

GEORGIA



SECTION 316 – Guidelines and Requirements for Caregiver Services

316.1**PURPOSE:**

This section establishes the guidelines and requirements for Area Agencies on Aging (AAAs) that provide or contract for provision of non-Medicaid-Home and Community Based Services for family and informal caregivers of older individuals, at-risk adults, and persons with disabilities. These requirements apply to services funded wholly or partially by funds received through the Department of Human Services Division of Aging Services (DAS) and are suggested for use by agencies providing caregiver services on a fee-for-service basis.

AAAs can provide information to family caregivers about available community services and assist in gaining access to those services in order to enhance decision-making, reduce burden, and improve the health and wellness of those providing care to older adults and persons with disabilities. Supportive programs and services for caregivers can strengthen care partnerships and help care receivers to remain in their communities for as long and as safely as possible.

AAAs may choose from a variety of caregiver targeted programs and services, including but not limited to: adult day care, respite services, material aid, assistive technology, community and public education, case management, and kinship care. Many of these caregiver services have their own standards and policy requirements as outlined in applicable sections of the DHS Online Directives Information System Manual 5300, "Home and Community Based Services".

This section establishes overall standards for caregiver services, including evidence-based and evidence-informed programs aimed at caregivers. DAS strongly encourages AAAs to provide educational resources for caregivers through community and public events; webinars and other media; and caregiver-oriented support groups as discussed in these standards.

To be eligible for caregiver services, the caregiver must be providing periodic or ongoing care for a care receiver. The service or services delivered must provide support to and address the needs of the client in their role as a family or informal caregiver.

**316.2
DEFINITIONS:**

Activities of Daily Living (ADLs) are the basic tasks of everyday living required for self-care and independent living, and include eating, dressing, bathing, grooming, transferring, and continence.

Caregiver is an adult family member, or another individual, who provides in-home and community care for:

- an older individual;
- an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction; or
- a person with a physical or intellectual disability.

Care Receiver is the person provided care by a caregiver.

Care Partnership is a term that affirms the collaborative nature of the caregiver/care receiver relationship, each an active participant in the balance of giving and receiving care.

Care Plan is a document created through involvement of the consumer and his/her support system that identifies the needs of the client as well as the goals and steps to achieve those goals.

Community and Public Education is instruction provided to caregivers or the general public regarding available support services for caregivers or practical information on the methods and techniques of caregiving.

Consumer Direction affords the option for caregivers to manage funds and choose service providers for the care receiver in accord with an established care plan.

Evidence-Based Programs (EBPs):

- Have undergone experimental or quasi-experimental design;
- Have been submitted to peer review with results published in a professional journal; and
- Include fidelity measures by which community level program delivery seeks to achieve the demonstrated results of the model intervention.

Evidence-Informed Programs (EIPs):

- Have not necessarily undergone experimental or quasi-experimental design, or been submitted for peer review;
- Have a training manual that specifies the components of the practice protocol and describes how to administer it; and
- Employ pre- and post-tests indicative of statistically significant improvement on caregiver outcomes using valid and reliable measurement instruments (see NADRC: Evaluating Dementia Services and Supports: Instrument Resource List in Appendix 316-A: “References”).

Frail Older Adult is a functionally impaired older individual who:

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

Instrumental Activities of Daily Living (IADLs) are the more complex series of life functions necessary for maintaining a person’s immediate environment, and include managing money, telephoning, preparing meals, laundry, housework, going outside the home, routine health, special health, and being alone. IADLs require the application of judgment and higher-level cognitive capacity.

Intention to Place is a self-reported measure by a caregiver of whether they would consider placement of the care receiver into a different type of care setting, such as a nursing home or another care facility, given the care receiver’s current condition.

Respite Care is a service which offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers.

Supplemental Services may include transportation, home modifications, assistive technology, and medical equipment.

Support Group is a service led by a trained individual, moderator, or professional to facilitate caregivers to discuss their common experiences and concerns and develop a mutual support system. Support groups are typically held on a regularly scheduled basis and may be conducted in person, over the telephone, or online.

Volunteer is a person who freely offers to take part in an enterprise or undertake a task. Volunteers are unpaid; however, training and stipends may be arranged by AAAs to incentivize volunteer service.

**316.3
CORE PRINCIPLES:**

AAAs will ensure that caregiver services are implemented according to the following Core Principles:

1. Family-centered: Program staff approaches families in an interactive process that accounts for a person's and family's strengths, preferences, needs, and values. The family is the best authority regarding its needs, limitations, resources, and goals. A family-centered approach actively engages families in developing and implementing their support plans.
2. Flexible: Caregiving is a journey for all members of the care partnership. As needs change over time, staff should be skillful in assessing these changes, working with families to address these changes, and modify support plans. The Aging Network system must be flexible to meet these changing needs, both in type, quantity, and methods of service delivery.
3. Holistic: Staff must recognize that caregiving involves many characteristics of the family system, including physical, mental, spiritual, financial, and emotional. The practices of assessment, support planning, and service delivery must be holistic in its approach and delivery.
4. Creative: Every caregiving family's journey is different, and both staff and the Aging network system must respond creatively to these varied needs, values, and preferences.

5. Capacity based: Caregivers have the capacity for continued growth and autonomy and are the authority on their own needs, have the capacity to know what they need most to achieve well-being, and have abilities, competencies, and resources to help achieve their goals. It is the responsibility of the Aging network to help develop skills necessary to help caregivers be successful.
6. Conflict-free: Program staff remains neutral with no interest in the choices made neither by consumers nor in the types of services or providers selected by the consumers; and to the extent possible, avoids the appearance of conflicts regarding referrals on behalf of consumers.
7. Culturally humble: Program staff hold an interpersonal stance that is other-oriented rather than self-focused, characterized by respect toward an individual's and family's cultural background and experience.

**316.4A
SERVICE GOALS:**

The goals of caregiver services include:

1. Maintaining the greatest possible amount of independence and dignity for each person in the care partnership;
2. Identifying and enhancing the knowledge and skills of caregivers through community and public education;
3. Empowering individuals in the care partnership so that the caregiver may most effectively help the care receiver to remain in the safest and most appropriate environment, according to their preference;
4. Ensuring that the right services are provided at the appropriate levels, for the right duration, to the satisfaction of the care partners, and at the preferred times to the extent possible;
5. Increasing access for caregivers to community-based services by helping them navigate the service system, and by providing information and support necessary for caregivers to access services; and
6. Building and strengthening community supports for family care partnerships.

**316.4B
SERVICE
OUTCOMES:**

The desired outcomes of consumers receiving caregiver services include:

- Reduced levels of caregiver burden;
- Improved caregiver mental and physical health;
- Increased caregiver ability to provide sustained care and support to a care receiver, reducing out-of-home placement;
- Improved confidence in their caregiving abilities, i.e. caregiver self-efficacy;
- Opportunity for caregiver respite: a break from caregiving responsibilities to rest or attend to their own needs; and
- Increased knowledge of and access to community programs, resources, and supports.

Indicators used to measure desired caregiver service outcomes include:

- Scores on items of “Section H: Caregiver Burden” of the Risk Assessment Tool (RAT);
- Scores on items of the Bakas Caregiving Outcomes Scale (BCOS) assessment;
- Responses to pre- and post-measures on survey instruments completed by participants in Community and Public Education, Evidence-Based Program, and Evidence Informed Program training sessions;
- Number of services and educational activities offered, referred, and/or provided to caregivers; and
- Number of hours of respite services provided caregivers.

Survey and assessment protocols for caregiver programs are discussed in Section 316.8 “Assessment” of this document.

**316.5
TARGET GROUPS:**

Caregiver services provided through the AAAs must be targeted toward family and other informal caregivers of older adults and persons with disabilities. The caregiver must be identified as the client.

The following eligibility criteria apply for program funding

through the Older Americans Act, Title III Part E – National Family and Caregiver Support Program (Title III-E):

- Adult family members or other informal caregivers age 18 and older providing care to individuals 60 years of age and older;
- Adult family members or other informal caregivers age 18 and older providing care to individuals of any age with Alzheimer’s disease and related disorders;
- Older relatives (not parents) age 55 and older providing care to children under the age of 18; and
- Older relatives, including parents, age 55 and older providing care to adults ages 18-59 with disabilities.

This section establishes policy for the first two specific populations. For policy regarding older relative caregivers, refer to Manual 5300, Section 216 “Kinship Care Services”.

In providing caregiver services under Title III-E, AAAs shall give priority to family caregivers who provide care for individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction.

In providing caregiver services, AAAs shall give priority to caregivers who are:

- older individuals with the greatest social need;
- older individuals with the greatest economic need (with particular attention to low-income older individuals);
- older individuals providing care to individuals with severe disabilities; and
- individuals providing care to frail older adults.

Additionally, other allowable, non-federal fund sources may be used for services targeting caregivers who fall outside of the above eligibility criteria: for example, to serve a caregiver under 60 years-of-age caring for a disabled military veteran. DAS encourages this approach to manage gaps that may be encountered by AAAs when administering caregiver programs in the community.

**316.6
CORE SERVICES
FOR CAREGIVERS:**

Core services for caregivers shall include:

Information for Caregivers about Available Services:

Caregivers can learn about a range of supports, resources, and services available.

Assistance to Caregivers in Gaining Access to Services:

Access assistance helps connect caregivers with services offered by private and voluntary agencies.

Caregiver Education/Training, Individual Counseling, and Support Group: These services help caregivers better manage their responsibilities and cope with the stress of caregiving.

Respite Care: Trained caregivers provide care for individuals, either at home or at adult day care facilities, so that caregivers can rest or attend to their own needs.

Supplemental Services: Additional services provided to caregivers may include transportation, material aid, home modifications, assistive technology, and medical equipment.

**316.7
ACCESS TO
SERVICES:**

The AAAs shall screen potential clients for caregiver services as appropriate. The AAA will initiate service delivery or refer applicants to provider organizations or other resources; or place them on a waiting list for services.

For information regarding screening through Aging & Disability Resource Connection, see MAN 5200, Section 5025. The AAAs will maintain and manage waiting lists for the services, as necessary. See Manual 5000, Section 5038 "Waiting List Management".

Not every applicant will request, require, or benefit from caregiver services. Each AAA will clearly identify in its Area Plan how services will be coordinated and how resources will be allocated and managed to optimize the effectiveness and efficiency of caregiver services.

**316.8
ASSESSMENT:**

AAAs and providers should follow the assessment protocols as outlined in Manual 5300, Section 114 "Guidelines for Client Assessments" and particularly in Section 114.6 "Assessment for Caregiver Services".

Instruments specifically designed to evaluate caregiver

burden and help determine needed caregiver services include “Section H: Caregiver Burden” of the Risk Assessment Tool (Manual 5300, Section 114.5-E and Appendix 114-E) and the Bakas Caregiving Outcomes Scale (Manual 5300, Appendix 114-L).

Questions on Section H of the Risk Assessment Tool (RAT) may be used during client screening to preliminarily assess the level of caregiver burden and intention to place. If it is determined that the caregiver needs services, the Bakas Caregiving Outcomes Scale (BCOS) must be performed.

For Community and Public Education, EBP, and EIP training sessions, AAAs and providers must use the survey or assessment protocols designed by the developers of the respective programs.

**316.9
CONSUMER
DIRECTED
CAREGIVER
SERVICES:**

Consumer direction allows the caregiver to manage payment and choose service providers in accord with an established care plan. This approach reflects the family-centered principle that people are the best judges of what assistance they may need and of how that assistance should be delivered. DAS encourages consumer direction of funds to the maximum extent possible for qualified caregivers to meet the varied and changing needs and preferences of a care partnership.

Consumer-directed funds may be used to purchase services from providers whose service area is located outside that of the caregiver, i.e. the region where the care receiver resides. DAS encourages the development of consumer-directed funding strategies when regional separation of caregiver and care receiver is at issue.

AAAs may establish referral and payment mechanisms between AAAs to enable reimbursement to caregivers for purchased services. AAAs may establish or use mechanisms already in place to directly reimburse caregivers for:

- expenses incurred in obtaining respite care services, transportation to respite care service locations, or other supportive services, and consumable supplies such as incontinence pads; and
- expenses incurred in obtaining home modifications or assistive devices, as approved by the department,

such as grab bars, safety devices, and wheelchair ramps.

See O.C.G.A. §49-6-70 to §49-6-77 “Georgia Family Caregiver Support” in Appendix 316-A: “References”.

AAAs may set monetary limits on reimbursement for consumer directed caregiver services, up to but not in excess of that required in the above statute.

Consumer direction of caregiver funds must comply with the policies, guidelines, and standards established in Manual 5300, Section 212 “Consumer Directed Services”.

Purchased services must benefit the caregiver by providing respite from their usual caregiving duties or by lessening the stress or burden of caregiving as measured by the BCOS assessment.

**316. 10
FEE FOR SERVICE
GUIDELINES:**

Each AAA is encouraged to offer caregiver services as a fee-for-service enterprise to enhance the sustainability of the Aging network. In so doing, the AAA must follow all requirements of the Older Americans Act and MAN 5600, Section 2025 “Fee for Service System Overview” and MAN 5600, Section 2028 “Private Pay Services.”

Caregiver services provided to consumers as a fee-for-service should not differ in quality from service provided to consumers funded through public funds.

In establishing its fee for service structure, the AAA should account for the actual cost of the services, including administrative costs, and consider comparable rates within the service market area.

**316.11
USE OF
VOLUNTEERS:**

Each AAA that accepts Title III-E funding shall make use of trained volunteers to expand the provision of the available caregiver services and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants in community service settings.

See Older Americans Act of 1965, Sec. 373 in Appendix 316-A: "References".

Refer to Manual 5600, Section 4020 "Volunteer Management Procedures".

Volunteer applicants must comply with background check and fingerprint policy established in Manual 5600, Section 3036 "Criminal History Investigation".

A sample volunteer application and suggested volunteer interview questions are included in MAN 5600, Appendix D: "Forms and Templates".

**316.12
RESPIRE CARE:**

Respite care is a service which offers temporary, substitute supports or living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers.

Particular tasks or activities which may provide respite to caregivers include, but are not limited to:

- Assistance with activities of daily living (ADLs);
- Assistance with instrumental activities of daily living (IADLs);
- Adult day care and adult day health programs;
- Skilled care such as medication management and medical care;
- Companionship and supervision activities; and
- Short-term or extended lodging at residential facilities.

Respite services can be provided in the home or outside the home. Respite care may be available to families through formal programs that hire and train their staff or may be available to families through informal networks such as volunteer programs or faith-based initiatives.

Consumer direction of caregiver funds in the form of vouchers allow family caregivers to purchase appropriate

	<p>in-home or out-of-home respite care and choose providers according to the changing needs and preferences of the care partnership. Refer to Section 316.9 “Consumer Directed Caregiver Services”.</p> <p>Agencies providing respite must comply with all regulatory requirements associated with the specific tasks performed.</p> <p>Appendix 316-A “References” includes links to information and resources regarding respite care for family caregivers.</p>
<p>316.13 COMMUNITY AND PUBLIC EDUCATION:</p>	<p>Community and Public Education is instruction provided to caregivers or the general public regarding available support services for caregivers or practical information on the methods and techniques of caregiving.</p> <p>AAAs can assess the need for education and training services in the constituent communities based on information obtained through the client intake and screening process; public hearings; community surveys; stakeholder recommendations; and other methods.</p> <p>Caregiver training includes but is not limited to webinars, face-to-face sessions, tutorials, and conferences organized by agencies or educational institutions. Individual training may be provided by practitioners with experience in or demonstrated knowledge of the training topic.</p> <p><u>Service Provider Eligibility:</u> AAAs may provide directly or contract for the provision of education and training services with individuals, agencies, or educational institutions that have demonstrated expertise and efficiency in the topic of training identified in the specified curriculum. The purchase of curriculum content developed by qualified individuals/sources as defined in this section is an allowable expenditure of state and federal funds.</p> <p>Qualified providers include, but are not limited to:</p> <ul style="list-style-type: none"> • Staff of education institutions; • Staff of licensed home health agencies, including home health aides, attendant care and personal care

- providers; programs, agencies or individuals approved by the Department of Human Services;
- Qualified staff of community mental health agencies operating through the Georgia Department of Behavioral Health and Developmental Disabilities or equivalent private entities;
 - Qualified staff of public or private health/human services agencies;
 - Qualified staff of hospitals, clinics, or other agencies and organizations;
 - Qualified providers of other services such as day or vocational services, and residential care providers;
 - Qualified individual practitioners may include, but are not limited to, licensed personnel such as:
 - ◆ registered and licensed practical nurses
 - ◆ physicians
 - ◆ psychologists
 - ◆ speech therapists
 - ◆ occupational therapists
 - ◆ physical therapists
 - ◆ registered, licensed dietitians
 - ◆ licensed social workers
 - ◆ attorneys

Individual non-licensed practitioners or contract consultants may qualify to provide services if they have the education, training, or experience directly related to the specified needs of a group of individuals with a common interest.

Staffing and Curriculum: AAAs shall assure that staff who provide community and public education are qualified by having appropriate education, training, or experience. AAAs should review the credentials of speakers prior to the training events. Specific educational programs may require the trainer to undergo a certification process.

Staffing requirements for events will be determined by the AAA, in consultation with the training facilitator(s). Staff support for the event, including publicity, host site, registration details, and other logistics, will be provided or negotiated by the AAA and coordinated with the speaker.

AAAs that develop or contract for the development of

curriculum content shall assure that persons responsible for such development are qualified by education, training or experience, or are supervised by such persons.

Data Collection and Reporting: AAAs shall report Community and Public Education activities under the appropriate group heading on the Client Groups Chapter – Activities Page in the DAS Data System.

Appendix 316-A “References” includes links to numerous educational resources and helpful organizations for family caregivers.

**316.14
SUPPORT GROUPS:**

Support groups are gatherings of people who share a common health concern or interest. Support groups meet on a regular, defined basis to discuss or focus on a specific situation or condition, such as Alzheimer’s Disease or diabetes. They are often formed by nonprofit or advocacy organizations.

Support groups are:

- Attended by peers, persons who are directly or indirectly affected by a particular issue or illness,
- Usually have either a professional or volunteer leader as the facilitator, and
- Often small in size, 12 persons or less, enabling everyone a chance to talk.

The benefits of participating in support groups may include:

- Discussion of common problems and sharing of experiences;
- Reduced feelings of isolation as members make connections with others facing similar challenges;
- Learning about community resources and information relevant to the group;
- Reducing stress, depression, or anxiety; and
- Developing a clearer understanding about what to expect regarding their care partnership.

Support groups are not the same as group therapy sessions, which are a formal type of mental health treatment that brings together people with similar

conditions under the guidance of a trained mental health provider. Through regularly scheduled meetings, support groups provide emotional support and educate caregivers to take better care of their own health and provide better care for their care partner.

Staffing: AAAs shall assure that staff, including volunteers (see Section 316.11 “Use of Volunteers”), who lead support groups are qualified to do so by having appropriate education, training or experience.

It is recommended that support groups have co-facilitators whenever possible. This allows for a back-up if one of the facilitators is absent and the back-up to be a person the support group members already know. Additionally, if one needs to leave the meeting, the other facilitator can continue the group without interruption.

An ideal combination of co-facilitators is a professional and a family caregiver.

Potential facilitators for support groups should be screened. The screening process must include:

- A face-to-face interview and
- Criminal background check.

During the interview process, the screener should ask questions to determine the applicant’s knowledge and experience, and look for any potential problems that would inhibit the applicant’s ability to be an effective facilitator.

Support group facilitator applicants must comply with background check and fingerprint policy established in Manual 5600, Section 3036 “Criminal History Investigation”.

Speakers at Support Groups: Support group facilitators may invite speakers to attend and present information on community resources. Speakers presenting to support groups should remain conflict-free, agreeing not to promote their organization or themselves for financial gain.

Interaction between speakers and support group members should be limited to group discussion and, to

the extent possible, avoid the appearance of conflicts of interest. Support group members may be provided with contact information to speak with the presenter individually, outside the group format.

Data Collection and Reporting: AAAs shall report Support Group activities under the appropriate group heading on the Client Groups Chapter – Activities Page in the DAS Data System. AAAs should report support group survey results to DAS via the Area Plan updates.

Appendix 316-A “References” includes links to information on how to create and facilitate peer support groups.

**316.15
EVIDENCE-BASED
AND EVIDENCE-
INFORMED
PROGRAMS:**

This section establishes guidelines and requirements for evidence-based programs (EBPs) and evidence-informed programs (EIPs) targeted primarily towards caregivers. Examples of state-approved caregiver-oriented EBPs and EIPs are listed below:

- Benjamin Rose Institute Care Consultation (BRI CC)
- RCI Dealing with Dementia (DWD)
- Powerful Tools for Caregivers (PTC)
- RCI REACH (Resources Enhancing Alzheimer's Caregiver Health)
- TCARE
- The Savvy Caregiver
- NYU Caregiver Counseling and Support Intervention
- Stress-Busting Program (SBP) for Family Caregivers

AAAs are required to provide BRI CC for their Planning and Service Area (PSA) or to make referrals to a licensed BRI CC program to serve clients in their PSA.

AAAs are further required to provide one other EBP or EIP targeted to caregivers. If the AAA chooses to provide a program not on the list above, they must substantiate to DAS that the selected program serves the target group as described in Section 316.5 and meets expected service goals and outcomes described in Sections 316.4-A and 316.4-B.

Caregiver EBPs and EIPs must adhere to DAS standards

regarding lay leader certification, training and credentials; number of classes offered; and number of caregivers served. Particular requirements may vary by PSA according to the chosen program. DAS may establish these requirements as needed to meet program goals and outcomes, and to increase regional capacity to serve caregivers.

