.

   People/businesses to be included in the coalition include but are not limited to:

   - Medical personnel
   - Brain health specialists
   - Care partners
   - PLWDs
   - Home Care Agencies
   - Social Workers
   - Home Health Care Providers
   - Hospice Providers
   - Attorneys
   - Real Estate Specialists
   - Grocery Store Managers
   - Bank Branch Managers
   - Pharmacists
   - Memory Care Directors
   - Assisted Living Directors
   - Owners of Personal Care Homes

- Direct care staff

3. **Supporting Care Partners and People Living with Dementia**
   - This domain can be achieved by building a supportive dementia capable community, with informed care partners, and by creating safe, supportive spaces throughout the community.
   - Encourage memory screenings and support using a diagnostic evaluation.
   - Offer referrals to support services that will allow PLWD to live in their own environment.
   - Offer referrals to research opportunities.
   - Connect care partners and PLWD to community resources such as memory cafes, support groups, and physical and cognitive engagement opportunities.
   - Provide information about dementia, communication strategies, safety considerations, and care planning.
   - Offer training on how to understand and respond to challenging reactions.
   - Provide referrals to support groups, respite for care partner, research opportunities, and other community resources.

7103 Responsibilities of the Dementia Care Specialist and the Area Agency on Aging

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Responsibilities of the Dementia Care Specialist and the Area Agency on Aging	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7103	**Previous Update:**	N/A

Summary Statement

The Area Agency on Aging (AAA) is responsible for monitoring the work and progress of the Dementia Care Specialist (DCS) by conducting annual performance evaluations for the DCS, including but not limited to, oversight of data entry into the Division of Aging Services Data System (DAS DDS), and participating in dementia trainings lead by the DCS.

The DCS acts as a liaison between state programs and initiatives, the local aging network, and constituents within the Planning and Service Area (PSA) to create a dementia educated, business engaged, and care partner supported community. Through educational and social programming, dementia awareness, skill building, and community collaboration, the DCS will support each community in creating a dementia capable environment.

Basic Considerations

AAA Responsibilities

- The AAA must employ at least one (1) full time equivalent (FTE) Dementia Care Specialist. The AAA may not combine the DCS position with other positions and responsibilities.

- At the beginning of employment, the AAA will provide the DCS with basic business tools such as a telephone, printer, computer, desk, and other essential items related to the scope of work.
- The AAA will also provide space, such as an office or conference room, that will be used by the DCS for confidential meetings with clients.
- The AAA must provide local supervision to the DCS position. The AAA must provide directions regarding the daily job performance of the DCS, including time management, reporting, productivity, and community outreach, including providing direction regarding outreach to target populations.
- The AAA must ensure the DCS attends all mandatory ongoing training coordinated and organized by DAS.
- If the DCS leaves their position or is on an extended leave, the AAA will develop a contingency plan to ensure ongoing programmatic services of the DCS Program.
- The AAA must ensure the DCS reports program-specific data in accordance with program tracking database protocols as established by DAS.

Dementia Care Specialist Responsibilities

- Conduct four dementia training sessions per fiscal year within the AAA and the aging network.
- Provide four education sessions per fiscal year to families and communities. Topics may include, but are not limited to, disease progression, nutrition, heart health, care partner support, social engagement, language, sleep, exercise, and brain health.
- Train other staff in the AAA and aging network to conduct support groups and other community outreach education.
- Refer PLWDs and care partners to appropriate resources.
- Work with volunteers and/or community partners who can provide memory cafes.
- By the fifth working day of the month, enter the previous month's activity into the DDS to report all community outreach programming including but not limited to coalition meetings, education sessions, community presentations, and outreach.
- Participate in community outreach events such as, but not limited to, health fairs, farmers markets, community events, and joint programming with other local organizations like hospitals, hospices, home care agencies, home healthcare agencies, and physicians' offices.
- Build a resource library for care partners. Examples include, but are not limited to:
    - Assistive Technology
    - Videos
    - Webinars
    - Books
    - iPods
- Provide information about and referrals to research studies and local resources that would be supportive to the care partner and PLWD.
- As the leader of the DCS Program, the DCS is responsible for building or joining a dementia-focused community coalition that will meet on a regular basis to exchange ideas, strengthen

resources, and build new partnerships. The coalition will meet quarterly (at a minimum) and can be in person, virtual or a hybrid meeting. People/businesses to be included on the collaborative include but are not limited to:

  - Medical personnel
  - Brain health specialist
  - Care partners
  - PLWD
  - Home Care Agencies
  - Social Workers
  - Home Health Care
  - Hospice
  - Attorney
  - Real Estate Specialist
  - Grocery Store Manager
  - Bank Branch Manger
  - Pharmacist
  - Memory Care Director
  - Assisted Living Director
  - Owner of Personal Care Home
  - Direct care staff
  - Faith Leaders
  - First Responders
  - Restaurant Managers
  - Retail Managers

- Create an outreach plan that should be used as a reference guide for programming, resources, and referrals. The plan for the coming state fiscal year should be submitted each April 30th, two months before the end of the fiscal year (June 30th), to the DAS Dementia Team Lead for review and approval.
  - As part of the outreach plan, utilize a spreadsheet or another organizational tool to record the resources and organizations within each community that would benefit from dementia services, provide dementia resources, or are potential partners. Include contact name, address, phone number, and a summary about the organization. For example:
    - Tab 1 - Faith Based Organizations
    - Tab 2 - Senior Living Communities
    - Tab 3 - Pharmacies
    - Tab 4 - First Responders
    - Tab 5 - Healthcare Systems/Medical Facilities

- Tab 6 - Businesses
- Tab 7 - Community Based Organizations

- Participate in monthly meetings with DAS Dementia Team Lead concerning program structure and development.

7104 Requirements and Training for Dementia Care Specialists

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	7000 Dementia Programs	**Effective Date:**	12/15/23
	Section Title:	Requirements and Training for Dementia Care Specialists	**Reviewed or Updated in:**	MT 2024-01
	Section Number:	7104	**Previous Update:**	N/A

Summary Statement

The Dementia Care Specialist (DCS) will maintain awareness of dementia trends, education, and research opportunities as well as attend trainings, webinars, or conferences to stay up to date on their own skills and knowledge.

Basic Considerations

Required Training for DCS

DCS must:

- Complete the Division of Aging Services (DAS) DCS Orientation within the first twelve weeks of employment.
- Attend DAS Orientation the quarter following hire.
- Participate in eight one-on-one sessions with the DAS Dementia Team Lead or assigned mentor within the first four months of employment.
- Maintain updated knowledge about dementia, evidence-based programming, best practices in dementia care, and research participation opportunities.
- Attend informal and formal education opportunities.
- Pursue continuing education by participating in conferences, webinars, and training events.
- Attend regional and statewide program meetings as well as DCS specific training.

Required Certification for DCS

The DCS and AAA will decide which of the following programs best fit their community needs. The DCS should participate in at least two of these training courses. Other certifications may be applicable with prior authorization from the DAS Dementia Team Lead.

- Ageucate
- Certified Dementia Practitioner

- Crisis Prevention Institute-Dementia Capable Care Training
- The Eden Alternative
- Positive Approach to Care
- Rosalynn Carter Institute
- Virtual Dementia Tour
- EssentiALZ
- Other dementia training/certification (with prior authorization from DAS Dementia Team Lead)

Appendix A Summary of Cover Letters

	Georgia Division of Aging Services Access to Services Manual			
	Chapter:	Appendix A Summary of Cover Letters	**Effective Date:**	
	Section Title:		**Reviewed or Updated in:**	MT 2019-01
	Section Number:		**Previous Update:**	