AAAs and providers must follow established protocols and program components for all EBP/EIPs, and must comply with licensing and fidelity guidelines as outlined by the developers of the particular intervention.

DAS encourages AAAs to consider utilizing their OAA required volunteers as EBP/EIP lay leaders where appropriate. Some volunteer lay leaders may be able to dedicate considerable time to teaching classes. See Section 316.11 “Use of Volunteers”.

Data Collection and Reporting: AAAs and/or providers shall report EBP/EIP activities under the appropriate group heading on the Client Groups Chapter – Activities Page in the DAS Data System.

EBP/EIP data should be reported in the DAS Data System in accordance with DAS and specific program requirements and may include:

- Specific EBP/EIP workshop information;
- Workshop pre-and post-test data;
- Workshop host site details; and
- Lay leader/master trainer certification and training history.

AAA staff or service provider program coordinators may contact the DAS Caregiver Services Specialist for technical assistance and support regarding caregiver EBP/EIP programs.

Links to information regarding specific caregiver EBPs and EIPs are included in Appendix 316-A “References”.

**316.16
PROGRAM
EVALUATION AND
MONITORING:**

AAAs and service providers shall adhere to policies and procedures as established by DAS or the specific program developers. DAS will periodically monitor the performance of the AAAs to determine the degree to

which defined program outcomes and objectives have been or are being accomplished.

Program elements to be monitored and evaluated include, but are not limited to, the following:

- Identification and tracking of indicators (see Section 316.4-B);
- Review of client records, including assessments and documentation;
- Review of client group activities records;
- Review of the degree to which target populations (see Section 316.5) are being served; and
- Review of compliance with these guidelines;

See Manual 5300, Appendix B “Review Guide: Caregiver Services (Ch 316)”.

APPENDIX 316-A

REFERENCES

**APPENDIX 316-A
REFERENCES**

OLDER AMERICANS ACT OF 1965, [Public Law 89–73], [As Amended Through P.L. 114–144, Enacted April 19, 2016], 42 U.S.C. §3001 et al

<https://legcounsel.house.gov/Comps/Older%20Americans%20Act%20Of%201965.pdf>

O.C.G.A. §49-6-70 to §49-6-77 “Georgia Family Caregiver Support”

<https://law.justia.com/codes/georgia/2017/title-49/chapter-6/article-6/>

Respite Care

<https://www.alz.org/help-support/caregiving/care-options/respice-care>

<https://archrespice.org/consumer-information>

https://archrespice.org/images/docs/ABCs_of_Respice/ABCsofRespice_Updated_6-17.pdf

Support Groups

<http://ctb.ku.edu/en/table-of-contents/implement/enhancing-support/peer-support-groups/main>

<http://www.adaa.org/finding-help/getting-support/support-groups/start-support-group>

https://caregiver.com/articles/starting_running_support_group/

NADRC: Evaluating Dementia Services and Supports: Instrument Resource List

<https://nadrc.acl.gov/node/70>

Benjamin Rose Institute Care Consultation

<http://www.benrose.org/Services/BRI-Care-Consultation-Services.cfm>

http://www.rosalyncarter.org/benjamin_rose/

TCARE

<https://www.tailoredcare.com/>

<http://www.tcarenavigator.com/>

Powerful Tools for Caregivers

<http://www.powerfultoolsforcaregivers.org/>

RCI REACH

http://www.rosalynncarter.org/rci_reach/

Rosalynn Carter Institute for Caregiving

<http://rosalynncarter.org/>

RCI Dealing with Dementia

http://www.rosalynncarter.org/Dealing_with_Dementia_copy/

RCI Dementia Webinar Series

http://www.rosalynncarter.org/dementia_webinars/

http://www.rosalynncarter.org/gdas_trainings/

ACL Dementia Capable Modules

<https://bhw.hrsa.gov/grants/geriatrics/alzheimers-curriculum>

Eden Alternative

<http://www.edenalt.org/>

The Savvy Caregiver

http://license.umn.edu/technologies/z08156_the-savvy-caregiver-program-for-alzheimer-caregiver-training

NYU Caregiver Counseling and Support Intervention

<https://med.nyu.edu/ad/researchers/affiliated-labs/dr-mary-mittelman>

Stress-Busting Program (SBP) for Family Caregivers

<https://www.caregiverstressbusters.org/>

National Alliance for Caregiving

<https://www.caregiving.org/>

Alzheimer's Association

<http://www.alz.org/index.asp>

AARP: Family Caregiving

<https://www.aarp.org/caregiving/>

AARP Public Policy Institute: Family Caregiving

<https://www.aarp.org/ppi/issues/caregiving/>

Family Caregiver Alliance

<https://www.caregiver.org/>

CHAPTER 216 – KINSHIP CARE SERVICES

216.1 PURPOSE	<p>This chapter establishes guidelines and requirements to be followed when Area Agencies on Aging provide or contract for the provision of services to grandparents or other relatives raising grandchildren or other minor children. Program activities are supported by funding from Title III-E of The Older Americans Act, other state funds, and local funds, subject to their availability. The primary goal is to provide maximum flexibility for AAAs to expand needed services, while continuing to protect the health, safety, and well-being of grandparents and other relative caregivers raising children.</p>
216.2 SCOPE	<p>These requirements apply to services provided in whole or in part with non-Medicaid federal and specially appropriated state funds managed by Area Agencies on Aging, and any associated matching and local discretionary funds. The Older Americans Act, as amended in 2006 authorizes Title III, Part E, as the National Family Caregiver Support Program, which establishes services to grandparents and other relatives age 55 and over who have custodial responsibility for grandchildren or other minor children.</p>
216.3 TARGET GROUP AND ELIGIBILITY	<p>The target group for these services comprises grandparents, step-grandparents, or other caregivers related by blood, marriage, or adoption, who:</p> <ol style="list-style-type: none"> (1) have children for whom they are responsible living with them (as opposed to providing daycare or after school care to children who reside elsewhere); (2) are the primary custodial caregivers because of the inability or unwillingness of the biological or adoptive parents to provide parental care; and (3) have a legal relationship to the children (legal custody or guardianship) or are raising the children informally. (4) Grandparents/relative caregivers served through the Older Americans Act portion of the program must be at least 55 years old. (5) The declaration of the caregiver relative regarding residence and full-time custodial responsibility for the children in their care is sufficient for determining eligibility for and admission to the Kinship Care program. Area Agencies on Aging that provide or contract for the provision of services to grandparents / relative caregivers shall give priority to caregivers who provide care for children with severe disabilities.

<p>216.4 ACCESS TO SERVICES</p>	<p>Area Agencies shall receive requests for Kinship Care services provided either directly or through their subcontract agencies and maintain and manage waiting lists, as needed. Sources of referrals include, but are not limited to: County Departments of Family and Children Services, libraries, schools, health and social services providers, case managers, Extension Service programs, churches, child care organizations, housing authorities, and family members.</p>
<p>216.5 DEFINITIONS</p>	<p><u>Child</u>: An individual under age 18.</p> <p><u>Support Group</u>: A group of persons who meet on a regular, defined basis to discuss common problems or life issues. The group can have a professional as a moderator, or be run by members alone. Support groups function to provide an expansion of social resources and knowledge relevant to members' situations, relief and reassurance, and enhanced coping skills. Also see Appendix 216-A. (Note: definition adapted from <i>Lean on Me - Support and Minority Outreach for Grandparents Raising Grandchildren</i>, September 2003 and About.com web content.</p> <p><u>Case Management</u>: Assistance either in the form of access or care coordination in circumstances in which the older person and/or a caregiver are experiencing diminished functioning capacities, personal conditions or other characteristics which require the provision of services by formal service providers. Also see Chapter 210, Case Management Services.</p> <p><u>Child(ren) with Severe Disability</u>: an individual under 18 years of age who has a mental or physical impairment, or a combination of mental and physical impairments that has lasted or is expected to last at least 1 year, and which severely limits daily activities. Conditions may include, but are not limited to: developmental disability, sensory impairments (hearing, visual, speech), emotional disturbance, autism, learning disability, or health impairments.</p> <p><u>Counseling</u>: Providing guidance and assistance with problem resolution by <i>professionally qualified</i> paid or volunteer staff to older persons or caregivers, including grandparents raising grandchildren. Counseling may be provided individually or in group settings, such as support groups or open forums to encourage sharing and questions.</p>
<p>216.6 LIMITATION ON USE OF FEDERAL FUNDS</p>	<p>Area Agencies may use no more than 10 percent of the total Older Americans Act Title III-E federal share of funds to provide support services to grandparents and older individuals who are relative caregivers of a child who is not more than 18 years of age. [Older Americans Act, §373(g)(2)(C)].</p>

**216.7
PROGRAM
OUTCOMES**

The primary outcomes expected to be achieved through Kinship Care services are:

- 1) Increased access to and use of formal resources by kinship families (caregivers and/or children), including, but not limited to: legal assistance, financial assistance, housing resources, mental/behavioral health services, food and nutrition services, child care services, physical health care services, school/educational resources, leisure/recreational resources and DAS Wellness Programs, including Chronic Disease Self-Management Education programs;
- 2) Development of enhanced coping skills by relative caregivers;
- 3) Prevention of disruption of family care systems, including avoidance of placement of children into the formal foster care system or the assumption of caregiving responsibility for children currently in the formal foster care system;
- 4) Decreased stress levels among caregiver relatives;
- 5) High degree of satisfaction among caregiver relatives with Kinship Care services.

The Kinship Care Survey (See MAN 5300 FORMS section) has been designed to measure all of the above outcomes. See also Section 216.11 MONITORING AND EVALUATION.

**216.8
ACTIVITIES**

Area Agencies on Aging may elect to provide two or more of the following services and/or kinship care group activities, based upon the needs identified in the respective regions. The services shall have the meaning and unit classifications established by the DAS Taxonomy of Service Definitions.

- a) Information and Assistance Services (Group): Current information on opportunities and services available within their communities for grandparents/relative caregivers and the children in their care, covering legal, financial and medical assistance and services, mental health and rehabilitation services, food and nutrition services and benefits, housing, transportation, child care, school/educational resources, leisure/recreation activities, employment services, and advocacy.
- b) Counseling (Individual or Group): Note that counseling as defined in Section 216.5 can be provided in a support group setting by a *professionally qualified staff or volunteer*, although counseling in

other settings and formats also may be provided.

- c) Case Management Service (Individual): See HCBS Manual 5300, Chapter 210 – “HCBS Case Management.”
- d) Respite Care – Out-of-Home (Individual): Services that offer temporary substitute supports of living arrangements for care recipients in order to provide a brief period of relief or rest for caregivers, (NAPIS_5_2007). Respite care for kinship care includes summer camps, childcare, and after school care.
- e) Home Modifications / Repair (Individual): Includes addressing child safety issues through the purchase or provision of electrical plug guards, smoke detectors, child safety gates, window safety / fall prevention devices.
- f) Kinship Care Group Activities (Group): Kinship Care Group Activities provided on behalf of kinship caregivers and kinship care receivers to support their continued independence and wellbeing. The service Kinship Care Group Activities may include any of the following activities:
- Care Receiver Supervision
 - Community Public Education
 - Recreational Events
 - Training
 - Tutoring
 - Support Group - Area Agencies will establish and sustain at least one grandparents’ support group in each region.
 - Counseling (group)
- g) Caregiver Conferences and Workshops (Group): Targeted information and/or interactive sessions for grandparents raising grandchildren that have a formal theme and agenda, at least one primary speaker or session, and are of at least four hours’ duration, inclusive of all activities.

Area Agencies on Aging are to develop formal and informal networks that support the provision of Kinship Care Services, and are to collaborate closely with organizations and programs as indicated by the needs of the communities being served. Potential partners may include: The DHS Division of Family and Children Services “Promoting Safe and Stable Families” Program (PSSF); Project Healthy Grandparent Programs; Parent Teacher Organizations (PTOs); faith communities; Boys and Girls Clubs; Big Brother/Big Sister programs; YMCAs and YWCAs; and Head Start programs.

	<p>The Area Agencies on Aging may retain a reasonable portion of funding to directly provide community/public education services and/or conferences and workshops, and for collaboration activities with other public or private organizations. Area Agencies may establish line item budgets using Kinship Care funds for both community/public education and collaboration activities noted above. The Division of Aging Services encourages the use of Evidence-Based Programs whenever possible.</p>
<p>216.9 STAFFING</p>	<p>Area Agencies will provide adequate numbers of staff, qualified by training and experience qualified by training and experience, to implement the Kinship Care program. Area Agencies may directly employ staff or contract for the implementation and administration of the program.</p>
<p>216.10 DATA COLLECTION AND REPORTING</p>	<p>The Area Agencies and subcontractors will collect, record and maintain client information in the form and formats specified by the Division. The Division may establish additional reporting requirements and formats when necessary to account for program activities and outcomes.</p> <p>For the purposes of establishing individual client records in the DAS Data System, the <i>grandparent/caregiver</i> is recorded as the caregiver for the Older Americans Act. The HCBS Kinship Care Intake Form assessment will be completed for all grandparent/caregivers.</p> <p>Area Agencies will submit to DAS a quarterly program report of collaboration activities conducted with other organizations not later than the 15th working day of the month following the end of each quarter (October, January, April and July). See Appendix 216-B.</p>
<p>216.11 MONITORING AND EVALUATION</p>	<p>Area Agencies on Aging will monitor providers at least annually to assure accountability for the use of program resources and evaluate the effectiveness of the program activities, using criteria and tools specified or approved by the Division, and other discretionary measures. Standards and guidelines established by the Division apply to eligible service components.</p> <p>Area Agencies will provide written feedback to providers within thirty (30) days of completing program monitoring, and provide technical assistance for continuous improvement in program performance.</p> <p>If providing program components directly, the Area Agencies will develop objective means of self-evaluation of program compliance and performance.</p> <p>The Division will evaluate program data periodically and may conduct on-site monitoring evaluations of activities and records.</p>

Using the format and timeframes specified by the Division, Area Agencies/subcontractors will evaluate program results by surveying participants regarding their satisfaction with services provided. Evaluation results, including agency self-evaluations, are to be used as a basis for program improvement and long-range planning to meet the needs of individual consumers and the larger communities. Results indicators may include:

- the number and percent of program participants who would recommend the program to others;
- the number and percent of participants who continue to participate in support groups or other activities over time;
- the number and percent of participants who continue to provide care over time;
- the number and percent of grandparents who report lowered levels of stress as a result of Kinship Care program participation;
- the number and percent of grandparents who report that their coping skills have improved;
- the number and percent of grandparents who report that their overall sense of health and well-being has improved.

Participant surveys are to be administered at least semi-annually in a manner that will gain maximum input from as many program participants as possible. If a participant leaves the program prior to that point, staff should attempt to administer the survey at that time.

If Kinship Care services are subcontracted, the AAA may decide whether the surveys are to be administered by the AAA, or administered directly by the organization providing services.

Area Agency staff will submit a compilation and analysis of survey results, to be included with the subsequent Quarterly Program Report. See Appendix 216-B for the survey format.

REFERENCES

The Brookdale Foundation, Relatives as Parents Program (RAPP):
<http://www.brookdalefoundation.org>

University of Georgia Cooperative Extension Service:
<https://www.fcs.uga.edu/extension/family-supporting-seniors>

Grand Facts - AARP Kinship Care Georgia Fact Sheet:
<http://www.aarp.org/content/dam/aarp/relationships/friends-family/grandfacts/grandfacts-georgia.pdf>

Zero to Three – National Center for Infants, Toddlers, and Families:
<https://www.zerotothree.org/parenting/grandparents-extended-family>

National Research Center on Grandparents Raising Grandchildren:
<http://www.wmich.edu/grandparenting/>

AARP (information on caregiving for an older adult and grandchildren):
<https://www.aarp.org/caregiving/>

Support Group Training Manual for Kinship Care and Grandparents Raising Grandchildren, State of Arizona, Governor’s Task Force on Aging
<http://www.nysnavigator.org/documents/grandparentsmanual1.pdf>

Lean on Me – Support and Minority Outreach for Grandparents Raising Grandchildren, AARP
<http://www.aarp.org/relationships/grandparenting/info-2003/aresearch-import-483.html>

APPENDIX 216-A
SUPPORT GROUPS

Characteristics of Support Groups

Support groups –

- create a safe and supportive environment in which participants can discuss their experiences
- provide respite from the cares and worries of day-to-day problems
- educate and inform members
- assist members in developing methods and skills for solving problems
- encourage personal growth and development of members

While a support group can offer emotional support and provide assistance in finding resources, a support group is *not* a replacement for –

- formal, private (one-on-one) counseling with a professional
- legal advice from a practicing attorney or paralegal
- direction from a licensed school psychologist or guidance counselor
- any other services that depend upon professional training and certification¹

Starting a Support Group² --

Selecting a meeting site

Consider using churches, schools, banks, social service agencies, hospitals, libraries, YMCAs, YWCAs.

NOTE: Keep in mind that some grandparents are reluctant to attend meetings at "social service agencies" so you may wish to hold meetings at a "neutral" facility.

Consider the following when selecting a meeting site...

- Is there a separate and safe area for the children to meet/play?
- Is public transportation available?

¹ Adapted from *Support Group Training Manual for Kinship Caregivers and Grandparents Raising Grandchildren*, State of Arizona, Governor's Advisory Council on Aging.

² Adapted from materials developed by the Illinois State Unit on Aging

- Are there kitchen facilities for meal/snack preparation or to accommodate food deliveries?
- Is the area private?
- Is the area accessible to persons with disabilities?

Identifying grandparents who are raising grandchildren --

Outreach efforts should attempt to identify grandparents through a number of sources, for example:

- Public/private schools/school boards/PTAs
- Pre-schools and day-care programs
- Boys' and Girls Clubs'
- 4-H Clubs
- Pediatrician and dentist offices
- Local public health departments and clinics
- After school programs
- Community centers
- Church bulletins
- Grocery stores
- Banks
- Social service agencies
- Hospitals
- Libraries
- Senior centers
- United Way
- Police and Sheriffs' departments
- Lawyers
- Court systems

Ways to market and promote support groups to the community:

- Develop a one-paragraph, easy to read summary describing your group and how it will benefit grandparents and grandchildren.
- Develop a flyer announcing the group, meeting date, time, location, child care, contact person, phone number. Post this in
 - grocery stores
 - drug stores
 - banks
 - child care facilities
 - libraries
 - hospitals

- church bulletins
 - senior or community centers
 - doctors' offices
 - health clinics
 - Head Start programs
 - social service agencies
 - local Departments of Family and Children Services
 - social service or counseling agencies *or*
 - request it be sent home with school children or in school newsletters
- Have a "kick off" event in collaboration with an agency, hospital, library, or school on an issue relevant to grandparents raising grandchildren.

For example: An evening or lunch hour presentation by an attorney discussing guardianship or custody issues. Supply the support group with "take away" information and have grandparents "sign in" at the session.

- Contact local newspaper reporters and ask them to write an article on grandparents raising grandchildren; mention the support group.
- Contact local TV and radio stations regarding opportunities for public service announcements and talk shows.

What Makes A Good Support Group³

Although what is "good" differs for each person, there are some universal signs that indicate a well-functioning group:

- Up-to-date, reliable information
- Prompt response to contacts
- Regular meetings or newsletters
- Access to appropriate professional advisors (for example, doctors, therapists for grief support, or employment attorneys for workplace discrimination)
- Strong leadership
- A clearly stated "confidentiality" policy
- Ensuring accessibility of the support group by planning for the time, location, and availability of transportation

³ Adapted from *Genetichalth.com* web content

APPENDIX 216-B
KINSHIP CARE QUARTERLY PROGRAM REPORT

**Georgia Division of Aging Services
Quarterly Program Report
Kinship Care Program**

Name of Area Agency on Aging	
Name of Subcontracting Agency (if any)	
Report Period	
Date Report Submitted to DAS	
Name of Person Completing Report	
Phone Number of Person Completing Report	
Email Address of Person Completing Report	
Reports are due not later than the 15th working day of the month following the end of the quarter.	

1. **Highlight your main Kinship Care Program success during this quarter and describe the strategies you used to accomplish this success. If your success story is specific to a family, how did this family benefit from your program?**

2. **Describe any program strengths and barriers within your Kinship Care Program during this quarter, and how you addressed/are addressing the barriers.**

3. **Briefly describe your ongoing collaborative efforts with other organizations and/or programs, and explain the benefits that relative caregivers gain from these efforts.**

4. **Describe the outreach activities you have undertaken to expand awareness of the issues faced by grandparents and other relative caregivers and/or to stimulate the expansion of services to relative caregivers and their families in your area.**

5. **Describe any new or future initiatives and/or partnerships being created in your Kinship Care Program. Include any new support groups and/or activities that were started during the quarter.**

- 6. Describe any new support groups, discontinued support groups, or changes in dates/times/locations of existing support groups.**

- 7. Describe methodology and significant findings of the most recent Kinship Care Survey and describe any actions planned as a result of Survey findings. Include how the information will be used to improve the program and to advocate for additional resources and services**



NEBRASKA



*Please note the "Nebraska Caregiver Coalition Caregiver Organizer" is copyrighted and is not to be duplicated or sold.

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PERSONAL INFORMATION FOR CARE RECIPIENT

Name _____

Maiden name _____

Address _____

City State Zip _____

Phone(s) _____

DOB _____ Place of birth _____

Driver's License # _____

Other information _____

EMERGENCY CONTACTS

Name _____

Address _____

City State Zip _____

Phone(s) _____

Relationship _____

Name _____

Address _____

City State Zip _____

Phone(s) _____

Relationship _____

Phone _____

MEDICAL / Health Care Providers, page 1

PRIMARY CARE PHYSICIAN: _____

SPECIALTY/PRACTICE: _____:

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

NAME : -----

SPECIALTY/PRACTICE: _____

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____:

NAME : -----

SPECIALTY/PRACTICE: _____

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

NAME : -----

SPECIALTY/PRACTICE: _____

ADDRESS: _____

PHONE: _____ FAX: _____ EMAIL: _____

NAME : -----

SPECIALTY/PRACTICE: -----

ADDRESS: -----

PHONE: _____ FAX: _____ EMAIL: _____

MEDICAL / Health Care Providers, page 2

NAME: _ _ _ _ _

SPECIALTY/PRACTICE: _ _ _ _ _

ADDRESS: _ _ _ _ _

PHONE: _ _ _ _ _ FAX: _ _ _ _ _ EMAIL: _ _ _ _ _

NAME: _ _ _ _ _

SPECIALTY/PRACTICE: _ _ _ _ _

ADDRESS: _ _ _ _ _

PHONE: _ _ _ _ _ FAX: _ _ _ _ _ EMAIL: _ _ _ _ _

NAME

SPECIALTY/PRACTICE: _ _ _ _ _

ADDRESS: _ _ _ _ _

PHONE: _ _ _ _ _ FAX: _ _ _ _ _ EMAIL: _ _ _ _ _

NAME

SPECIALTY/PRACTICE: _ _ _ _ _

ADDRESS: _ _ _ _ _

PHONE: _ _ _ _ _ FAX: _ _ _ _ _ EMAIL: _ _ _ _ _

NAME

SPECIALTY/PRACTICE: _ _ _ _ _

ADDRESS: _ _ _ _ _

PHONE: _ _ _ _ _ FAX: _ _ _ _ _ EMAIL: _ _ _ _ _

MEDICAL / Personal Health History

Blood type_ _ _ _ _

Surgeries / year_ _ _ _ _

Chronic conditions_ _ _ _ _

Physical conditions_ _ _ _ _

Allergies_ _ _ _ _

Other_ _ _ _ _

MEDICAL / Family Health History

Father _____

Mother _____

Siblings = _____

Paternal grandparents _____

Maternal grandparents _____

Other family members _____

MEDICAL / Pharmacies

Name _____

Phone _____ Fax _____ Web site _____

Address _____

Name _____

Phone _____ Fax _____ Web site _____

Address _____

Name _____

Phone _____ Fax _____ Web site _____

Address _____

Name _____

Phone _____ Fax _____ Web site _____

Address _____

Name _____

Phone _____ Fax _____ Web site _____

Address _____

INTERACTION WITH MEDICAL SERVICES

The following are possible suggestions to help you prepare for accompanying the care recipient to medical appointments:

1. Before seeing the physician, organize your thoughts, consider current symptoms, make a list of your questions.
2. Take insurance cards and the Caregiver Organizer with you.
3. If the physician agrees, you might write or fax current symptoms, problems, etc. a few days prior to your appointment.
4. Flag the current prescription and over-the-counter medications in your Organizer so that information can be accessed quickly in the physician's office.
5. While with the physician, help the care recipient in reporting symptoms and asking questions.
6. Make notes of physician's instructions.
7. Ask how to contact doctor after hours.
8. Make follow-up appointment if required.
9. Look over all instructions, medication changes, update Caregiver Organizer and mark calendar for next appointment.

More suggestions to help caregiver present information concisely to a healthcare provider, depending upon individual circumstances:

1. What are treatment options?
2. What tests are involved?
3. Are there risks?
4. Is hospitalization a possibility?

5. If so, will care recipient be able to go home after discharge?
6. Will special home health or therapy services be needed?
7. Who will make these arrangements?
8. How long will recovery take?
9. What is covered/ not covered by insurance?

Suggestions for a trip to the emergency room:

1. Have emergency phone numbers close at hand.
2. Take the Caregiver Organizer with you.
3. Flag the current prescription and over-the-counter medications in your Organizer so that information can be accessed quickly by the hospital staff.
4. Give critical information about care recipient to hospital staff.
5. Remain calm, listen and ask questions when appropriate.

CONFIDENTIAL RECORDS AND INFORMATION / Financial

Social Security# _____

Advisers (financial consultant, accountant, etc.)

Name _____

Address _____

Phone _____ Fax _____

Name _____

Address _____

Phone _____ Fax _____

Bank _____

Address _____

Phone _____ Fax-- _____

Checking Account# _____

Authorized signers _____

Savings Account# _____

Authorized signers _____

Lock Box# _____

Authorized for access _____

Income will come from _____

Investments - bonds - mutual funds

Contact name _____

Address. _____

Phone _____ Fax. _____

Contact name _____

Address _____

Phone _____ Fax. _____

Financial obligations (i.e., mortgage, loans, etc.)

Name _____ Account# _____

Address _____

Phone _____ Fax _____

Name _____ Account# _____

Address _____

Phone _____ Fax _____

Name _____ Account# _____

Address _____

Phone _____ Fax _____

Credit Cards

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

CONFIDENTIAL RECORDS AND INFORMATION / Financial

Social Security# _____

Advisers (financial consultant, accountant, etc.)

Name _____

Address _____

Phone _____ Fax _____

Name _____

Address _____

Phone _____ Fax _____

Bank _____

Address _____

Phone _____ Fax _____

Checking Account# _____

Authorized signers _____

Savings Account# _____

Authorized signers _____

Lock Box# _____

Authorized for access _____

Income will come from _____

Investments - bonds - mutual funds

Contact name _____

Address _____

Phone _____ Fax _____

Contact name _____

Address _____

Phone _____ Fax _____

Financial obligations (i.e., mortgage, loans, etc.)

Name _____ Account # _____

Address _____

Phone _____ Fax _____

Name _____ Account # _____

Address _____

Phone _____ Fax _____

Name _____ Account # _____

Address _____

Phone _____ Fax _____

Credit Cards

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

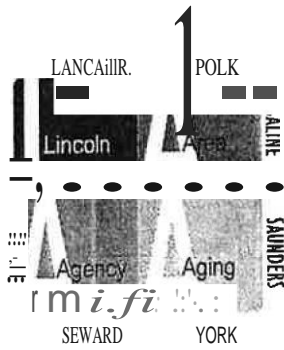
Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____

Company _____ Account# _____

Customer Service Phone _____ Expiration Date _____



Lincoln Area Agency on Aging/LIFE

Who will pay for In-Home Services?

Medicare Medicare pays the full cost of medically necessary home health visits that meet specific criteria by a Medicare approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy, and other therapeutic services in the patient's home. These services are usually provided on a periodic basis by a visiting nurse and/or home health aide. You need to be confined to your home and be under a physician's care.

Medicare **Hospice Care** - Medicare pays for hospice care for terminally ill beneficiaries who choose to receive hospice care rather than regular Medicare benefits for management of their illness. Under Medicare, hospice is primarily a program of care generally provided in the patient's home by a Medicare-approved hospice provider. The focus is on care and not cure. Hospice services covered under Medicare part A include: physician, nursing care, medical appliances and supplies, drugs (for pain and symptom relief), medical social services, physical, occupational therapy, speech/language, pathology services, dietary and other counseling.

Department of Health and Human Services:

Medicaid - Medicaid qualified individuals can obtain in-home services based on an evaluation of your situation by Health and Human Services staff. The services provided are personal care or nursing care. For further information you can contact your Medicaid worker.

Medicaid Waiver - The waiver allows Medicaid recipients money to purchase the following services that are not usually considered "medical," i.e., chore services, (housekeeping, meal preparation, shopping, escort and supervision), adult day care, respite care, independent skills management and transportation. There is a maximum payment for services per individual per month. For information on individuals who are age 65 or over, contact the Lincoln Area Agency on Aging/Life Office at 441-7070. For information on individuals under age 65 contact your Medicaid worker.

Block Grant - A benefit which is designed to provide financial assistance to older adults to help them remain independent in their homes. Services that are paid by the program are homemakers, HandyVan, Meals-On-Wheels, adult day care, congregate meals and respite. Private providers register and are paid directly by Block Grant funds to provide services.

Disabled Persons and Family Support Program - Services are purchased to help families keep a disabled family member at home or to allow a disabled adult to live independently. This program has higher guidelines than other Health & Human Services programs. The program may authorize payment for disability related expenses such as architectural home modification to remove barriers, attendant care, home health care, housekeeping, special equipment, respite care, housekeeping, and transportation. In addition to financial and need eligibility, this program requires medical information to determine severe chronic disability.

Lincoln Area Agency on Aging/LIFE - Supportive Services Program (In Lancaster County)

The Supportive Services Program subsidizes personal care, housekeeping, and adult day care on a sliding scale based on your monthly income. Agencies that contract to provide services at a reduced rate are Madonna Adult Day Services 483-9454, Home Services for Independent Living 441-7501, Interim Health Care 421-7920, and Gentiva Health Services 434-8081. (Call **any** of the above agencies listed for further information or call Lincoln Area Agency on Aging/ Life.)

Rudge Support Services (Lancaster County only)

Rudge Support Services is a program funded by the Rudge Memorial Trust Fund of Tabitha. Its purpose is to provide in-homesupport for individuals who need assistance to continue living independently in their own homes. The program is designed to provide services to a maximum of 20 clients at any one time. A home visit be done for any individual interested in the services to explain the program. Services provided are homemaking, personal care, and heavy cleaning services. All clients admitted the Rudge Support Services Program will be seen by a nurse at least once a month. All fees are assessed on a sliding fee scale. Clients' cost for services will depend upon their monthly income and their ability to pay. (Call Tabitha Case Management at 486-8520 for more information.)

Lincoln Area Agency on Aging/LIFE
1005 "O" St., Ste. 300
Lincoln, NE 68508
(402) 441-7070

LEGAL

Name _____
Attorney _____

Address _____ Phone _____ Fax: _____

Durable Power of Attorney - Financial

Name _____

Address _____

Phone _____ Fax _____

Durable Power of Attorney - Health Care

Name _____

Address _____

Phone _____ Fax _____

Guardian / Conservator

Name _____

Address _____

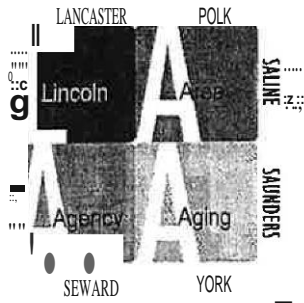
Phone _____ Fax _____

Location of will and advanced directives for health care _____

Do not resuscitate (DNR) Yes No

If yes, location of DNR document _____

The single most important thing you can do to promote clear communication and function effectively as a caregiver is to create and maintain a comprehensive file of information about the person for whom you are caring.



Lincoln Area Agency on Aging/LIFE

LEGAL TERMS FOR CAREGIVERS

It is becoming increasingly clear that elderly people have very specific legal needs. It is also clear that there are some special legal concerns for those who provide care (caregivers) for the elderly. The following is a brief list of some of the terms that elderly people and their caregivers might find useful in working through their special legal needs.

(h) **ALTERNATIVE DECISION-MAKING:** Elderly people are often in need of someone to assist them in making decisions. There are several ways to make someone else the "legal decision-maker" for oneself, including:

- ▶ Guardianship
- ▶ Conservatorship
- ▶ Representative Payeeship
- ▶ Protective Payeeship
- ▶ Durable Power of Attorney
- ▶ Trust Agreements

(h) **GUARDIANSHIP:** This is the most restrictive form of alternative decision-making, requiring a court order. The guardian must report annually to the court. The "ward" (person subject to the guardianship) loses all of his or her rights, and is not considered competent to make any decisions. The person requesting the guardianship must prove by clear and convincing evidence that the proposed ward is not competent.

//:ji **CONSERVATORSHIP:** Much the same as guardianship but restricted to making financial decision-making, i.e., the conservator has complete control over the ward's finances. Not as restrictive as a guardianship, but almost.

//:ji **REPRESENTATIVE PAYEE SHIP:** A representative payee is a person appointed by the Social Security Administration to handle all of the protected person's Social Security affairs. In order to be appointed, a person must file an application with the Social Security office and have medical verification that the protected person is not capable of handling his or her own Social Security matters.

//:ji **PROTECTIVE PAYEE SHIP:** Much the same as the representative payee ship. A protective payee is appointed by the Nebraska Department of Social Services to handle the protected person's state benefits such as Medicaid and Aid to the Aged, Blind, or Disabled (AABD).

//:ji **DURABLE POWER OF ATTORNEY (POA):** A document signed by an individual in which he or she appoints another to serve as his or her agent. It is valid beyond disability or incapacity. A person does not forego any of his or her legal rights by signing a DPOA. The document can be modified or revoked at any time prior to disability or incapacity. It is a very useful document because it allows the "incapacitated" to make his or her own decisions to the extent possible. It also gives the "incapacitated" person a choice in who will serve as the alternate decision maker. A Durable Power of Attorney can be signed only when one is "competent" to do so. It is very important to consider naming an alternate agent in the event that the first agent predeceases the protected person. The document must be notarized. Two witnesses are recommended as well.

- fhi* **SPRINGING DURABLE POWER OF ATTORNEY:** Same as a Durable Power of Attorney except that it becomes effective *upon* disability or incapacity. A definition of disability or incapacity must be included in the document.
- fhi* **TRUST:** A legal entity in itself, capable of owning property. A trust is managed by a trustee for the benefit of another (beneficiary). It is possible to be your trustee. It is sometimes used by people who want to ensure that they will be cared for in later years. Can be a good estate planning tool; however, can be more costly than a will or probate, depending upon the size of the estate involved.
- fii* **LIVING WILL:** A document signed by an individual in which he or she expresses what his or her desires are in the event of a terminal illness or irreversible coma. Living wills have no legal status in Nebraska. However, it is likely that a court would find a living will valid if challenged in a court. In a recent United States Supreme Court case, the court held that a person can refuse medical treatment and nourishment and hydration. The Living Will is very important in that regard because one cannot express his or her desires when in a vegetative state. It should be notarized and witnessed, and can be included in a Durable Power of Attorney.
- fhi* **MEDICAL DURABLE POWER OF ATTORNEY:** Same as a Durable Power of Attorney except specifically designed for medical decision making.

Lincoln Area Agency on Aging/LIFE

1005 "O" St. Ste. 300
Lincoln, NE 68508
(402) 441-7070

END OF LIFE DECISIONS / What Is Hospice?

Hospice offers:

- Choices in medical care after a diagnosis of a life-limiting illness
- Your physician continuing to direct terminal care
- Quality of life & dignity for patients
- Comfort oriented care
- A team approach of doctors, pharmacists, RNs, social workers, chaplains, CNAs
- 24-hour a day/7 days a week symptom management & optimal pain control
- Emotional & spiritual needs addressed for all involved
- Assistance with everyday activities
- Assistance with decision-making process
- Availability of equipment
- Medicare, Medicaid, & most private insurance plans usually cover
- Professionals & trained volunteers focusing on living as fully & completely as possible
- Bereavement service for families after death of their loved one

Hospice also offers you the right:

- To direct the care you receive
- To remain at home with family members
- To services in a nursing home in most cases



When Is It Time For Hospice?

Hospice care is an important step in the final months of a person's life. It requires compassion, emotional support, experience and wisdom in working with terminally ill persons. However, caregivers often find it hard to identify when a loved one is ready for hospice.

If you witness any of the following conditions it may be time for you and the attending physician to consider a hospice evaluation:

- Decline in overall physical/mental status
- Unintended weight loss
- Frequent hospitalizations or ER visits
- Repeat infections
- Profound weakness or fatigue
- Difficulty swallowing
- Shortness of breath or chest pain at rest
- Recurrent edema or swelling
- Continuous oxygen use
- Uncontrolled pain or vomiting

Who is a candidate for hospice services? Someone who:

- Has a life limiting illness
- Is under the care of a doctor
- Chooses comfort care that manages symptoms rather than aggressive treatment focused on a cure
- Requests hospice services

Hospice is not just for cancer patients. The following diseases can also qualify someone for hospice are:

- Heart Disease
- Pulmonary Disease
- Dementia
- Renal Disease
- Liver Disease
- Stroke or Coma
- ALS (Amyotrophic Lateral Sclerosis)
- HIV Disease
- Adult Failure to Thrive Syndrome

(Continued)

What to look for:

- Continued decline in health in spite of treatments
- Multiple hospital stays in the past six months
- New diagnosis following hospitalization or diagnostic evaluation
- Repeat or multiple infections
- Unintentional weight loss
- Changes requiring multiple calls to physician for new medication, laboratory, or treatment orders
- Increased or uncontrolled pain
- Weakness and fatigue
- Shortness of breath
- Difficulty swallowing
- Changes in mental status
- Uncontrolled nausea and vomiting
- Any other uncontrolled symptoms

Thank you to Aseracare Hospice, 1600 S. 70'h Street, Ste. 201, Lincoln, NE for their assistance in creating this Tip Sheet.

END OF LIFE DECISIONS / Final Arrangements

Mortuary of choice _____

Address _____ Phone _____

Burial location _____

Pre-arrangements / personal wishes _____

Memorial/ donation preference(s) _____

There are many things that must be done following a death. Mortuaries are a good resource and can provide detailed information and guidance to help you. A few of the notifications which may be needed are listed below:

- Social Security
- Pension plan
- Insurance-life, medical, long-term care, homeowners, auto)
- Employer
- Title/deed transfer
- Credit cards
- Bank accounts, IRAs, mutual funds, stocks, bonds
- Change beneficiary on spouse's life insurance
- Attorney re: will and other legal issues
- Utilities/service providers
- Mortgage holder
- Health care providers
- Memberships, subscriptions, etc.

COMMUNITY RESOURCES

*To request information about the following,
call LIFE (Lincoln Information for the Elderly)
402-441-7070 or 800-247-0938*

LIFE Guides

- In - Home service providers
- Transportation Options

Housing (for Butler, Fillmore, Lancaster, Polk, Saunders, Saline, Seward & York Counties)

- Retirement Housing
- Assisted Living
- Nursing Homes
- Nursing Homes with Alzheimer's Units

Financial Issues

- Medicaid
- Block Grant
- Division of Assets

Legal Issues

- Power of Attorney
- Wills
- Living Wills
- Guardian and Conservatorship
- LIFE Guide to Legal Services

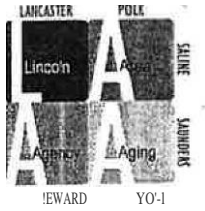
Mental Health Assistance

- Harvest Project (55+ program for mentally ill or substance abuse individuals)
- Psychologists/Counseling

Senior Companion Program

- Day Services
- Emergency Lifeline Unit
- Caregiver Support and Education Group
- Lifetime Health Opportunities
- Living Well Magazine
- Activities for Active Agers
- Geriatric Assessments
- Respite
- Support Groups (see following pages)

***For additional information, refer to the Blue Pages or
the Human SeNices Directory in your local phone book or
answers4families.org/elder-care.***



Lincoln Area Agency on Aging/LIFE

Support Groups in the LIFE Office 8 Counties

Butler County

- Alzheimer's Support Group
Meets the 4th Monday of each month 7:00PM
St. Joseph Villa, 927 N. 7th Street, David City
Contact: Rita Polak #402-367-3363 or Sue Zlomke #402-367-3045
- Cancer Support Group
"H.O.P.E." (Helping Other People With Encouragement)
Meets the 3rd Monday of each month 7:00PM
David City Library
Contact: Geri From #402-542-2307
- Diabetic Support Group
#402-367-1200
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

Illmore County

- Breast Cancer Support Program
"Reach to Recovery"
Contact: Sharon Krejci #402-268-2641
- Cancer Support Program
"Look Good...Feel Better"
Contact: Carolyn Ackerman #402-759-3636
- Caregivers (of older adults) Support Group
Meets the last Thursday of each month at 2:30PM
Pioneer Manor, Geneva
#402-759-3862
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

Lancaster County

There are many meetings available in Lancaster County. Please contact the individual organizations listed below for specific information, or call the LIFE Office #402-441-7070.