MT Number	Date	Subject
1	November 24, 2008	Access to Services Manual Transmittal 2008-01
2	February 12, 2009	Access to Services Manual Transmittal 2009-02
3	February 25, 2009	Access to Services Manual Transmittal 2009-03
4	March 10, 2009	Access to Services Manual Transmittal 2009-04
5	May 21, 2009	Access to Services Manual Transmittal 2009-05
6	November 1, 2010	Access to Services Manual Transmittal 2011-01
7	March 24, 2011	Access to Services Manual Transmittal 2011-02
8	December 27, 2011	Access to Services Manual Transmittal 2012-01
9	January 4, 2013	Access to Services manual Transmittal 2013-01
10	January 17, 2013	Access to Services Manual Transmittal 2013-02
11	April 10, 2013	Access to Services Manual Transmittal 2013-03
12	March 25, 2014	Access to Services Manual Transmittal 2014-02
13	September 18, 2014	Access to Services Manual Transmittal 2015-01
14	January 5, 2015	Access to Services Manual Transmittal 2015-02
15	December 29, 2014	Access to Services Manual Transmittal 2015-03
16	April 25, 2015	Access to Services Manual Transmittal 2015-04
17	August 18, 2015	Access to Services Manual Transmittal 2016-01
18	September 4, 2015	Access to Services Manual Transmittal 2016-02
19	September 23, 2015	Access to Services Manual Transmittal 2016-03
20	February 15, 2016	Access to Services Manual Transmittal 2016-04
21	March 28, 2016	Access to Services Manual Transmittal 2016-05
22	June 20, 2016	Access to Services Manual Transmittal 2016-06
23	August 30, 2016	Access to Services Manual Transmittal 2017-01

MT Number	Date	Subject
24	November 30, 2016	Access to Services Manual Transmittal 2017-02
25	December 7, 2016	Access to Services Manual Transmittal 2017-03
26	May 23, 2017	Access to Services Manual Transmittal 2017-04
27	December 8, 2017	Access to Services Manual Transmittal 2018-01
28	June 8, 2018	Access to Services Manual Transmittal 2018-02
29	September 17, 2018	Access to Services Manual Transmittal 2019-01
30	April 15, 2019	Access to Services Manual Transmittal 2019-02
31	May 9, 2019	Access to Services Manual Transmittal 2019-03
32	May 30, 2019	Access to Services Manual Transmittal 2019-04
33	September 23, 2019	Access to Services Manual Transmittal 2020-01
34	August 1, 2019	Access to Services Manual Transmittal 2020-02
35	December 15, 2023	Access to Services Manual Transmittal 2024-01

[1] Advocacy in the sense used in this policy does not include legislative advocacy or lobbying.

[2] Reference: DHS Policies for providing services to persons with limited English proficiency and sensory impairments. The manual and related forms are located at dhs.georgia.gov/language-access under LEPSI Resources.

[3] The Division encourages Area Agencies to provide a balance in staff between social service and nursing professionals, to assure that the perspectives of both the social and medical models of service delivery are shared among the staff. See Appendix 5060-B for reference to minimum qualifications for social services staff. See 5024 for description of ADRC staff duties.

[4] The unit of service for all access system components is one contact. Refer to the DAS Taxonomy of Service Definitions.

[5] Refer to the ADRC Counselor Harmony User Guide for instructions on correctly entering access service data.

[6] It is the recommendation of the DAS that as much demographic information as possible be collected and entered in to the DDS to demonstrate call volume and types of individuals served.

[7] Targeted populations include: aging and disability populations, minorities and LGBT groups.

[8] Methods of outreach may include personal contacts; speaking engagements; community meetings; public service announcements/listings; radio; television; paid advertisements; feature articles; news stories; interviews; newsletters; displays; telephone directory listings; print materials (brochures, posters, business cards, billboards, bus posters); mailing inserts; Internet web pages.

[9] NHT funding was appropriated to transition seniors in nursing homes who want to transition to community settings. Using the numbers of individuals under age of 60 who transitioned by MFP and the number estimated still in nursing homes, age 55 increased the opportunity for individuals who will transition.

[10] As determined in the Department of Family and Children Services (DFCS) Medicaid manual, Appendix A1, Chart A1.3 Average Nursing Home Private Pay Billing Rate. odis.dhs.ga.gov

[11] Senate Bill 160 (Act No. 27), effective July 1, 2013, limited the use of passports issued by foreign nations to satisfy the requirements for submission of secure and verifiable documents to only those passports submitted in conjunction with a United States Department of Homeland Security (“DHS”) Form I-94, DHS Form I-94A, DHS Form I-94W, or other federal form specifying an individual’s lawful immigration status or other proof of lawful presence under federal immigration law.