- Alzheimer's Association, Great Plains Chapter
#402-420-2540
- Alzheimer's Support Group
#402-483-9417
- American Cancer Society
#402-423-4888
- Caregiver Educational Group
Meets the 4th Tuesday of each month from 2-4:00pm
St. Paul United Methodist Church
1144 M Street, Lower Level, Lincoln
Contact the LIFE Office #402-441-7070
- Caregiver Support Group
Meets the 2nd Thursday of each month from 7-9:00pm
Madonna Rehabilitation Hospital, Nemaha Room
5401 South Street, Lincoln
Contact the LIFE Office at #402-441-7070
- Diabetes Support Groups
BryanLGH Medical Center, Lincoln
#402-481-3055
- Diabetes Support Groups
St. Elizabeth Regional Medical Center
#402-486-7000
- Multiple Sclerosis Support Group, Lincoln
#402-474-5543 or #B00-755-3959
- Parkinson's Support Group
#402-464-5081 or #402-466-1629
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

Polk County

Alzheimer's Support Group
Meets 3rd Monday of each month 7:00PM
Osceola Good Samaritan Center
600 Center Drive, Osceola
Contact: Carmen Braasch or Renae Farmen #402-747-2691

- Cancer Support Group
Midwest Covenant Nursing Home
615 East 9 Street, Stromsburg
- Caregiver Support Group
Meets the second Tuesday of each month at 2:30pm
Midwest Covenant Home, 615 East 9 Street, Stromsburg
Contact Caroline Hopkins #402-747-2211
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

Saline County

- Alzheimer's Support Group
Meets 3rd Tuesday of each month at 3:00pm
Warren Memorial Hospital, Conference Room
905 2nd Street, Friend
Contact: Calli Kohl #402-947-2541, ext. 110
- Cancer Support Group, Crete
#402-826-2886
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

Saunders County

- Alzheimer's Association
#1-888-487-9668
- American Cancer Society
#1-877-232-4787
- Stroke Foundation, Nebraska Chapter
#1-800-484-5678

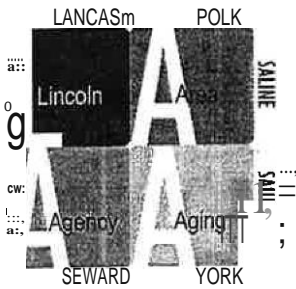
Seward County

Alzheimer's Support Group
Meets 2nd Tuesday at 7:00pm
1245 N. 2nd Street, Faith Lutheran Church
Contact Karen McConnell #402-643-2640

- Breast Cancer Support Program
Reach To Recovery
#402-643-2656
- Look Good...Feel Better
Contact the American Cancer Society _at #1-877-232-4787 to schedule a session.
- Stroke Foundation, Nebraska Chapter
#1.;800-484-5678

York County

- Alzheimer Dementia Support Group
Meets 2nd Tuesday of each month at 7:00pm
Hearthstone, Fireside Room, York
#402-362-4333
 - Arthritis Support Group
York General Hospital
#402-362-0436
 - Breast Cancer Support Group
Look Good...Feel Better
Contact Karrie Otoupal #402-362-0446
 - Cancer Support Group
York General Hospital
#402-362-0446
 - Heart Throbs Support Group (Cardiac Support)
York General Hospital
#402-362-0462
 - Diabetes Support Group
York General Hospital
#402-362-6349
 - Fibromyalgia Chronic Pain
Kilgore Library- York
#402-362-7134
 - Parkinson's Support Group
York General Hospital
#402-362-0440
 - Stroke Foundation, Nebraska Ch.apter
#1-800-484-5678
- Traumatic Brain & Stroke Support
York General Hospital
#402-362-0436



Lincoln Area Agency on Aging/LIFE

Grief Support Groups in Lincoln, Nebraska

AseraCare Hospice

5 week program that will include education on healthy grieving, structured activities, and group participation and sharing. This group is for any adult who has experienced the death of a family member or friend. There is no fee, and the group will be facilitated by a licensed mental health professional. You can register by calling Nancy or Holly at AseraCare hospice, (402) 488-1363

Agigq Services Widowed Person's Service

(402) 441-7028

Cancer Resource Center

Counseling and information. Call Barb Morton, (402) 483-2827

Christ's Place

Adult grief sessions for both members and non-members. Spring and Fall sessions. There is a small fee for book and materials.

(402) 421-1111

1111 Ola Chent; W Place
Lincoln, NE 68512

Community Friends Support Group

Community Friends is a self-help program facilitated by qualified volunteers and professionals. This group, supported by Saint Elizabeth Regional Medical Center, Bryan LGH Medical Center East, Bryan LGH Medical Center West, and Madonna Rehabilitation Hospital, offers support and networking to promote healthy grieving and recovery for those who have experienced the death of a child. These monthly on-going, open-ended meetings are based on working to promote healthy grieving and recovery for those who have experienced process of sharing experiences, seeking information and offering support. Meetings are held at Madonna Rehabilitation Hospital, Flanagan Room the third Thursday evening of each month from 7:00 to 8:30 p.m. There is no fee. Please call (402) 477-0857 for more information.

Dr. Alan Wolfelt Grief Program

A 10-week session that runs periodically throughout the year. No fee for the class, but must pay for the book. For grief education and support associated with the loss of a loved one. Non-denominational.

(402) 483-4126 (Ask for the Pastor)

Our Saviour's Lutheran Church
40th & C Streets
Lincoln, NE 68510

End Of Life Issues

A program for caregivers, includes current issues on end of life situations and sacredness of life.

(402) 474-3600

Grief Recovery Workshop

Sponsored by First-Plymouth Church, 20th & D Street in Lincoln. This workshop is designed to explore the dynamics of grief and recovery from loss and learn how to deal successfully with loss so the sun will once again shine in your life! If you have experienced a loss of any kind consider joining us on Tuesday evenings from 7-8:30 PM starting October 5 November 2 in Classroom A. Course topics include: Staying Open to Grief, Grief Recovery: How Does it Work Confusion About Staying, When Is It Time to Begin to Recover?, Myths About Dealing With Grief Not Knowing What to Say, Participating in Your Own Recovery The cost is \$50 and includes a workbook. The course is led by Becky Walkowiak RN, LMHP and Laurie Reinsch., LMHP, both whom have years of experience leading Grief Recovery Workshops. For information contact Sarah at 476-7550. Limited enrollment.

Grief Resolution Program

Grief care support group for anyone who is grieving death or significant loss. New class begins first Thursday of each month.

(402) 474-36-00

GriefShare

A 12-week small group session. Offered at various times throughout the year. There is a small fee for books.

(402) 483-6512

Lincoln Berean Church

Contact: Mags Bohling

6400 South 70th Street

Lincoln, NE 68516

Growing Through Grief Program

As a 4-week session of dual education and group support offered quarterly. Free to hospice family survivors; a \$50 negotiable fee for others.

(402) 483-7671

(402) 483-1844

Tabitha Care Services

4720 Randolph Street

Lincoln, NE 68510

Growing Through Grief Program

Eight week grief recovery group for adults who have experienced the death of a loved one.

(402) 486-5506

Healing Hearts Catholic Social Services

For widows and widowers. A six-week focused session including education, support, and a memorial mass. Topics include death of a spouse; death of a family member; death of a child.

Call (402) 488-2040 or (402) 489-1834

Helping Ourselves As We Grieve

5 week support group at St. Mark's church.

8550 Pioneers Blvd.

(402) 489-8885

Hospice Bereavement Support - Tabitha

Individual support group for the terminally ill.

(402) 86-8506

4720 Randolph St.

Lincoln NE 68510

Hours: Monday - Friday, 8 am to 5 pm

For children and youth and their families dealing with grief. Families remain in program until they feel ready to leave. The free support group is led by trained volunteers and professionals. A lending library is also available.

(402) 423-1416

Contact: Pam Dinneen

Pen Parents

A correspondence network for bereaved parents. Publishes a newsletter.

P.O. Box 8738

Reno, NV 89507

Ray of Hope

Support group for people who have survived after someone has died from suicide. Meets first and third Mondays of every month at 7 pm.

(402) 483-4126 for the Pastor

Our Saviour's Lutheran Church

49th and "C" Streets

Lincoln, NE 68510

Sharon's Support System

A service offering bereavement counseling and grief education programs.

(402) 473-2822

St. Elizabeth Helping Hearts

The support group offers the bereaved the opportunity to share their loss with others who have experienced similar losses. Helping Hearts allows the support group to journey through grief with the aid of Peer group members, professional grief educators and facilitators. The group meetings are held four times a year from 5:30 p.m. to 7:00 p.m. at the Cherry Hill office building at 245 South 84th, Suite 111. The meetings are closed and there is a fee. For more information, please call 219-7043 or 219-7311

S . Mark's United Methodist Church Grief Support Group

An eight-week education/support series where confidentiality and compassion are present as healing the loss of a loved one takes place. The series is held at St. Maries Church, 8th 550 Pioneers Blvd., Lincoln, NE 20. There is a fee for the book only, open to all, please pre register. For more information Susan Macy at 489-8885.

THEOS (They Help Each Other Spiritually.)

Free support for adults. Meets first Saturday in the McGee parlor. Potluck dinner at 6:15 pm and meeting at 7:00 pm. Open to all.

(402) 466-5218

Warren Umtea Methodist Church

1205 North 45th Street

Lincoln, NE 68503

Widowed Persons Service/Grief Support Services

Grief support for loss of a spouse or partner through death. Call for times and dates. Also provides social activities with other widows/widowers at various locations.

(402) 441-7028

129 N. 10th St., #241

Lincoln NE 68508

Hours: Monday - Friday, 8 am to 4:30 pm

Widower's Breakfast

Gathering for breakfast and sharing.

Contact: Ivan Grams, (402) 488-2661 or the WPS office, (402) 441-7028

Widows' Breakfast

Gathering for breakfast and sharing.

Contact: Hazel Scott, (402) 464-5747 or the WPS office, (402) 441-7028

Widows' Luncheon

Meets the first Thursday of each month at 11:30 a.m.

Call Melzie Rademaker (402) 423-6996 or the WPS office for time, location or more information.

Lincoln Area Agency on Aging/LIFE

1005 "O" St., Ste. 300

Lincoln, NE 68508

(402) 441-7070

Things to Do With Your Loved One at the Nursing Home

- Participate in special activities with her/him; i.e., holiday parties, bingo, cards.
- Go through old photo albums to recall memories and stories from the past.
- Remind her/him of funny things the grandchildren did when they were young.
- Ask questions about her/his childhood or when spouse first met.
- Find humorous or interesting programs on TV to watch with her/him.
- Hang special photos or paintings in her/his room; make large posters with special family and friends' photos labeled with names to help with memory.
- Go to other parts of the nursing home to see what's going on in other areas.
- Sit and visit in lounge areas or go to main lobby where there is always activity.
- Enlarge appropriate e-mail cartoons for a laugh.
- Go out for fresh air whenever weather is pleasant.
- Spend quiet time with her/him; just your presence is a comfort.

TIPS FOR THE LONG-DISTANCE CAREGIVER

- **Gather information.** Determine with your loved one (and other family members) what help they need. Look for community services that help. You can get information over the phone and the Internet. the Eldercare Locator (800-677-1116) can tell you which local agencies provide services and will refer you to the Area Agency on Aging in your loved ones' community.
- **Be prepared.** Before a crisis occurs, work with your loved one to collect the necessary medical, financial, and legal information. All family caregivers should have a copy of their loved one's doctors and medications, insurance information, assets, Social Security numbers. Perhaps you can keep a copy of their local phone book on hand, just in case.
- **Make an appointment with their doctor.** During a visit to your loved one, take time to go to their doctor with them to introduce yourself, ask questions, and learn about their healthcare needs (medications, diet restrictions, etc). Write out a list of questions you have and bring it with you to the appointment. If there is a local family caregiver, be sure to ask for their input in planning for this visit. Avoid "too many cooks in the kitchen" when working with physicians.
- **Make a list.** Identify family, friends, clergy, and others who might help. On your next visit, introduce yourself to neighbors and friends and keep their phone numbers and addresses. If you can't reach your loved one, calling these people can ease your mind. They may also be able to help with some needed tasks.
- **Assess the situation.** When you visit your loved one, look for health or safety problems. Professional consultants are available to help older people and family members decide when all older adult needs assistance. Involve your loved one in the assessment of their needs.
- **Offer to assist with bills, paperwork, etc.** You can still help across the miles! Give your loved one a large brown envelope, addressed to you. Tell them to put all bills, paperwork, and anything else they may need help with in the envelope and then put it in the mail. You can work on these documents from your own home. Some caregivers encourage their loved one to do this on a monthly basis.
- **Be sensitive to your loved ones' views.** Your loved one may still be able to be independent and in control. Explain that the services will help them remain independent. Explain how the services work. Sometimes it's helpful to have someone your loved ones respect recommend the service.
- **Family Conferencing** is a wonderful tool to keep everyone "in the loop" on your loved one's situation. Conferencing can be done through the telephone (three-way calling or a conference call feature) or Internet (Instant messaging or Conference call feature).
- **Provide a break,** when you visit, for the on-the-scene members of your team if they are involved with direct care or supervision.
- **Take care of your own needs.** Learn and use coping skills, get support or counseling, and take time for yourself. Accept that it's impossible to be everything to everyone. Ask for help when you need it. Give yourself credit for doing the best you can.

ELDE Senior Side Series

ng

- 19. The Age of Opportunity
- 143. Older People- Do We Really Know Them?
- 0 165. Changes of an Aging Nation

Alcoholism

- 0 72. Older People Prime Targets for Alcoholism

Caregiving

- 0 14. Sandwiched in the Middle
- 0 45. Seniors Value Independence and Control
- 0 47. Day Care for Adults
- 0 182. Planning Ahead Can Reduce Struggles When An Older Parent Needs Care

Eyes - Ears

- 0 30 Eye Exams - Best Defense Against Glaucoma
- 0 31. Speak up Please, I Can't Hear You
- 0 34. Cataract Surgery Restores Vision
- 0 66. Tinnitus--A Noisy Problem
- 0 73. Presbyopia - If You're Over 40, You've Got It
- 0 108. Eye Exams Can Detect Macular Degeneration
- 0 136. Changing Vision Need Not Hamper Lifestyle

Elderly in the Work Force

- 0 55. Older People Opt for Second Careers

Jd

- 0 28. Elderly Often Targets of Medical Fraud
- 0 75. The Elderly Often Victims of Crime

Grief

- 0 17. Coping With the Loss of a Loved One
- 0 87. Sharing Feelings Can Ease The Grieving Process

Health and Safety

- 0 1. Don't Take It Easy- Exercise
- 0 6. Don't Put Yourself at Risk - Get a Flu Shot
- 0 8. Think Twice Before Shoveling Snow
- 0 9. Tainted Food Can Spoil the Holidays
- 0 10. Fire Hazards in the Home
- 0 11. Avoiding Slips, Trips and Falls
- 0 18. Safeguard Your Teeth
- 0 20. Living with Physical Disabilities
- 0 21. Pets Provide More Than Companionship
- 0 23. Warding off Shingles
- 0 26. Battling High Blood Pressure
- 0 37. Annual Exams Best Guard Against Cancer
- 0 39. Protect Your Skin, Avoid the Sun
- 0 40. Choice of Doctor Determines Care
- 0 41. Prostate Problems Plague Older Men
- 0 42. Appendicitis Risky for Seniors
- 0 43. Few Extra Pounds May Benefit Seniors
- 0 44. Gallstones May Not Need Surgery
- 0 46. Mammograms Help Detect Breast Cancer
- 0 48. Protect Your Future - Prevent A Stroke
- 0 49. Polio Survivors Go Second Round
- 0 51. You're Never Too Old to Stop Smoking
- 0 53. Aching Backs Can Cramp Your Style
- 0 54. Shaking Leg Pain
- 0 59. Living with Parkinson's Disease

- 0 60. Pneumonia Can Be Life Threatening
- 0 61. Promote Good Health - Wear a Safety Belt
- 0 65. Breaking the Cigarette Habit
- 0 67. Magic Potion Slows Aging
- 0 71. Dizziness Can Signal Medical Problems
- 0 74. How to Crime Proof Your Home
- 0 76. Hip Fractures Dangerous for the Elderly Problem
- 0 84. Treating and Preventing Bursitis
- 0 86. Protect Yourself From Lyme Disease
- 0 90. What to do When it Hurts to Sit
- 0 91. When Grandchildren Visit, Childproof Your Home
- 0 92. Preventing Tired, Aching Feet
- 0 102. When Heartburn Strikes, Hiatal Hernia maybe Culprit
- 0 115. Seek Treatment for Chronic Pain
- 0 120. Constipation Often Plagues Older People
- 0 121. Managing an Embarrassing (Incontinence)
- 0 126. Making Holiday Shopping Fun
- 0 127. Home Test Kits May Cause More Harm Than Good
- 0 128. Preventing Falls Enhances Independence
- 0 131. Varicose Veins Plague Many Older Adults
- 0 135. Your Health is in Your Hands
- 0 139. Hot Weather and Older People Don't Mix
- 0 141. Cavities Aren't Just Kid Stuff
- 0 142. Autumn Ushers in Allergy Season
- 0 144. An Aging Heart Can Still be Healthy
- 0 146. Hair Loss Plagues Many Older People
- 0 147. Nosebleeds Can be Serious in Older People
- 0 150. New Hips for the Old
- 0 152. As Autumn Approaches, So Does the Time to Get a Flu Shot
- 0 157. The Little Pebble That Hurts
- 0 158. Humidifiers Can Ease Symptoms of a Cold
- 0 161. New Option for Patients Facing Bladder Surgery
- 0 162. Sun Exposure Causes More Than Burns and Skin Cancer
- 0 164. Should You Take Estrogen?
- 0 170. Oral Dryness Can Be a Sticky Problem
- 0 172. Fry **Now**, Pay Later
- 0 173. Sunburn Causes Devastating Effects on Older Skin
- 0 174. Winning the Battle Against Stress
- 0 176. Curing Hiccups Sometimes Takes More than a Glass of Water
- 0 177. The "Yips" Can Ruin a Perfect Golf Game
- 0 178. Keep Grandkids Safe - Poison Proof Your Home
- 0 179. Protect Your Eyes When Out in the Sun
- 0 62. Alzheimer's or Just Plain Forgetfulness?
- 0 63. Diagnosing Alzheimer's Disease
- 0 64. Caring For a Relative with Alzheimer's
- 0 69. Coping with AIDS
- 0 77. Nasal Polyps Usually Only a Nuisance
- 0 78. Aneurysms Possible in Older Folks
- 0 105. Prostate Cancer Often a Silent Killer
- 0 109. Learn the Early Warning Signs of Cancer
- 0 118. Older People are Most Likely to Develop Diabetes
- 0 134. Vague Symptoms Sometimes Signal Thyroid Disease
- 0 148. Curing Heart Problems with a Pacemaker
- 0 153. Burning Stomach Pain May signal an Ulcer

- 155. Early Medical Advice Can Prevent Disabling Arthritis
- 163. Compensating for Congestive Heart Failure
- 180. Fighting Off Those Blasted Cold Sores
- 181. When Anxiety Prevails, Your Doctor Can Help

Spice

- 93. Hospice Care for the Terminally Ill

Insurance - Medicare - Finances

- 50. Sign Up Early for Medicare
- 89. Building a Credit History important for Women
- 133. Organizing Financial Information
- 166. Access to Medical Care a Problem for Many Seniors

Legal Documents

- 38. Writing a Will
- 112. More Seniors Write Living Wills
- 113. Living Wills Safeguard Your Interests
- 160. New Law Requires Advance Directives

Medications - Drugs - Alcoholism

- 27. Understanding the Medicines You Take
- 171. Heat, Light and Humidity Can Make Medicines Toxic

Mental, Emotional, Cognitive

- 35. Seniors Often Target for the Blues
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- 68. Driving Refresher Course Good Bet for Seniors
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- 79. Snoring is not a Hopeless Problem
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- 137. The Healing Power of Pets
- 151. Television and Catalog Shopping Easy for Seniors
- 154. Who Will Take Care of MyPet?
- 167. The Resurgence of Home Health Care Aids Elderly

Please send the Senior Sides to:

Name _____

Home Address _____

City/State/Zip _____

Home Phone _____

Work Phone _____

Please mail this form to:



Lincoln Information for the Elderly
 1005 O Street, Suite 300
 Lincoln, NE 68508-3628

Question or concerns? Call us at 441-7070

101 Things To Do With Someone Who Has Alzheimer's

Daily activities for people with AD tend to change as the disease progresses. Alzheimer's disease tends to limit concentration and cause difficulties in following directions. These factors can turn simple activities into daily challenges. Individuals with AD often don't start or plan activities on their own. When they do, they may have trouble organizing and carrying out the activity. Many caregivers state that the individual often sits in one area of the room, paces the floor, or searches for familiar objects with little interest in doing the things that ad once brought meaning and pleasure to life. By using a variety of activities matched to the person's abilities, the caregiver can help the family member enjoy his current level of skill or talent, as well as retain his sense of positive self-esteem. Here are some ideas to help pass the time throughout the year.

<ol style="list-style-type: none"> 1. Clip coupons 2. Sort poker chips 3. Count tickets 4. Rake leaves 5. Use the carpet sweeper 6. Read out loud 7. Bake cookies 6. Look up names in the phone book 9. Read the daily newspaper out loud 11. Listen to polka music 12. Plant seeds indoors or out 13. Look at family photographs 14. Toss a ball 15. Color pictures 16. Make homemade lemonade 17. Wipe off the table 18. Weed the flower bed 19. Make cream cheese mints 20. Have a spelling bee 21. Read the <i>Reader's Digest</i> out loud 22. Fold clothes 23. Have a calm pet in to visit 24. Cut pictures out of greeting cards 25. Wash silverware 26. Bake homemade bread 27. Count tickets 28. Sing Christmas carols 29. Say "Tell me more" when they start talking about a memory 30. Put silverware away 31. Make a Valentine collage 32. Play favorite songs and sing together 33. Take a ride 34. Make a cherry pie 35. Read aloud from labels 36. Dye Easter eggs 	<ol style="list-style-type: none"> 37. Make a basket of socks 38. Take a walk 39. Reminisce about the first day of school 40. String Cheerios to hang outside for the birds 41. Make a fresh fruit salad 42. Sweep the patio 43. Color paper shamrocks green 44. Fold towels that have been just warmed in the dryer. When finished, place them back in the dryer for 5 more minutes and then fold them again. 45. Have afternoon tea 46. Remember great inventions 47. Play "Pictionary" 48. Paint a sheet 49. Cut out paper dolls 50. Identify states and capitols 51. Make a family tree poster 52. Color a picture of our flag 53. Cook hot dogs outside 54. Grow magic rocks 55. Water house plants 56. Reminisce about the first kiss 57. Play horse shoes 58. Dance 59. Sing favorite hymns 60. Make homemade ice cream 61. Force bulbs for winter blooming 62. Make Christmas cards 63. Sort playing card by their color 64. Write a letter to a family member 65. Dress in red on a football Saturday 66. Pop popcorn 67. Name the presidents 	<ol style="list-style-type: none"> 68. Give a manicure 69. Make paper butterflies 70. Plant a tree 71. Make a May basket 72. Make homemade applesauce 73. Finish famous sayings 74. Feed the ducks 75. Mold with Play Dough 76. Look at pictures in a National Geographic 77. Put a simple puzzle together 78. Sand wood 79. Rub in pleasant-scented hand lotion 80. Decorate paper place mats 81. Arrange fresh flowers 82. Remember famous people 83. Straighten underwear drawers 84. Finish nursery rhymes 85. Make peanut butter sandwiches 86. Wipe off patio furniture 87. Cut up used paper for scratch paper 88. Take care of a fish tank 89. Trace and cut out leaves 90. Ask simple questions 91. Finish Bible quotes 92. Paint with string 93. Cut out pictures from magazines 94. Read classic short stories 95. Put coins into a jar 96. Sew sewing cards 97. Put bird feed out for the birds 96. Clean out a pumpkin 99. Reminisce about a favorite summer 100. Roll yarn into a ball 101. Make a birthday cake
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For further information about Alzheimer's disease or related disorders, contact the Alzheimer's Association at: Great Plains Area Chapter, 402-420-2540 or 1-800-272-3900 www.alzgreatplains.org

COMMUNICATING EFFECTIVELY WITH PERSONS WITH HEARING LOSS

- Face the person to whom you are speaking.
- Be sure to have their attention.
- Speak in a normal voice - don't shout.
- Choose a quiet area, with good light on your face.
- Speak clearly, at a moderate pace.
- Do not hide your mouth, chew food or gum.
- Rephrase if you are not understood.
- Give clues when changing the subject.
- Talk to them, not about them.
- Be patient, positive and relaxed.

NEW HAMPSHIRE



New Hampshire Family Caregiver Support Program

PARTICIPANT GUIDE FOR CONSUMER-DIRECTED SERVICES



This is a handy reference guide for things you need to know about managing a consumer directed budget and family managed employees.

With thanks to the team who worked together to develop the processes outlined in this guide. Their wholehearted commitment to provide comprehensive supports to family caregivers in a consumer directed model is exemplary.

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Chapter 1 - Introduction

Welcome to consumer directed services for family caregivers through the NH Family Caregiver Support Program. Before you begin using consumer directed services, there are some things you need to know. This Participant Guide is designed to give you answers to your questions and basic information to get you started. Make sure that you read this Guide thoroughly.

The consumer directed services made available through the NH Family Caregiver Support Program are designed to give caregivers more control over how they receive respite and other services.

Since this type of service may be new to you, there may be some terms, words and guidelines that you may not be familiar with. The first things we will go over are some of the terms and definitions.

Useful Definitions

Assessment – Face to face meetings between you and the Caregiver Specialist from the ServiceLink Resource Center for the purpose of assessing your caregiving situation and to assist in identifying services, local resources, equipment, home modifications and trainings that will allow you to augment your ability to continue to provide care for another individual. The assessment will be scheduled after the referral at your convenience and again at the end of the year to evaluate the project's effectiveness.

Budget Worksheet and Spending Plan – Family caregivers eligible for services under the NH Family Caregiver Support Program will have funds set aside for services. You will work with a Caregiver Specialist to complete a budget worksheet and spending plan based on the amount of respite and other supplemental services you may require. An authorized staff member at ServiceLink approves the budget and spending plan for services. A cap on the dollar amount for services is applied. The spending plan assists the family caregiver to spend the funds accurately and on a time schedule so as not to have the funding returned to the NH Caregiver Support Program.

Caregiver Specialist – The Caregiver Specialist is an employee of the ServiceLink Aging and Disability Resource Center. Their role is to help guide you through the process, provide you with enough information to make informed decisions about local services and resources available to you, and offer assistance should you need it. They will periodically check in with you and serve as an important contact for you should you have questions.

Consumer Direction or Consumer Directed Services – Consumer Direction refers to an approach where individuals, such as yourself, manage your own support services. You will have the opportunity, with assistance from the Caregiver Specialist to assess your own caregiving needs, decide how your needs are to be met, and monitor the quality of the services you receive.

Family Managed Employee – A Family Managed Employee is an individual recruited, trained and managed by you, the family caregiver or your representative. The Financial Management Services agency serves as the “Employer of Record” and hires this Family Managed employee.

Financial Management Services, “Agency with Choice” model – Gateways Community Services is the agency that the Bureau of Elderly and Adult Services has contracted with to handle the financial and personnel matters for NH Family Caregiver Support Program participants who are eligible for and receiving consumer directed services. They provide bill payer services to pay for invoices you submit to them under the guidelines of the NH Family Caregiver Support Program consumer directed services and acts as an “employer of record” should you choose an individual not associated with an agency as a service provider.

Participant – A participant in the program is an informal, unpaid family caregiver (you) who meets the eligibility requirements of the NH Family Caregiver Support Program for funded respite services.

Person-Centered Planning - Person centered planning is a service philosophy that emphasizes an individual’s personal preferences balanced against their need. Consumer directed services are an outcome of person centered planning.

Provider – A person or agency who/that provides respite and other services for a fee. This could include: Family Managed Employees (see definition above) or an agency worker.

Respite Services – Services provided to the individual you are caring for to allow you, the family caregiver, to take a break from your caregiving responsibilities. These services may include companion care, personal care assistance, homemaker services, adult day programs or a temporary stay in a facility. It is important to note that these services are for you and should provide you with a period of rest or relief from caregiving.

Representative – An authorized representative is a person designated by you, the family caregiver, to assist you in managing some or all of the requirements of the program. This person acting as your representative **cannot** be paid to provide this assistance.

Supplemental Services – These are goods and/or services that complement the care that you are providing. These services could include: chore services (such as heavy house work/spring cleaning, yard work, snowplowing), health related consumable supplies (such as incontinence supplies), home safety repairs or modifications (that assist you in providing care, and/or aids with mobility), transportation (such as cost of a driver or funds for gas to and from an adult day program and medical appointments), adaptive or assistive equipment (a device or equipment to maintain or improve the functional capabilities of individuals with disabilities) or emergency response system (such as Lifeline™ or other related service). There are limited funds and multiple rules for using supplemental funds. Your Caregiver Specialist will answer any questions you have about this.



The consumer directed services that are part of the *NH Family Caregiver Support Program* are designed so that you will have maximum control over the services you receive, while adhering to the requirements of the program to meet funding obligations. You will have two types of agencies providing you with assistance along the way. The two types of agencies are the ServiceLink Aging and Disability Resource Center and Gateways Community Services, which provides the Financial Management Service. The roles they will fill in assisting you are as follows:

ServiceLink Caregiver Specialist (and other ServiceLink staff) will assist you in:

- Assessing your own needs
- Planning what services you could benefit from and helping you locate them
- Completing your Budget Worksheet and Spending Plan as well as providing guidance on how much help you need, who might help you, and how much to pay them
- Monitoring your program by regular or periodic contact with you

Gateways Community Services will help you:

- Keep an “account” for you so you can track how much you are spending out of your budget.
- Make payments to your providers based on your instructions and approved Budget Worksheet.
- Inform you of procedures for payment requests for goods and services.
- Review and submit payment for items or services that you purchase based on your approved Budget Worksheet.
- Provide you with a monthly statement so that you can track how you are spending your budget and also to ensure that Gateways is handling your budget appropriately and accurately.
- Act as a co-employer of Family Managed Employees:
 - Conduct Criminal Background checks on all likely individual respite or service providers should you choose one as a Family Managed employee. (Home care and other agencies are required to do these checks on their staff.)
 - Inform you of the procedures and forms to be used when reporting the hours worked by your Family Managed Employee (time sheets).
 - Review the timesheets you submit to ensure that they agree with your approved Budget Worksheet.
 - Handle personnel activities for individuals who act as Family Managed Employees such as: withholding of taxes, providing worker’s compensation liability insurance and other wage related functions.

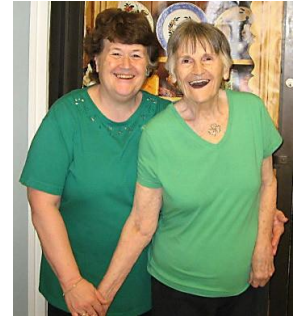


Participant Rights and Responsibilities

The following is a list of your rights and responsibilities as a participant.

You have the right to:

- Be treated with dignity and respect at all times
- Privacy in all interactions with ServiceLink, Gateways and others as necessary and be free from unnecessary intrusion
- Make informed choices based upon appropriate information provided to you, and to have those choices respected, while respecting the rights of others to disagree with those choices
- Freely choose between providers for both respite and supplemental services
- Voluntarily withdraw from the program at any time
- Ask questions until you understand
- Manage respite and other providers by:
 - Deciding whom to hire (if an individual not employed by an agency)
 - Deciding what special knowledge or skills the individual provider must possess
 - Training the provider to meet your individual needs
 - Scheduling the work hours
 - Replacing providers, either an individual or an agency who do not meet your needs
- Change your Spending Plan and/or Budget Worksheet as your needs or goals change (however, you do need to contact your Caregiver Specialist with changes)
- Receive monthly statements showing how you have spent your budget
- You have the right to contact Gateways to request your current balance.



You have the responsibility to:

- Manage your budget and expenditures. This means if you spend more than your budget you will be responsible for these expenses.
- Follow through on your Spending Plan
- Have the skills and abilities needed to self-direct providers without jeopardizing your health and safety, or designate a representative to assist you.
 - Act as a supervising employer (if you choose an individual as your respite provider) by:
 - Deciding wages for your workers (that are not less than the minimum determined by Gateways)
 - Taking part in the orientation of your prospective worker, coming up with a job description and learning about what it is to be a “supervising employer”
 - Following all requirements of Gateways Community Services as the Financial Management Services agency in regards to completing all necessary forms, reviewing time sheets for accuracy and submitting them in a timely manner.



Chapter 2 Individual Budget and Spending Plan

What is my Budget and How is it Determined?

Your budget is the amount of funds you have available to you to purchase respite care and other services that help you in providing care. Your budget is determined on a case by case basis taking into consideration other resources you have for respite services such as having family member and friends who regularly help out or means to purchase respite services.

The Caregiver Specialist will guide you in filling out your Budget Worksheet and Spending Plan.

Your Caregiver Specialist completes an assessment of your needs during your first meeting. He/she will ask you questions about your situation to help determine what local resources may be of benefit to you in your caregiving role. They will ask you about the care recipient's need for assistance with bathing, dressing and using the bathroom or if they have been diagnosed with Alzheimer's disease or other type of dementia.

Your ServiceLink Caregiver Specialist will review the assessment to figure out and make recommendations on local resources and services that may assist you and will also assist you and the Caregiver Specialist in filling out your Budget Worksheet and Spending Plan.

You will use the Budget Worksheet to detail how you intend to spend your budget amount to meet your respite care and other related needs. When you fill out the Budget Worksheet you need to keep in mind that every purchase that you make must be based on your Budget Worksheet or it will not be paid for by Gateways Community Services. Refer to guidelines below on what you can and cannot spend your budget on.

Once you complete your Budget Worksheet, your ServiceLink Caregiver Specialist will review it to ensure that it meets program requirements. Once it is approved, a copy of the Budget Worksheet will be given to you, a copy will be maintained at the ServiceLink site and a copy of the Budget Worksheet (only) will be sent to Gateways Community Services. All invoices and receipts you submit to them for payment will be checked against your planned budget.

The Spending Plan is more detail focused. When your ServiceLink Caregiver Specialist gets your Budget approved, s/he will then make a Spending Plan with you. Your spending plan will note what type of grant you received, how much, and the details of how you will spend that such as Adult Day Care 1x per week for 6 months at \$X per day, totaling X amount of dollars. Both you and ServiceLink will have a copy of this. This ensures that you are spending the grant funding as planned.

If your situation changes and you need to make changes in your Budget Worksheet or your Spending Plan, contact your ServiceLink Caregiver Specialist so a revised budget and



plan can be drawn up. A budget will not be revised without a spending plan securely in place. A copy of the revised Budget Worksheet and the Spending Plan will be approved by the Caregiver Specialist and sent to Gateways. It is important that a revised budget is approved and sent in to Gateways. Not doing this could impact whether or not the services will be paid for. Budget increases are only available if funds are.

Please keep in mind that the respite and supplemental services funds in your NH Family Caregiver budget are not intended to pay for all care and services. It is intended as a supplement to your own and other local resources.

Budget Responsibilities

You have several responsibilities for using your NH Family Caregiver Support budget. These include:

- Filling out a Budget Worksheet that is approved by the ServiceLink site.
- Establish a plan for spending allocated funds
- Making purchases that are consistent with your Budget Worksheet and Spending Plan
- Providing Gateways with documentation such as: invoices, receipts and/or timesheets to support payment requests
- Keeping track of what you are spending, including hours provided by your worker, so you do not overspend your budget
- Updating your Budget Worksheet and Spending Plan when your needs change

Let's discuss each of these responsibilities.

Note: The funds in your budget are available until specified end of allocation cycle. The funds do not roll over beyond that date. Your Caregiver Specialist will inform you of the dates.

Filling out the Budget Worksheet and Spending Plan

Your Budget Worksheet and Spending Plan serve several purposes.

1. They describe how you plan to spend your services budget.
2. Filling out the Budget Worksheet will ensure that you understand how much money you have to spend.
3. It provides Gateways Community Services with authorization to fulfill your payment requests.
4. Purchasing only what is on your Spending Plan will prevent you from overspending
5. The Spending Plan gives your ServiceLink staff an understanding of how your respite needs and other service needs will be met.

If you are purchasing goods or services directly from a vendor or store, try to shop around to get the best price. Also check to see if the vendor is willing to be paid with a check from Gateways.

Work with your Caregiver Specialist to develop your Budget Worksheet and spending plan and make sure he/she reviews it with you before you are ready to submit it for approval.



While reviewing your Budget Worksheet, your Caregiver Specialist will check to make sure it conforms to the NH Family Caregiver Support Program guidelines. He/she may ask you questions in order to get a better understanding of your plans. Your Caregiver Specialist will tell you if your plans for using the budget do not agree with NH Family Caregiver Support Program guidelines.

You and the caregiver specialist will sign the completed budget and spending plan. The ServiceLink manager (or designee) will sign the budget for approval. You and your Caregiver Specialist will get a copy of the signed original for your file and a copy will also be sent to Gateways.

Making Purchases Consistent with Your Budget

Since your providers' invoices will go to you, it is your responsibility to fill out the check request form and submit it to Gateways for timely payment. You have no more than 60 days to submit your invoices for payment to Gateways upon receiving them. Invoices submitted after that date will not be paid and will become your responsibility.

If you are having difficulty managing the invoices and payments talk to your Caregiver Specialist. They may suggest you consider having an authorized representative help you with that part of the program.

Keep Track of Your Budget and Spending Plan

Gateways will send you a monthly statement that lists what was allocated on your budget worksheet, your expenses to date and the balance of funds in your account. The statement will be mailed to you. Please keep in mind that invoices that were sent in after the monthly statement was run will not be reflected in your expenses to date.

- **You must** keep track of your spending so you do not overspend. Any expenditure outside of your budget will be your responsibility
- **When You Need to Make Changes to Your Spending Plan** Contact your Caregiver Specialist to discuss the new plan and make sure it is compliant.
- **When You Need to Make Changes to Your Budget** You can purchase only what you wrote down on your Budget Worksheet. However, changing needs may prompt you to alter how you use your funds.

You DO NOT need to Update your Budget Worksheet if:

The new services you are using are still within the respite or supplemental services categories. For instance, the individual you are caring for is no longer able to attend adult day and you find in-home respite would be more appropriate. You switch services. Adult day and in-home respite are both in the respite fund category. Therefore you do not need to submit a new budget worksheet. You will need to update your spending plan.



You *DO NEED* to Update your Budget Worksheet if:

You want to move funds between what you had originally allocated for respite and supplemental services. For instance, you had funds in your budget for yard work under Supplemental Services; however, you find you have a greater need for additional respite. You will need to fill out a revised Budget Worksheet moving the funds into the respite category and have it approved by your ServiceLink Caregiver Specialist. Call ServiceLink if you need a blank Budget Worksheet form. You should also update your spending plan.

Determining Your Needs

The NH Family Caregiver Support Program allows you to decide what types of eligible services and purchases will best meet your respite care needs. Before you actually complete your spending plan, you will need to decide the best use of allocated funds to best meet your respite care needs. Spend some time thinking about what is most important to you and what you are currently getting help with now. Think about what things would make it easier for you to provide continued care. This information will help you when you fill out your Spending Plan and Budget. If you need some guidance with filling out the Spending Plan or Budget feel free to contact your Caregiver Specialist at ServiceLink.

Remember that the first priority (and major part) of NH Family Caregiver Support is that you have control and choice over who provides you with help, when, and how they provide it. So the first thing that needs to be done is to figure out how much help you want, what you want the help with, when you want the help and how much do you want to pay for the help. Your answers to these questions will determine how you write your budget.

Important to Consider: *Think about arranging back-up coverage. Do you have a backup plan for emergencies?*

The help in terms of goods and services available through NH Caregiver Support can be broken down into two main areas: Respite Care and Supplemental Services.



Respite Care

Respite care services are intended to provide you with a break from your day-to-day caregiving responsibilities so that you can get out for a while, meet with friends, engage in activities you used to enjoy and take some time for yourself and your personal well-being.

***NHFCSP respite does not offer payment or coverage so the caregiver can work.**

Respite services can be in the form of companion care (someone to stay with the individual you provide care for), in-home respite care (an individual or an employee of a home care agency who will attend to the needs of the person you care for), an adult day program, or a short term respite stay (for a few days) in a residential facility. The goal is to give you a chance to “recharge your batteries.” The respite services you choose can be provided by an agency or a Family Managed Employee.

Supplemental Services

Supplemental services are services or goods other than respite that help you provide continued care. These services can include “chore services” (such as house cleaning or spring cleaning - the big stuff, yard work such as raking leaves or shoveling snow); transportation (such as transport or gas expense to and from an adult day program or medical appointments); consumables – nutritional supplements (such as Ensure) or incontinence supplies (such as attends, creams and powders related to incontinence); assistive or adaptive equipment (assistive devices such as a Pocket Talker Pro® to aid in communicating with the care recipient who has hearing difficulties, other devices that aid in mobility or accessibility); emergency response systems such as LifeLine®; home modifications or safety repairs (such as modifications to the bathroom, for example grab bars or raised toilets, and home repairs for safety reasons such as repairs to stairs or walkways that pose a risk of tripping or falling).

Figuring out your budget may take some trial and error to determine exactly what the right way to go is. So think of different ways that you can get things done before filling out your Budget Worksheet and Spending Plan. Please be aware that you can change your budget as different needs or situations arise.



In Home Respite Providers – Family Managed Employee or Contracting with an Agency?

Having someone come into your home to care for a loved one requires thought and planning. Here are some issues and ideas to consider.

Contracting with an Agency

There are many in-home care agencies that provide respite services, companion care, home health aides and homemaker services. You may find that working with an agency is more costly than employing an individual; however, an agency offers several advantages. Among the advantages is the assurance that your loved one will be cared for by a trained individual. Emergency coverage is also available if the employee becomes ill.

If you decide to contract with an agency, inquire about its accreditation and/or audit. Ask the state licensing body if the agency has any serious deficiencies. You might want to request references from the agency. It is also helpful to provide a job description that outlines the kind of care and assistance that is needed.

Using an Individual as a Respite Provider/Worker – “Family Managed Employee”

You may choose to use an individual as a respite provider rather than contracting with an agency. That individual can be a family member (living in another household), a friend, a neighbor or an individual you recruit (see how to recruit a worker in the next section). But, in order to do so that individual will need to be formally hired under Gateways as the “employer of record,” and you will take on the role as the managing supervisor of that individual. You will in fact be co-employers. That means that Gateways will provide the staff intake, orientation and typical employer functions of providing the job application, background checks, payroll processing, and liability coverage, while you train and supervise the individual’s work. It is a shared role designed to relieve you of having to tackle payroll, workman’s compensation and tax withholding.

If you already know the individual you want to use as your respite provider, work with your ServiceLink Caregiver Specialist to set up an appointment with Gateways’ Regional Agent to meet with the individual to get them started in the hiring process. The Regional Agent will have them fill out an application and all applicable forms. The individual will need to show proof of identification and citizenship. The Gateways Regional Agent will orient them on the payroll process and show them two training videos. Once the background checks are complete and you receive the okay, you are ready to start using them as a provider.

- It is very important that you follow-up with your staff being hired to ensure that they meet their obligations in the new hire process (such as keeping scheduled intake appts and submitting needed information to Gateways in a timely manner).



Chapter 3 - Family Managed Employees

Note: *This section is only applicable if you choose to hire an individual as a respite care provider rather than paying for services from a home care agency.*

Finding Respite Care Providers

Remember you can hire anyone you choose; the individual does not need any special training or license (unless you want them to have that.) A provider CAN be a family member (except a spouse or another individual living in the same household), if you feel more comfortable hiring a family member. If you don't have anyone in particular in mind to hire then you will need to find someone, and there are several ways to go about doing that.

You could use the old stand-by, word of mouth. Let people know you are looking to hire someone to help you. Many times a friend of a friend is looking for work, and usually a friend would not recommend someone to you unless they would be a good worker. You can also develop an advertisement or flyer and post it in the community (see the Guide for sample ads). Places you could post ads include bulletin boards at local markets, senior centers, libraries, colleges, etc. You could also place an ad in a local or regional newspaper, but this would cost you money (remember that you can put aside funds in your spending plan to cover the cost of advertising for your respite care provider). You can also ask your ServiceLink Caregiver Specialist for ideas.

This section provides information, helpful hints and suggestions on recruiting a respite provider/worker. The topics covered in this section include: recruitment, interviewing a worker, reference checks and selecting the worker.

Advertising

There are both paid and free advertising options available to you. Regardless of the type of advertising you choose or where you advertise, there are some basic guidelines to keep in mind:

- Give clear job expectations and candidate requirements
- Emphasize important details and worker characteristics
- Be honest, realistic, and make no vague promises
- Comply with state and federal laws on discrimination (this means you cannot state in an ad that you need someone to be Catholic or Jewish, male or female, or black or white).
- Protect your privacy! (It is not a good idea to list your address or full name. Instead, use just your first name and phone number.)

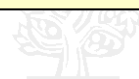
Sample Ads

IN-HOME RESPITE PROVIDER

Individual needed to provide respite care for older adult and assist primary caregiver in a variety of needs. Flexible schedule. HS or GED, clean driver's license, and reliable transportation are required. This position is located in Plymouth. Call.....

HOME HELPER WANTED

Dependable person to do housework, grocery shopping and prepare light meals for older adult. Mornings, M,W,F. References required. Phone.....



Telephone Screening

Screen all applicants over the telephone and take notes on each. This is your chance to screen applicants and decide whom you should meet in person to interview. The screening should involve three general steps:

1. Inform the Caller

- a. Let the candidate know the hours you will need someone to work.
- b. Let the candidate know the general location of the house but do not give out the address (protect your privacy!)
- c. Outline the tasks to be done and any requirements. This might include someone who can drive or lift a specific amount of weight.

2. Ask Questions

It is a good idea to ask applicants questions, whether they are your own or some suggested ones below. Listen carefully to their responses and take notes. You might get a sense of their attitude and personality. Note: See chart below for important do's and don'ts of interview questions.

- a. Are you 18 or older? (they must be 18 or older to be hired)
- b. What experience do you have? Have you been in a similar position?
- c. If so, where did you work, how long did you work there, and what did you do?
- d. What days and hours are you available to work?
- e. Can you perform all the duties that I have outlined?
- f. Do you have transportation to get you to the job?
- g. Have you ever been convicted of a crime?
- h. If you are hired, when could you start?
- i. What is your wage expectation?

Conclude with thanks. Each caller should be informed that you are still taking calls for the position. If you are interested in the applicant, indicate that you will call back in a few days to set up an interview.

3. Select Applicants and Arrange for Face-to-Face Interviews

You should only select people that sound extremely good to you for a formal interview. Make sure to write down the person's name and phone number in case you need to contact them again before the interview.

- a. Arrange the interviews in a public place rather than in your home.
- b. Allow 45 minutes to an hour for each interview
- c. Have a list of questions prepared prior to the interview
- d. Start on time
- e. Listen more and talk less
- f. Never make the offer on the spot; keep your options open
- g. Tell the candidate that you will check all references before making an offer
- h. Bring a family member or friend along on the interview. A second person will be able to observe the candidate and be able to offer a second opinion.



Important!! Important!! Important!! Important!! Important!!

There are rules involved when interviewing someone for a job. There are certain questions that you cannot legally ask someone during the interview process. If you do ask those questions you are breaking the law. A list of those questions is included below. Make sure you familiarize yourself with it **before** you start interviewing people.

Interview Questions – Important Do’s and Don’ts		
There are certain questions that are illegal to ask under both the federal and state laws and include questions about an applicant’s birth date, race, national origin, sexual orientation, native language, health problems or disabilities, physical fitness, marital or parental status or religion.		
Subject	Illegal Questions	Legal Questions
National Origin/ Citizenship	<ul style="list-style-type: none"> • Are you a citizen? • Where were you/your parents born? • What is your “native” tongue? 	<ul style="list-style-type: none"> • Are you authorized to work in the U.S.? What languages do you read, speak and write fluently? (this ability must be relevant to the job)
Age	<ul style="list-style-type: none"> • How old are you? • What is your birthday? 	Are you over the age of 18?
Marital/Family Status	<ul style="list-style-type: none"> • Are you married? • Are you living with someone? • Do you plan to have a family? • How many kids do you have? • What are your childcare arrangements? 	Ask questions like: <ul style="list-style-type: none"> • This job requires some evening hours. Would you be willing to work some evenings as necessary? • Punctuality is essential in this job. Can you assure you will be on time?
Affiliations	To what social or religious organizations do you belong?	Do you belong to any professional groups that you consider relevant to your ability to perform this job?
Personal	<ul style="list-style-type: none"> • How tall are you? • How much do you weigh? 	Questions on personal attributes are illegal. If you need assistance with transfers, you can ask all applicants Are you physically able to transfer someone of a particular size and build?
Disabilities	<ul style="list-style-type: none"> • Do you have any disabilities? • Have you had any recent or past illnesses or operations? • What was the date of your last physical exam? 	Are you able to perform the essential functions of this job with or without reasonable accommodations? (You must first thoroughly describe the job before asking this question.)

4. Check References

- Confirm the length of employment at each position.
- Determine the actual job description or assistance provided.
- Ask about interaction between employee and the person receiving care.
- Check to see how the employee accepted direction and supervision.
- Ask about the worker’s reliability and dependability.
- See if there were any problems encountered in the work relationship.
- Ask if the previous employer received timely information regarding the loved one’s needs.
- Ask if the previous employer would hire the candidate again.



*** Remember that the employee you want with your loved one should be caring, conscientious, competent, compassionate and considerate. ***

The NH Family Caregiver Support Program has only a few requirements of respite care providers. No individual can get paid utilizing funds in your budget unless they:

- Are at least 18 years of age
- Are legally able to work in this country
- Submit to, and pass a statewide criminal background check as well as the Department of Health and Human Services' Central Registry check
- Are not a Spouse or Legal Guardian of the participant or an individual residing in the same household.

The above information must be verified for all individuals who are employed by Gateways Community Services as a Family Managed Employee. This is done by Gateways as part of their employment verification process.

What if something shows up on the Criminal Background or the Bureau of Elderly and Adult Services (BEAS) Registry check?

You will **NOT** be able to hire an individual if the following happens:

- They have a criminal **conviction**.
- Their name appears on the BEAS Registry.

Training your respite provider

Training is one of the most important parts in managing your respite provider. You are the expert in knowing what needs to be done. Even experienced respite providers need to be trained in how YOU want things done. If you have had a respite provider before, you probably have a good idea of what works for you.

There is more than one way to train your provider. Some people will respond well to verbal instructions while others may respond better to hands on demonstrations. The main thing to make sure of is that the respite care is provided in the way that you prefer.

If you are training a new person, here are some things you might want to cover:

- Talk about the care needs of the care recipient and their abilities or disabilities. The more they know the better they will be able to meet your needs.
- Give a lot of examples and explain any technical terms you use.
- Talk about any symptoms or health concerns they need to be aware of. Include anything that may arise and how to handle that situation. Also include how you want emergency situations handled.



- As you go through your routine, explain why tasks need to be done. This will help your respite provider realize the importance of these tasks.
- Provide training on how to operate or use any special equipment like wheelchairs, lifts, shower chairs etc.

By providing good training up front, you may increase the chances of a provider being able to be more effective at their job. Taking more time in the beginning can lead to better overall results.

Impromptu Respite Reimbursement

Sometimes things happen that we do not anticipate. When life's little emergencies happen the program allows for up to 10% of your budget to go towards impromptu respite. For example, something comes up where you need to leave the individual you are caring for an hour or two. You ask a neighbor or a friend to come and stay with the care recipient until you return and you offer them a bit of money by way of thanks.

If the amount you pay them is within 10% of your total budget (For example: a \$600 budget would allow up to \$60 for impromptu respite. However, that amount will come out of your total budget) you can submit a form for reimbursement of what you had paid them.



Chapter 4 - Working with Your Two Support Agencies

The two support agencies that you will be in contact with in the NH Family Caregiver Support Program are ServiceLink Aging and Disability Resource Center and Gateways Community Services.

The Caregiver Specialist at ServiceLink can provide you with assistance with your budget and connecting you with local resources that can help you in your role as caregiver such as support groups, networking with other caregivers or trainings such as Powerful Tools for Caregivers.

Gateways Community Services provides the Financial Management Services for the program, namely, the bill payer and “employer of record” and payroll services.

The first thing to remember is that everyone is different; some people can handle working with a budget for services and dealing with invoices easily and won't need a lot of help from the ServiceLink staff or Gateways. Some people need more help in the beginning as they get used to the program. There is nothing wrong with contacting the Caregiver Specialist at ServiceLink or Gateways when you have a question. Remember, they are there to help you as needed. So don't be shy about picking up the phone!!!

Having two agencies to help you with the program could be confusing at times, and you may not know which agency to contact with any questions you may have. Each agency has different responsibilities in helping you manage the NH Family Caregiver Support program. The following table should help you decide which agency to contact with particular questions or issues.



Question or Issue	Caregiver	ServiceLink	Gateways
Employer of Record			✓
Pays Family Managed Employee			✓
Pays vendors and providers for approved purchases			✓
Prepares monthly budget statements for caregivers			✓
Reviews Caregiver Program Guide	✓	✓	
Conducts Assessment		✓	
Develops and follows Spending Plan	✓	✓	
Recruits Family Managed Employee	✓		
Approves all time sheets and invoices for payment	✓		
Enrolling in or Leaving the program	✓	✓	



Chapter 5 – Working with Gateways Community Services as a Financial Management Services Agency

Below are some basic instructions you will need in working with Gateways as your Financial Management Services Agency. Following these basic instructions will help the process work smoothly. As always, if in doubt please do not hesitate to call. Remember, they are there to help you.

Services Provided – Payments, Respite Reimbursements, Payroll services.

Payment Schedule - Gateways processes payments and respite reimbursement requests within two weeks of receipt of request, with direct deposit as an option.

Payroll Schedule for Family Managed Employees – Gateways is on a bi-weekly pre-defined payroll schedule, with direct deposit as an option. The back of the timesheet has the payroll dates listed on it.

Direct Deposit – Gateways provides direct deposit services for Family Managed Employees. Some set up is required in order to do this.

Payments

- Invoice payments can be made directly to an individual or company that, has provided services or goods and provides you with an invoice listing the date(s) and service(s)/good(s) provided, cost of service(s), and to whom the payment should be made, including mailing address.
- Receipt payments can be made directly to you if you have already paid the invoice and provide proof of payment in the form of a receipt; bank or credit card statement (note: on the credit card statement you can white out information that is not pertinent to this transaction); copy of cancelled check front and back.

Process for Invoice Payments:

1. Complete the Gateways Payment Request Form (be sure to sign and include cost center)
2. Attach original invoice
3. Mail both the completed payment request form and the invoice(s) information to
Gateways Community Services
144 Canal Street
Nashua, NH 03063
Attention: Fiscal Coordinator – Donna Waring



Process for Receipt Payments:

1. Complete the Gateways Payment Request Form (be sure to sign and include cost center)
2. Attach original receipt
3. Mail both the completed payment request form and the invoice(s) information to
Gateways Community Services
144 Canal Street
Nashua, NH 03063
Attention: Fiscal Coordinator – Donna LaFlamme

Note: One Payment Request Form can be used to request multiple payments

Impromptu Respite Reimbursements

“Impromptu Respite Reimbursement” is a category that is used to pay for ‘quick’ out of pocket expenses that do not need to be accompanied by an invoice or receipt. For example, a neighbor or friend came to stay with your loved one on a one-time basis because your worker cancelled and you gave them \$20.00 as a “thank you.” Due to the nature of this category not requiring evidence of payment there is a limit of 10% of the total amount of your budget that can be used in this way.

Process for Impromptu Respite Reimbursement:

- Complete the Gateways Respite Reimbursement Request Form (be sure to sign and include cost center)
- Mail both the completed respite reimbursement request form to
Gateways Community Services
144 Canal Street
Nashua, NH 03063
Attention: Fiscal Coordinator – Donna Waring

Payroll

Gateways provides what is called “Employer of Record” services for persons providing respite services under the NH Family Caregiver Support Program and is responsible for completing tax, labor, and social security documents, as needed. They calculate and file tax documents, distribute wages to Family Managed Employees, manage workers’ compensation, disability, and benefit insurances, verify citizenship/legal alien status, and background record of support providers. As a co-employer you hire, supervise, and discharge individuals in conjunction with Gateways. This is referred to as the Agency with Choice Model of service.



Process for Payroll (Worker-Family Managed Employee Payments):

- Time sheets are provided by Gateways
- Worker completes and signs time sheet
- Family supervisor reviews and sign time sheet
- Worker sends completed and signed time sheet to Gateways Fiscal Coordinator to be received, by 9 am Monday following the Friday pay period end date, via:
 - Fax: 603.889.5460 Attention: Fiscal Coordinator - Donna LaFlamme
 - Postal Service to
 - Gateways Community Services
 - 144 Canal Street
 - Nashua, NH 03063
 - Attention: Fiscal Coordinator – Donna Waring
- Gateways maintains an outside locked drop box marked Time Sheets to the right of our main entry for after hours drop off.
- Time sheets may be submitted via Electronic submission by the family supervisor. This does require a computer and training. If interested contact Gateways Fiscal Coordinator. Check Register



Question or Issue	Caregiver	ServiceLink	Gateways
Employer of Record			✓
Pays Family Managed Employee			✓
Pays vendors and providers for approved purchases			✓
Prepares monthly budget statements for caregivers			✓
Reviews Caregiver Program Guide	✓	✓	
Conducts Assessment		✓	
Develops and follows Spending Plan	✓	✓	
Recruits Family Managed Employee	✓		
Approves all time sheets and invoices for payment	✓		
Enrolling in or Leaving the program	✓	✓	

If your question doesn't fall under any of those topic areas, feel free to contact your ServiceLink Caregiver Specialist, if he/she can't answer the question they will direct you to where you need to go.

Remember that both agencies are there to help you when needed so don't be afraid to contact them as needed.

Important Contact Numbers

ServiceLink

Name: _____ Phone: _____

Gateways Community Services:

Name: _____ Phone: _____

NORTH DAKOTA



Family Caregiver Support Program (FCSP) Service Standard 650-25-30 (Revised 1/1/17 ML#3484)

[View Archives](#)

The family caregiver support program provides for a multifaceted system of support services for family caregivers and for grandparents or older individuals that are relative caregivers. Priority for services shall be given to:

- caregivers residing in rural areas;
- caregivers with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- caregivers with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas);
- older relative caregivers of children (not more than 18 years of age) with severe disabilities;
- older relative caregiver of individuals with disabilities (ages 19-59) who have severe disabilities;
- caregivers with limited English proficiency;
- caregivers of individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction, regardless of the age of the individual with dementia; and
- caregivers of individuals at risk for institution placement.

Performance Standards 650-25-30-01

Eligible Clients 650-25-30-01-01

(Revised 1/1/17 ML#3484)

[View Archives](#)

All caregivers must reside with the care recipient, provide 24-hour care, and meet one of the following criteria:

1. Family caregivers age 18 and older caring for individuals age 60 and older.

2. Older relative caregivers age 55 and older who care for children not more than 18 years of age.
3. Older relative caregivers age 55 and older providing care for adult children with a disability who are between 19 and 59 years of age.
4. Family caregivers age 18 and older caring for an individual with Alzheimer's disease or a related dementia, regardless of the age of the individual with dementia.

Location of Service 650-25-30-01-10

(Revised 10/1/15 ML#3454)

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The majority of services will be provided in the home where the caregiver and care recipient resides. Respite care may also be delivered in the home of the qualified service provider, adult and child day care setting, licensed adult or child foster care homes, community settings, or institutional settings.

Educational opportunities, support groups, and other services may be delivered in the community.

Service Categories 650-25-30-01-15

(Revised 1/1/17 ML#3484)

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The following service categories identify services available through the Family Caregiver Support Program and require reporting through the Social Assistance Management System (SAMS) data collection system to document need. The reporting tool is available through the web-based SAMS data collection system.

1. Access Assistance – a service that assists caregivers in obtaining access to services and resources available within their communities.
 - Case Management – includes completion of a SAMS Caregiver Assessment to identify caregiver needs; development/renewal of the Caregiver Option Plan; providing individuals with information on available services; linking the individual to services and opportunities that are available within the community; authorizing services; and follow-up for as long as the individual is eligible to receive program services

2. Counseling/Support Groups/Training – a service that assists caregivers in making decisions and solving problems relating to their caregiving tasks. Services in this category include:
 - Counseling – individual and family
 - Support groups
 - Caregiver training for individual caregivers and families

3. Information Services – a service that provides the public and individuals with information on resources and services available within their communities. Services in this category are directed to large audiences and include activities such as disseminating publications, conducting media campaigns, participating in health fairs, and other similar activities.

4. Respite Care – a service that offers temporary, substitute supports, or living arrangements for care recipients in order to provide a brief period of relief for caregivers. Respite care can be provided by qualified respite care providers and/or qualified family members in the following settings:
 - FCSP Adult Day Care Respite
 - FCSP Caregiver In-Home Respite
 - FCSP Institutional Respite
 - FCSP Respite Child Care

5. Supplemental Services – a service provided on a limited basis to complement the care provided by caregivers. Reimbursement can be made for:
 - Incontinent supplies including pads, diapers, wipes, and other protective products
 - Assistive safety devices including adaptive and preventive health aids

6. FCSP Disaster/Emergency Contact – a service to assure the caregiver and care recipient’s safety in the event of a disaster/emergency.

Delivery Characteristics 650-25-30-01-20

(Revised 4/1/18 ML #3526)

[View Archives](#)

[PI 18-22](#)

Caregiver support services must be available statewide.

1. All referrals must be contacted within two working days.

2. The Caregiver Assessment Tool must be completed in SAMS.
3. Individuals seeking services must be provided with service options. The individual has the right to make an independent choice of service providers.
4. All contacts, including telephone calls, must be documented in the narrative section of the SAMS data collection system. The documentation shall include a brief descriptive statement of the interaction, including any service needs identified, alternatives explored, and service delivery options offered.
5. Each client and provider case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or a restricted computer program.
6. Service activities must be coordinated with existing community agencies and voluntary organizations to maximize service provision and avoid duplication.
7. All services must be promoted through a variety of networks i.e., churches, service organizations, schools, professional conferences, etc.
8. A signed release of information document for every service provider must be on file before information can be shared or released.
9. A Notice of Privacy Practices (DN 900) will be given to every caregiver and a signed Acknowledgement of Receipt of the Notice of Privacy Practices ([SFN 936](#)) will be kept in the record.
10. Determine eligibility for rural differential rate as per the standard NDFCSP Rural Differential Unit Rate for Qualified Service Providers and complete the Rural Differential Authorization form (SFN 225).
11. Provide services on American Indian reservations to caregivers who are not enrolled tribal members.
12. The NDFCSP Program Administrator may grant approval for FCSP services to address special or unique service needs for up to a six-month period. Additional approval for services beyond the six-month period may be made available on a case-by-case basis with prior approval from the NDFCSP Program Administrator. Requests must be in writing in order to be considered.

Billable Services 650-25-30-05

(Revised 1/1/17 ML#3484)

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The following outlines billable services provided by the program:

1. Counseling/Support Groups/Training

- One counseling service equals one session per participant (FCSP Counseling - Individual and FCSP Counseling – Family). Reimbursement for counseling is based on the current statewide human service center rate for individual or family counseling
- One support group equals one session per participant (FCSP Support Groups). Reimbursement can be made for initial start-up costs for support groups that have a caregiver component on a case-by-case basis with prior approval from the NDFCSP Program Administrator.
- One caregiver training equals one session per participant (FCSP Training for Caregiver). Reimbursement for caregiver training shall not exceed the maximum Medicaid rate for that service as established by the Department. Rates for training needs not addressed by Medicaid shall be negotiated with the NDFCSP Program Administrator

2. Respite Services

- Respite Services are based on actual hours spent doing respite care. Reimbursements for individuals and agencies are based on the current maximum Medicaid QSP rate or the individuals' or agencies established rate

3. Supplemental Services

- Reimbursement is made to a caregiver based on actual cost of the item(s)

The North Dakota Caregiver Support Program Provider Service Log – Individual (SFN 135) and North Dakota Caregiver Support Program Provider Service Log – Agency (SFN 492) must be reviewed and approved as soon as possible but within three days of receipt. Reimbursement for other services must be completed in accordance with human service center procedures.

Access Assistance, Information Services, and FCSP Disaster/Emergency Contacts are not considered billable units of service. Time spent completing those activities must be documented monthly in the Department's Workforce system. Information Services must be recorded in a SAMS Consumer Group. FCSP Disaster/Emergency Contacts are recorded as Service Delivery in the individual consumer record.

If funding from federal or other sources is not obtained or continued at levels sufficient to allow for continued provision of services or purchase of supplemental services as indicated on the Caregiver Option Plan, the Plan may be modified (in writing) to accommodate the reduction in funds.

Service Activities 650-25-30-10

(Revised 6/1/18 ML #3530)

[View Archives](#)

1. Access Assistance – Case Management includes the following activities:
 - Accept and respond to referrals to the program
 - Make home visits or arrange for visits in a location convenient for the caregiver
 - Complete individual caregiver assessments on all eligible caregivers using the SAMS Caregiver Assessment Tool to determine need. Caregiver assessments must be updated on an annual basis
 - Using the SAMS Caregiver Assessment Tool, develop and implement an individualized Caregiver Option Plan (SFN 165) that addresses the needs unique to the individual providing care. The plan must identify services to be received, the entity providing the service, and the expected outcomes. The effective date on the Caregiver Option Plan (SFN 165) will not exceed the 12 month enrollment period (July 1 to June 30)
 - A follow-up telephone call to the caregiver must be conducted within 30 days of enrollment
 - The Caregiver Option Plan (SFN 165) must be reviewed every three months at a minimum to monitor service usage and assure caregiver goals and outcomes are being met
 - Completion of required Department forms needed to authorize services (i.e. SFN 135 – North Dakota Family Caregiver Support Program Provider Service Log – Individual, SFN 492 - North Dakota Family Caregiver Support Program Provider Service Log – Agency, SFN 549 – Respite Home Evaluation, and SFN 225 – NDFCSP Rural Differential Unit Rate Authorization)
 - New Caregiver Option Plans (SFN 165) must be completed when the effective date expires. Caregiver Option Plan (SFN 165) updates may be completed by meeting with or making phone contact with caregivers and acquiring signatures via the mail. A copy of the

Caregiver Option Plan must be mailed to the caregiver after each review date if there were changes in services or providers

- Conduct a minimum of one contact per quarter (one face-to-face and three telephone contacts) during the enrollment period; additional contacts may be conducted as needed
- Create/maintain working partnerships with other agencies and organizations that provide services to support caregivers

2. Counseling/Support Groups/Caregiver Training – Individual and Family

A. Counseling

- Identify and arrange for payment for qualified professionals to complete up to four sessions during a 12-month enrollment period for individual or family counseling of eligible caregivers. If it can be demonstrated that the caregiver has an extraordinary need for additional counseling beyond the four sessions, a written request must be submitted to the NDFCSP Program Administrator. A one-time extension will be considered on a case-by-case basis. Caregivers who require on-going counseling will be referred as needed. A qualified professional includes a psychologist, licensed social worker, and counselors as defined by North Dakota Century Code. Counseling may include, but not be limited to the following topics:
 - Caregiver Stress and Coping
 - End of Life Issues/Grief Counseling
 - Family Relations/Dynamics
 - Substance Abuse
 - Decision Making and Problem Solving

B. Support Groups

- Facilitate development/maintenance of caregiver support groups. Reimbursement may be provided for start-up costs for support groups that have a caregiver component on a case-by-case basis with prior approval from the NDFCSP Program Administrator. The goal is to encourage each group to become self-sustaining. Educational materials may be provided as needed

C. Caregiver Training

- Identify and arrange payment for qualified professionals to complete individualized caregiver training that meets the needs of the eligible caregiver. Qualified professionals include, but are not limited to:
 - Nurses
 - Occupational therapists
 - Physical therapists
 - Dietitians
- Promote the department approved Powerful Tools for Caregivers training. A list of FCSP caregivers attending Powerful Tools for Caregivers must be sent to the NDFCSP Program Administrator

Whenever possible the training should be held in the home where care is being provided

- Training may include but not be limited to the following areas:
 - Generally accepted practices of personal care tasks and personal care endorsements
 - Assistive technology
 - Planning for long term care needs
 - Health and nutrition counseling
 - Behavior management

- Financial literacy
 - For the provision of the department approved caregiver dementia trainings, sessions must be scheduled with the department approved provider. The trainings should be limited to caregivers enrolled in the FCSP and their providers. A copy of the list of caregivers and respite providers attending department approved caregiver dementia trainings must be sent to the NDFCSP Program Administrator
3. Information Services – Public education, information, and training activities directed to large audiences including but not limited to the following:
- Booths at health fairs
 - Mailing out FCSP brochures
 - Posting FCSP flyers
 - Public service announcements advertising the FCSP and services
 - Church bulletin inserts
 - Media events which advertise the FCSP and services
 - Public newsletters promoting the FCSP and services
 - Participate in coalitions and/or planning committees which focus on aging/caregiving service needs, issues, events
 - Public presentations regarding caregiving and grandparent issues
 - Newsletters/newspaper articles which provide information on caregiving or grandparent issues
 - Public caregiver trainings that focus on caregiving or grandparent issues; i.e. dementia training
4. Respite Care
- A caregiver is eligible to receive funding for respite services if they are providing 24-hour care and the care recipient has two or more activities of daily living (ADL) limitations or a cognitive impairment which makes it unsafe for them to be left alone. The ADL impairment requirement for respite services eligibility does not apply to children ages 18 and under

- Respite care services available to a caregiver cannot exceed the service cap for respite care service in a twelve-month period (July 1 to June 30) as established by Aging Services Division. Additional funds may be made available on a case-by-case basis with prior approval from the NDFCSP Program Administrator
- Respite care must be allocated on a quarterly basis. If services begin within the quarter, the allocation must be prorated based on the number of months remaining in the quarter
- Service dollars not used within the quarter will not carry forward to the next quarter; a new allocation will be established based on usage
- Individual [i.e. qualified family members and qualified service provider (QSP)] rates for respite care services shall not exceed the current maximum Medicaid QSP rate
- Providers who have an individual QSP rate different from the state maximum Medicaid QSP rate shall be paid at their established individual rate, not the maximum Medicaid QSP rate
- Agency unit respite rates shall not exceed the current maximum rate for the service under Medicaid. Agency providers who have an agency QSP rate different from the maximum state Medicaid QSP rate shall be paid at their established agency rate, not the maximum Medicaid QSP rate
- For reimbursement purposes, overnight/24-hour respite care is based on the hours of 12 am (midnight) to 11:59 pm
- Payment for overnight/24-hour, in-home respite provided by an enrolled QSP, qualified family member or agency shall not exceed the current Medicaid hospital swing bed rate. Payment for one day of respite care cannot exceed the current Medicaid hospital swing bed rate whether or not the person received overnight care
- Overnight/24 hour respite care provided in a hospital swing bed or long-term care facility shall not exceed the current Medicaid swing bed rate
- Overnight respite care services for eligible grandchildren may be provided in a licensed child foster care home. Approval from the local county social service case manager working with the child foster care home must be obtained prior to making arrangements for respite services

- Respite care that will be provided in the home of a qualified service provider (QSP) cannot be authorized until a home visit and Respite Home Evaluation (SFN 549) has been completed with the QSP. The Respite Home Evaluation is not required when respite services are being provided in the home of a qualified family member or in a licensed adult or child foster care home
- Respite Home Evaluations (SFN 549) are valid for no longer than 24 months from the date of issuance or the date of expiration of the provider's status as a qualified service provider (QSP), whichever comes first. The QSP expiration date can be obtained from Aging Services Division. A copy of the evaluation form must be provided to the QSP and the original should be maintained in the provider's file
- Caregivers and their providers who meet the eligibility for the NDFCSP Rural Differential QSP unit rate will receive a service cap adjustment over the established service cap for the enrollment period. Rural differential service cap information will be issued as changes occur. The NDFCSP Program Administrator must be notified via email every time a caregiver has been authorized to receive the rural differential unit rate and again when their enrollment has been terminated
- Caregivers eligible for the FCSP rural differential respite care services unit rate will receive an overnight/24-hour care rate that exceeds the current Medicaid hospital swing bed rate. The Aging Services Division, in conjunction with Medical Services Division, will establish the maximum daily rate based on rural differential care services unit rate for the current enrollment period. Overnight/24-hour care rates will be issued as changes occur
- Caregivers providing care for a person with Alzheimer's disease or a related dementia may be eligible to receive an enhancement of \$600 over the established service cap for the enrollment period if they and at least one of their respite providers have successfully completed the FCSP approved caregiver dementia training; the allocation must be pro-rated based on the number of quarters remaining in the twelve-month enrollment period. If services begin within the quarter, the allocation must be prorated based on the number of months remaining in the quarter
- Caregivers who successfully complete the FCSP approved Powerful Tools for Caregivers training may be eligible to receive an enhancement of \$600 over the established service cap for the enrollment period; the allocation must be pro-rated based on the number of quarters remaining in the twelve-month enrollment period. If services begin within the quarter, the allocation must be prorated based on the number of months remaining in the quarter

5. Supplemental Services

- Identify and arrange for up to \$300 in supplemental services based on identified need. The service dollars may be made available in any combination of the following:
 - Purchase of incontinence supplies, not to exceed \$75 per quarter; service dollars not used within the quarter will not carry forward to the next quarter
 - Purchase of assistive safety devices not to exceed \$300 per enrollment period
- Additional funds for supplemental services may be made available on a case-by-case basis with prior approval from the NDFCSP Program Administrator
- Contact should be made with the Assistive Safety Devices Distribution Program to determine whether or not the caregiver/care recipient can obtain the device through this service
- Supplemental services dollars cannot be used as a partial payment for an assistive safety device

6. Disaster/Emergency Planning

- At the direction of the Aging Services Division, contact the caregiver to assist in planning to assure the caregiver and care recipient's safety in the event of a disaster/emergency
- Document in the Narrative Section of the SAMS FCSP Assessment the stated purpose of the contact and a brief description of the caregiver's plan for safety

**Documentation Requirements 650-25-30-10-05
(Revised 1/1/17 ML#3484)**

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INITIAL ASSESSMENT:

Assessment data must be documented in the SAMS web-based data system. Document the following in the Narrative section of the SAMS Caregiver Assessment form:

- A brief descriptive statement of the interaction with the caregiver, including any identified service needs;
- Alternatives explored;
- Service delivery options offered;
- Rationale for amount of service hours/funds allocated;
- Services accepted or refused by the caregivers;
- The caregiver's choice of provider(s); and
- Copies of Caregiver Handbook/Voluntary Contribution Statement/other materials provided to caregiver.

FOLLOW-UP CONTACTS:

Document in the Narrative section of the SAMS Caregiver Assessment form all activities and contacts with caregivers, family, agencies, respite providers, etc. in relation to the caregiver.

Documentation must include, as applicable:

- The purpose of the contact;
- Condition of or changes in the caregiver or care recipient situation;
- Outcome(s) of any referrals provided to or made on behalf of the caregiver;
- Impact of the FCSP involvement for the caregiver;
- Observations and/or concerns regarding caregiver home conditions; and
- Reports of any caregiver concerns from other parties involved with caregiver.

FCSP SPREADSHEET:

The RASPA must complete the FCSP spreadsheet according to guidelines included with the form.

Service Delivery Reporting Requirements 650-25-30-10-10

(Revised 1/1/17 ML #3484)

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For reporting purposes, document service delivery in the web-based SAMS data collection system, on a monthly basis.

Document the following in the individual client record:

1. Access Assistance

One case management service equals one contact (FCSP Case Management)

- Case management services includes all interactions that are directly related to the caregiver (i.e. initial assessment, completion of authorization of services, contacts with individuals or agencies to arrange for services, and all follow-up contacts)
- Every contact (service delivery) must have a corresponding narrative documented in the Narrative section of the consumer assessment

2. Counseling/Support Groups/Training - includes counseling, support groups, and caregiver training

Select the respective service provided:

- One counseling service equals one session per participant (FCSP Counseling - Individual and FCSP Counseling - Family)
- One support group equals one session per participant (FCSP Support Groups)
- One caregiver training equals one session per participant (FCSP Training for Caregiver)

3. Respite Care

Select the respective service provided:

- FCSP Adult Day Care Respite - Full Day
- FCSP Adult Day Care Respite - Half Day
- FCSP Adult Day Respite - Hourly
- FCSP Caregiver In-Home Respite - Hourly
- FCSP Caregiver In-Home Respite - Overnight
- FCSP Institutional Respite - Overnight

- FCSP Respite Child Care – Overnight
 - FCSP Respite Child Care – Full Day
 - FCSP Respite Child Care – Hourly
4. Supplemental Services
Enter actual reimbursement amount in Unit Price.
 5. FCSP Disaster/Emergency Contact
One disaster/emergency contact equals one unit of service.

Document the following in the SAMS Consumer Group:

Information Services – activities directed to larger audiences

One information service equals one activity (Consumer Group: RASPA/FCSP PUB ED-TRNG)

- Record activities in the SAMS Consumer Group Comments Section indicating the date, location where activity occurred, audience, and number of participants

For reporting purposes, document the following in the Department of Human Services network drive:

- RASPA must complete the FCSP spreadsheet according to guidelines included with the form.

Rural Differential Unit Rate for Qualified Service Providers 650-25-30-10-15

(Revised 1/1/17 ML #3484)

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Purpose

The purpose of the rural differential rate is to create greater access to home and community based services for caregivers who reside in rural areas of North Dakota by offering a higher rate to Qualified Service Providers (QSPs) who are willing to travel to provide services. QSPs that are willing to travel at a minimum distance of 21 miles round trip to provide care to authorized individuals in rural areas will be reimbursed at a higher rate to provide respite care services for FCSP caregivers. Rural differential unit rates vary based on the round trip mileage. QSPs are not paid for the time they drive to or from the client's home; the rural differential rate may only be used for the time spent actually providing services.

Standards for Providers

Only enrolled agencies or individual QSPs authorized to provide FCSP services are eligible to receive the rural differential rate. Family members are not eligible to receive rural differential rate unless they enroll as a QSP with the NDFCSP.

Service Activities, Authorized

The rural differential rate is based on the physical address of the eligible caregiver and must be identified on the Caregiver Option Plan (SFN 165).

The FCSP Rural Differential Rate Authorization (SFN 225) will be completed upon enrollment for each caregiver and QSP provider who meet the eligibility criteria for the rural differential rate. The SFN 225 will be completed upon closure to include the date of case closure.

Copies of the FCSP Rural Differential Rate Authorization when both opening and closing a case will be distributed as follows:

- Original to the QSP
- Copy to the caregiver file
- Copy to the Qualified Service Provider file
- Copy to the NDFCSP Program Administrator
- NDFCSP Program Administrator will forward a copy to Medical Services

The rural differential rate will be added on the FCSP Caregiver Option Plan as providers become eligible for the rate.

Service Eligibility

The rural differential rate is caregiver specific. A FCSP caregiver receiving services paid at the rural differential rates will meet the following criteria:

1. Must be eligible for NDFCSP services.
2. Reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.
3. Needs respite care services and does not have access to a QSP of their choice, within a minimum of a 21 mile round trip distance of their residence who is willing to provide care.

The distance between the caregiver's home and the QSPs home base must be verified by using the following website: www.mapquest.com. The most reasonable

route must be used. A printed copy of the MapQuest results must be kept in the caregiver file. A copy of the MapQuest mileage verification must be sent with the SFN 225 to the NDFCSP Program Administrator.

If there is a discrepancy in what is considered city limits, notify the NDFCSP Program Administrator. The Rural Differential Program Administrator, Medical Services Division, will make the final determination.

Service Delivery

The rural differential rate is based on the number of miles (round trip) a QSP travels from their home base to provide services at the home of an authorized FCSP caregiver.

- Home base is either the individual QSPs physical address, or the agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day because of distance) whichever is closer.
- If an agency employee is not required to report to the home office each day because of distance and they live 21 or more miles (round trip) from the caregiver's home the rural differential rate may be used. If the employee lives less than 21 miles (round trip) from the caregiver's home than the rural differential may not be used. Rural differential unit rates vary based on the number of round trip mileage.
- Rural differential rates are based on the distance it takes to travel to each individual caregiver's home even if the QSPs serve more than one caregiver in the community or in the same home.
- Information on the rural differential unit rate will be provided as changes occur.

Addresses

The physical address (PO BOX is not acceptable) listed on the QSP list or NDFCSP Provider Agreement must be used when determining which rural differential rate to use for individual QSPs and Agency providers.

Staffing Requirements 650-25-30-15

(Revised 1/1/16 ML 3463)

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Minimum qualifications include:

- Bachelor degree in Social Work, Nursing, Sociology, Psychology, Human Services, Business Administration, Gerontology, or two years related professional work experience or a Master's degree in one of the fields listed above
- Public speaking experience
- Ability to effectively communicate both verbally, to include active listening, and in writing
- Basic understanding of fiscal management
- Marketing and/or outreach experience
- Ability to work with and willingness to learn various computer software programs
- Valid driver's license required
- Knowledge of or willingness to learn of available community resources within a defined service area

Prohibited Activities 650-25-30-20

(Revised 4/1/18 ML #3526)

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1. Duplication of services.
2. Breach of confidentiality.
3. Provision of FCSP services to a caregiver, who does not meet the definition of a grandparent or older relative caregiver, who is providing support to an individual between the ages of 19 and 59 regardless of disability or cognitive status.
4. Provision of FCSP services to a caregiver who is providing care and assistance on a daily basis but does not live with the care recipient.
5. Provision of FCSP services to a caregiver who is caring for an older individual who resides in an institutional setting or an assisted living setting.
6. Provision of FCSP services to a caregiver who is receiving services that provide relief from direct care and/or supervision of a care recipient as part of a public program, or being paid by private arrangement to provide care more than eight hours per week (for caregivers enrolled on or after January 1, 2017 and for caregivers enrolled prior to January 1, 2017 if there is a change in circumstances).

7. Provision of FCSP services to a caregiver who is out of the home more than two hours per day where the welfare and safety of the care recipient can be maintained (for caregivers enrolled on or after January 1, 2017 and for caregivers enrolled prior to January 1, 2017 if there is a change in circumstances).
8. Provision of FCSP services to a caregiver where there are informal supports in the home (i.e. other adults living in the home who provide relief from direct care and/or supervision of a care recipient) for more than eight hours per week (for caregivers enrolled on or after January 1, 2017 and for caregivers enrolled prior to January 1, 2017 if there is a change in circumstances).
9. Provision of FCSP services to a caregiver who is employed outside the home (for caregivers enrolled on or after January 1, 2017 and for caregivers enrolled prior to January 1, 2017 if there is a change in circumstances).
10. Provision of FCSP services to a caregiver who is providing care to a care recipient who is receiving hospice services if the service is included as a part of a Medicare or other hospice plan (for caregivers enrolled on or after January 1, 2017).
11. Provision of FCSP services to a caregiver who is providing care to a care recipient who may be eligible or is determined eligible to receive services as part of a public pay program but refuses to apply or chooses not to access those services.
12. Provision of FCSP services to a caregiver who is providing care to a care recipient who has private long-term care insurance coverage that provides relief from direct care and/or supervision of a care recipient of more than eight hours per week (for caregivers enrolled on or after January 1, 2017 and for caregivers enrolled prior to January 1, 2017 if there is a change in circumstances).
13. Provision of FCSP continued enrollment of a caregiver who temporarily relocates their residence (2 months or longer) outside of North Dakota.
14. Provision of FCSP services when the caregiver's health prohibits adequate care for the care recipient.
15. Provision of FCSP services when the care needs of the care recipient exceed the standards for service delivery and allowable tasks/activities for respite (QSP) providers as contained in the "Individual Qualified Service Provider Handbook" and/or when the care needs of the care recipient exceed the caregiver's abilities to safely and adequately provide care to the care recipient.

Qualified Service Provider Complaints 650-25-30-25

(Revised 4/1/18 ML #3526)

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A complaint against a qualified service provider, family or agency provider may be made to the Regional Aging Services Program Administrator (RASPA) at the human service center or to the Aging Services Division of the North Dakota Department of Human Services. A recipient of NDFCSP services or a friend, family member, guardian, legal representative or neighbor of the recipient or any other interested/anonymous party may file a complaint.

When a complaint is received about a NDFCSP service provider follow these steps:

1. Ask for the name of the person who is making the complaint, the name of the caregiver or care recipient and the name of the qualified service provider, family or agency provider. Ask for a complete description of the problem or complaint.
2. The complaint must be reported in writing to the NDFCSP Program Administrator. When applicable, the NDFCSP Program Administrator will notify the provider in writing of the changes that they must make in order to maintain their provider status or Aging Services will remove a qualified service provider, family or agency provider from the list of approved providers if the seriousness and nature of the complaint warrant such action.
3. Complaints regarding an enrolled Qualified Service Provider will be handled by the NDFCSP Program Administrator and the Home and Community-Based Services Program Administrator regarding the investigation and resolution of the complaint. A qualified service provider whose enrollment with the Department of Human Services is either terminated or closed will not be eligible to receive payment from the FCSP.
4. If there are reasonable grounds to believe that the caregiver's or care recipient's health or safety is at risk of harm, contact the Vulnerable Adult Protective Services (VAPS) central intake. If the vulnerable adult is in immediate danger, contact law enforcement immediately and then contact the (VAPS) central intake.
5. If there is no immediate risk but a problem exists, Aging staff will work with the caregiver and other interested parties to resolve the complaint.

Denial and Closure of Services 650-25-30-30

(Revised 4/1/18 ML #3526)

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1. An individual (not currently enrolled in the program) who is ineligible for and denied services under the FCSP may submit a grievance as outlined in Section 650-25-25-35.
2. FCSP services may be discontinued if the caregiver has not accessed services within a consecutive three-month period.
3. FCSP services will be discontinued when the caregiver or care recipient, or both, no longer meet the program requirements.
4. A caregiver will be notified in writing of the reason for denial or closure, the right to submit a grievance, and the grievance process through the NDFCSP Notice of Service Denial or Closure (SFN 331). The [SFN 331](#) is not required if the closure is due to the death of the caregiver or the care recipient.
5. Any individual or agency who applies to be a qualified service provider, is enrolled as a qualified service provider, or is a qualified family member providing caregiver services through the Family Caregiver Support Program is subject to rules outlined in the North Dakota Administrative Code Chapter 75-03-23-08: Termination of qualified service provider status and denial of application to become a qualified service provider.
6. If additional guidance is required, consult with the NDFCSP Program Administrator when denial or closure of services is being considered.

Administrative Requirements 650-25-30-35

Administration 650-25-30-35-01

(Revised 4/1/18 ML #3526)

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1. All caregivers enrolled in the FCSP must be provided the opportunity to contribute to the cost of the service. Acceptable format for receipt of contributions is limited to the use of self-addressed envelopes. Contributions received must be used to expand FCSP services.
2. All RASPA time used to complete FCSP activities must be documented in Workforce on a monthly basis, according to Department policy.
3. SAMS consumer data records, assessments, and service delivery for both individual caregivers and consumer groups must be completed no later than 25 days after the end of the monthly service period.
4. Complete the FCSP spreadsheet according guidelines included with the form.

5. RASPAs must process billings within three working days of receipt. Payment for services must be completed in accordance with human service center procedures.
6. Individual respite care providers are required to have caregivers co-sign on every entry of respite services on the North Dakota Family Caregiver Support Program Provider Service Log - Individual ([SFN 135](#)) to verify services have been provided. If the Provider Service Log is lacking a signature, the service log must be returned to the provider to obtain the caregiver signature prior to approval for payment.
7. Enrolled caregivers accessing Supplemental Services will be required to purchase the assistive safety device or incontinent supplies. The caregiver must submit a receipt of purchase of safety devices or incontinence supplies. RASPAs will complete and submit the NDFCSP Provider Service Log-Individual (SFN 135) for reimbursement.
8. Agency, institutional and adult day care providers of respite, and individuals providing training or counseling services will use North Dakota Family Caregiver Support Program Provider Service Log – Agency ([SFN 492](#)) for billing for respite, training and counseling services. Providers using SFN 492 for billing purposes are not required to obtain caregiver co-signatures on the provider service log.

Legal Requirements 650-25-30-35-05

(Revised 7/1/13 ML#3379)

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1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs
2. The North Dakota Family Caregiver Support Program (NDFCSP) shall apply the Department of Human Services rules, policies, and procedures regarding competency requirements for qualified service providers and termination of qualified service provider status to the NDFCSP respite care providers.
3. The North Dakota Family Caregiver Support Program (NDFCSP) shall apply the Department of Human Services rules, policies, and procedures regarding recovery of funds from providers upon establishment of noncompliance.

VERMONT



Section XI. NATIONAL FAMILY CAREGIVER SUPPORT PROGRAM

(Title III E)

A. Overview: Family Caregiver Support Services

The National Family Caregiver Support Program (NFCSP), Title III E of the Older Americans Act (OAA) was established in the 2000 reauthorization of the OAA to help families sustain their efforts to care for an older relative who has a chronic illness or disability.

All family caregivers should be recognized and supported for the valuable role they assume in the long-term care system. The NFCSP will provide access to accurate and reliable information, referral, and assistance. Caregivers will be able to choose from a broad array of service options available under the NFCSP. Access to respite care and other supportive services in their community will be available to sustain the caregiver. The desired outcomes of the NFCSP are as follows:

1. Improve quality and availability of information to families and caregivers;
2. Improve ease of access to existing services;
3. Increase options for respite care;
4. Increase availability of support groups, caregiver training and peer support options; and
5. Increase consumer choice.

In providing services under this subpart, priority shall be given to:

1. Family caregivers who provide care for older individuals with Alzheimer's disease and related disorders with neurological brain dysfunction; and
2. For grandparents or older individuals who are relative caregivers, priority shall be given to caregivers who provide care for children with severe disabilities.

AAAs receiving Title III E funding should develop the following considerations for the design of their regional NFCSP:

1. Development of a coordinated infrastructure to provide services to family caregivers;
2. Multiple, flexible services to meet the full range of needs of the caregivers being served;
3. A system that offers both flexibility for caregivers and consistency of access statewide;
4. Leverage funding as seed money for other resources to expand the program;
5. Use funding to enhance existing services and develop new service options;
6. Evaluate and document outcomes;
7. Allow flexibility for innovation;

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8. Provide for accountability to the state; and
9. Ensure the availability and consistent quality of services to caregivers throughout the state.

Elements of NFCSP should contain the following considerations:

1. Be driven by the needs and values of the caregiver;
2. Offer consumer choice
3. Be culturally sensitive;
4. Be cost effective;
5. Build upon the strength of families and empower them by providing information;
6. Add to and not supplant existing services and resources through collaboration and coordination;
7. Maintain a *regional network* so the program is accessible in all communities;

B. Allowable Services

The National Family Caregiver Support Program specifies five required categories of service. Each AAA is required to build a system to assure that all five services are available throughout the service region. There are multiple service activities allowable under each of the five NFCSP categories. Examples of such activities in each category are:

1. Information Services: Outreach through Group Activities:

- a) presentation of information to community organizations and groups;
- b) public service announcements;
- c) newspaper articles related to family caregiving;
- d) publicity campaigns;
- e) appearances on radio, TV programs, talk shows;
- f) development of educational programs/curricula;
- g) workshops in senior housing communities; and
- h) providing caregiver information through health fairs, through faith communities, and through other information sharing techniques.

2. Access Assistance: Assistance to Caregivers in Gaining Access to Services (Service to individuals):

- a) provide informal help to caregivers on a one-to-one basis in person, by phone, or other means to help gain access to long term care services for the care recipient;
- b) establish a telephone help line;
- c) provide information and referral services to caregivers;
- d) assist with benefits screening and eligibility assessment;
- e) help caregiver assess needs and problems;
- f) assist in accessing desired services;
- g) develop additional resources;
- h) help caregiver to develop an emergency plan
- i) develop a "library" of multi-media resource materials for caregivers; and

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- j) offer other assistance requested by the caregiver.

3. Individual Counseling, Organization of Support Groups, Caregiver Training:

The AAA staff will undertake activities that assist caregivers in the areas of health, nutrition, and financial literacy, and in making decisions and solving problems relating to their caregiver role. Such activities include:

- a) connect caregiver to appropriate support groups;
- b) assist in developing or connecting caregiver to disease specific support groups;
- c) connect caregiver to support groups for grandparents or older relatives raising grandchildren;
- d) connect caregiver to programs on legal issues for grandparents raising grandchildren;
- e) conduct or sponsor caregiver training events for family caregivers on care techniques, wellness, stress reductions, transfer techniques, etc.;
- f) connect caregiver to services for end-of-life issues;
- g) through visits to homebound families, counsel, train, and educate them about available resources;
- h) initiate peer support programs with trained peer counselors;
- i) establish or connect caregiver to workplace support programs; and
- j) sponsor caregiver conferences and other counseling, training and support group services.

4. Respite Care:

- a) provided through adult day care;
- b) coordinating in-home respite care programs with trained companions or aides
- c) coordinating institutional respite for overnight or week-end respite;
- d) providing access to emergency respite care; and
- e) promoting other short-term respite options

5. Supplemental Services:

- a) providing help obtaining caregiving supplies, such as incontinence items, adaptive clothing, personal emergency response units, assistive technology, environmental modifications, et cetera; and
- b) other services or resources identified by the caregiver, such as transportation.

In carrying out the NFCSP, each AAA shall make use of trained volunteers to expand the provision of the available services described and, if possible, work in coordination with organizations that have experience in providing training, placement, and stipends for volunteers or participants (such as organizations carrying out Federal service programs administered by the Corporation for National Community Service) in community service settings.

Self-Directed Care: This is an approach to providing care that is led by the care recipient often involving care provided by an informal caregiver. NFSCP funds may be dispersed to assist the family caregiver arrange and pay for 'Self Directed' care. In accordance with the definition-based on the care recipient and caregiver assessment, the AAA staff will develop a plan together with the care recipient and their family how these services will be planned, budgeted,

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and purchased, including steps to ensure the quality of services provided and the appropriate use of funds under the OAA.

C. Title III E NFCSP Funding

1. NFCSP shall supplement and not supplant funds previously applied to support caregivers.
2. The NFCSP requires a 25% non-federal share for both administrative costs and services delivered under the program.
3. The Administration on Community Living (ACL) requires the SUA to limit spending for supplemental services to 10% of NFCSP funding.
4. The AAA shall allocate a minimum of 5% and no more than 10% of Title III-E funds to support grandparents or older relatives raising children.
5. The AAA is allowed no more than 10% of the regional allocation of NFCSP funds for planning and administration activities related to the NFCSP.
6. The OAA and SUA allow AAAs to provide Title III E NFCSP services either through cooperative agreements with community organizations or as direct service.

D. SUA Responsibilities

The SUA has overall responsibility for ensuring the proper expenditure of OAA funds and for the continuing development of the statewide service delivery system that is responsive to family caregivers.

E. AAA Responsibilities

To oversee and support development of the NFCSP Program at the regional level, the AAAs are to ensure continued development of the agency service system in response to the emerging needs of family caregivers and to manage the program and provide support to AAA staff. Each AAA shall employ a Family Caregiver Support Specialist to play an active role in leveraging existing resources, developing partnerships, identifying and responding to caregiver needs, linking caregivers to community resources and services, developing needed community resources, expanding successful services and evaluating the program on an ongoing basis to guide continued development and improvements in the program. The AAA can establish the position using the allocated OAA funds to cover the administrative duties of the advocate and a portion of the NFCSP service funds to cover the activities that aid caregivers directly, or through establishment of needed resources and service partnerships.

F. Partnership Development

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The SUA requires the AAA to coordinate their activities with those of other community agencies and voluntary organizations providing services corresponding to those in Section B. above. The AAA shall identify and build upon existing resources and activities within the region and establish memoranda of agreement with those entities that are essential to carrying out the regional NFCSP plan. These interagency agreements should ensure that existing services are accessed first to assure that NFCSP are not supplanting existing resources.

G. Reporting:

All services provided using OAA Title III E funding shall be reported to the SUA annually via the required reporting system for OAA data. The SUA may at any time during the year request additional data about these services provided by the AAAs, and AAAs shall respond as accurately and timely as possible. More detailed instructions about data reporting shall be provided to AAAs annually; questions may always be directed to the SUA Director. *See Section XIV. Data Systems, Collection and Reporting.*

OAA Reference: Section 371-374.

WASHINGTON



WASHINGTON STATE
FAMILY CAREGIVER SUPPORT PROGRAM

CHAPTER 17
LONG TERM CARE MANUAL

Policies and Procedures
for Area Agencies on Aging

AGING AND LONG-TERM SUPPORT ADMINISTRATION

May 2015

**Washington State Family Caregiver Support Program (FCSP)
Policies and Procedures**

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FAMILY CAREGIVER SUPPORT PROGRAM (FCSP) INTRODUCTION

Supporting unpaid family caregivers keeps Washington families together and means less people need expensive long-term care placement or services. If family caregivers become unavailable, it's likely that adults would need to access more costly in-home and residential services. These caregivers need support to help prolong their ongoing caregiving activities as well as ensure their own mental and physical health stays intact while coping with related challenges. Cutting edge research demonstrates that it is critical to understand how a caregiver is feeling about their role in order to better tailor the support to their individual needs.

The FCSP, established in 2000, is available in every county in WA and offers unpaid family caregivers tailored services and resources. There are two goals for the FCSP:

- To provide information and support to unpaid family or other unpaid caregivers (who are not involved with the Medicaid funded Long-Term Care service system), and
- To postpone or prevent the need for more expensive forms of care for adults (care receivers) needing ongoing care or supervision.

Aging and Long Term Support Administration (AL TSA) administers FCSP through funds primarily received from state and federal monies as well as other funding and unpaid supports.

Caregivers may receive one or more of the following services:

- Information about long-term care and caregiver support services
- Assistance in gaining access to supportive services
- Evidence-based assessment of caregivers' needs and care planning
- Caregiver support groups
- Caregiver training, consultation and education (increasing skill building and self-care)
- Counseling services to cope with challenges
- Respite care services (in and out-of home settings, e.g. Memory Care and Wellness Services) to provide breaks
- Supplemental Services such as a housework and errands type service, bath bars and incontinence supplies
- Health and wellness referrals to cope with depression and medical issues

In 2007, the legislature revised 74.41.050 RCW mandating development of an evidence-based tailored caregiver assessment and referral tool. There was also legislative intent to have greater consistency in both policy and services within the FCSP. The Tailored Caregiver Assessment and Referral (TCARE®) protocol was the model that best matched the legislative mandate and intent. The company that officially oversees the management of TCARE® is Tailored CARE® Enterprises, LLC.

Who is eligible to receive FCSP services?

Under the **State FCSP**, an eligible “family caregiver” is an individual who is a spouse, relative or friend who has primary responsibility for the care of an adult with a functional disability* and who does not receive financial compensation for the care provided. (RCW 74.41)

*The term functional disability refers to any reduction in the adult’s ability to perform essential activities of everyday life. These activities are necessary to maintain health, independence and quality in an adult’s life.

Under the **National FCSP (Title III E – Older Americans Act)**, an eligible “family caregiver” is an adult family member or other “informal” (unpaid) caregiver, age 18 and older, who is providing care to either an individual, 60 years of age and older or to an individual of any age with Alzheimer’s disease and related disorders.

What is considered financial compensation?

If an individual receives wages for the care they provide to the care receiver, these wages are considered financial compensation. However, if transportation or lodging/room & board is offered to a family member to make it possible for them to provide care, these types of costs are allowable and not considered as financial compensation.

How is the caregiver age requirement different from state to national FCSP?

The age of the caregiver is not specified under the statute for the State FCSP, whereas under the National FCSP the caregiver must be an adult, 18 and over, in order to be served.

What is the priority caregiver population for State FCSP? The state legislature’s priority population for the State FCSP (SFCSP) is unpaid family caregivers whose care receivers are not receiving Medicaid funded, Long-Term Care Services (e.g., COPES and Medicaid Personal Care). The SFCSP is viewed as a resource to help divert care receivers from the Medicaid long term care system by way of supporting the unpaid caregiver. When SFCSP support is requested for an unpaid family caregiver whose care receiver is getting a Medicaid funded long-term care service, an Exception to Policy (ETP) should be utilized to help determine what percentage of total caregivers are served in this category.

TCARE® OVERVIEW

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Beginning July 2009, the TCARE® tool was implemented into the FCSP. The TCARE® process is based on the premise that providing the right service at the right time best supports those unpaid family caregivers who are burdened by their caregiving responsibilities. TCARE® includes screening, assessment, consultation and service planning elements that are designed to be utilized with the FCSP which is administered through the Area Agencies on Aging (AAA).

TCARE® is a theory-driven protocol designed to identify measures of caregiver burden and stress and produce recommended services and supports to address those stressors. The goals, strategies and services are determined based on the results of a screening and assessment using multidimensional measures of caregiver burdens and uplifts, depression scores, identity discrepancy as well as care receiver Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) scores. This protocol identifies and prioritizes services using a consultative planning process targeted to support the caregiver's abilities to provide care for the care receiver as well as to better care for themselves.

The TCARE® process:

- Validates the family caregivers' feelings and experiences along their journey
- Stimulates caregivers to reflect on their caregiving responsibilities through relevant and insightful questions
- Provides structure to the interview between the assessor and the caregiver
- Identifies a broad range of support services available through public and private funding that address the specific stressors and burdens of the caregiver

Parts of the TCARE® Protocol:

The first part in the TCARE® protocol is gathering and entering the demographic information into the system. When a family caregiver is identified as needing FCSP's Information and Assistance services, it is recommended that the caregiver be entered into the TCARE® system. Basic demographic information on the unpaid caregiver and care receiver allows for follow-up and provides the data required for state and federal reports.

The second part in the TCARE® protocol is the TCARE® Screening. Screening can be conducted in a variety of settings: in person, by telephone, or through a self-screen form called the Personal Caregiver Survey. The scores from the screening determine whether the caregiver should be referred on for the third part of the TCARE® protocol.

The third part in the TCARE® protocol is the TCARE® Assessment. The assessment includes all of the screening questions, as well as additional questions focused on both the caregiver's experience and the care receiver's situation. Some of the major areas covered in the assessment are: care receiver behaviors, memory issues, ADLs, IADLs, Cognitive Performance

questions and diagnoses/conditions. An Assessment and Care Plan must be completed within 30 calendar days of the screening.

The fourth part in the TCARE® protocol is the TCARE® Consultation and Care Plan development. The caregiver works with the TCARE® assessor to develop a plan of care based on targeting the most appropriate and timely services to address unmet needs.

TCARE® quantifies information received from the family caregiver and informs AL TSA, AAAs, their community partners, advocates and the legislature about the impact FCSP makes in the lives of caregivers. AL TSA and the Family Caregiver Support Policy Team are committed to revisiting the FCSP policies on a regular basis to make changes as needed.

PART 1: GATHERING DEMOGRAPHIC INFORMATION

The first part in the TCARE® protocol is gathering and entering the demographic information into the system. When a family caregiver is identified as needing FCSP's Information & Assistance services, it is recommended that the caregiver be entered into the TCARE® system. This will allow TCARE® to track the progress of the caregiver's journey.

[Refer to Appendix A for Step I Level of Support](#)

STEP I: LEVEL OF SUPPORT

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- Step I is available to any unpaid caregiver. Caregivers who do not want to participate in the TCARE® screening and assessment processes are still eligible for Step I services.
- A caregiver may undergo a TCARE® Screen but might not reach a particular AAA's threshold for Step II services, in which case that screened caregiver would only be eligible for Step I levels of support.
- Available Resources: Information and referrals to family caregiver or community resources are provided at Step I.
- Up to \$250 (based upon local AAA discretion) of services or tangible support(s) which is a one-time only expense per caregiver which is intended to last for a short time period. Both the caregiver and care receiver's demographic information is required if the caregiver will receive any tangible services or supports paid by FCSP.
- The FCSP encourages family caregivers to seek local supports (e.g., e.g. available friends, family, faith communities) and other funding sources (e.g., Medicare, Apple Health, health and long-term care insurance, Veteran's benefits) in order to maximize state and federal program funds.
- The FCSP funds may be used for the copay of caregiver related services when another funding source is the primary payer and the caregiver can't afford to cover the copay for a service.
- The Step I/II Planning Screen in TCARE® can also be used to track benefits and referrals in addition to the GetCare.

Listed below are some examples of resources and services at Step I:

- Caregiver Information and Assistance
- AAA Caregiver Websites
- Caregiver Workshops and Training including Powerful Tools for Caregiving
- Caregiver Kits
- Support Groups
- Educational Consultation (e.g., a one-time dementia consultation)
- Conferences
- Equipment and Supplies (e.g., incontinent supplies)
- Excludes Mental Health Counseling and Respite Care Services or other ongoing services.

A Step I family caregiver who has not completed a TCARE® screen may receive resources or services under Step 1 up to the level of \$250, (unless your AAA utilizes a lower cap), in the first year only. For subsequent years, a TCARE® Screening will be necessary if they request additional paid services.

Background Information: WA State TCARE® data indicates that caregivers who screen and move onto Step II do far better than those who receive only Step I services. If a caregiver does not complete a TCARE® screen and remains at Step I, TCARE® is unable to determine that initial services were helpful.

One-time or a short-term, caregiver-related event under Step I

Under Step I: When an unpaid caregiver wishes to attend a one-day event (e.g. conference or training) and is unable to find support to provide supervision/care for their care receiver, the FCSP staff has the option of offering assistance within Step I. The cost of the training for the caregiver and the supervision/care needed for the care receiver together should not exceed \$250 annually.

Select “one-time only funding” for the one-day event, under the Purpose code in TCARE® Case Notes and describe the service provided.

PART 2: SCREENING

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The second part in the TCARE® protocol includes a TCARE® Screening. Screening can be conducted in a variety of settings: in person, by telephone, or through a self-screen form, called the Personal Caregiver Survey.

The TCARE® Personal Caregiver Survey can be offered to any family caregiver either in hard-copy or at <http://www.alsa.dshs.wa.gov/Professional/TCARE®/> where a person can download a copy located under TCARE® Tools. This version of the screen does not include the scores/levels (e.g. high, medium, and low) of the six measures (e.g., depression, burdens, etc.). Any staff member who has completed the TCARE® Screening Training or TCARE® Certification may perform a TCARE® Screening. The TCARE® System allows FCSP-related staff to perform a

TCARE® Screening both on-line (connected to the network) or off-line (not connected to the network).

Before finalizing a TCARE® screen that has been sent in to the local FCSP office, it is recommended that a TCARE® Screener or Assessor contact the caregiver to discuss their answers with them and respond to any questions they may have had in filling out the survey. The process of contacting the caregiver and entering the screening scores in the TCARE® system must be completed within 10 business days.

When the TCARE® Screening process is complete, scores and ranges (low, medium and high) are determined for the caregiver's Identity Discrepancy, Burdens (Relationship, Objective, and Stress), Uplifts and Depression. These ranges are used to determine if the caregiver is referred for a full TCARE® Assessment.

STEP II: LEVEL OF SUPPORT

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To determine eligibility for Step II services, consult your local AAA eligibility thresholds.

Available Resources: Based on local AAA discretion, up to \$500 in services and/or tangible good(s), such as equipment/supplies in a 12-month period are available for an individual caregiver. **(NOTE: verify with your AAA, the Step II annual cap.)** If the caregiver received Step I services within the last 12 months, the cost of Step I services must to be included in the Step II \$500 limit. If a caregiver meets Step III threshold levels (consult local AAA eligibility thresholds), the FCSP staff is encouraged to complete an assessment with the caregiver prior to authorizing services at the Step II cap in order for the caregiver to receive a more robust service package.

If a Step II caregiver is caring for two or more care receivers, the caregiver's service package cannot exceed a total of \$500.00 annually. And, if eligible, a caregiver should be encouraged to proceed to Step III to receive a possible more robust service package.

FCSP encourages family caregivers to seek local support (available friends, family, faith communities) and other funding sources (e.g., Medicare, Apple Health, health and long-term care insurance, Veteran's benefits) to supplement state and federal FCSP funding.

Ongoing services, such as Respite Care and a housework and errands type service, etc., are not allowable at Step II.

Listed below are some examples of possible service offerings at Step II:

- FCSP Counseling (up to \$500)
- Respite to attend short-term Caregiver Education or a Training series**
- Registration fees for Caregiver Education Events (travel & accommodation excluded)
- PERs (Personal Emergency Response systems) Equipment, installation and/or monthly service costs not to exceed Step II monetary limit

- Assistive Devices, Caregiving-related Supplies or Equipment

[Refer to Appendix B for Step II for Level of Support.](#)

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FCSP Requirement: TCARE® Screeners and/or Assessors employed by a community FCSP TCARE® subcontractor through an AAA are required to inform caregivers of the relevant, available services in their community, including any FCSP services contracted by the local AAA. This is to ensure that caregivers have information to make well informed choices on services that best suit them.

**When an unpaid caregiver wishes to attend a short-term (e.g., six weeks) caregiver-related education, consultation or counseling series and is unable to find support to provide supervision/care for their care receiver, the FCSP staff has the option of offering assistance within Step II. The cost of the series for the caregiver and the supervision/care needed for the care receiver together should not exceed \$500 annually.

In order for the FCSP to identify either the one-day event under Step I, above, or the short-term series under Step II, above, screeners or other staff must:

1. Enter the demographic information on both the caregiver and care receiver into the Details Screens into TCARE® before authorizing services.
2. Complete a TCARE® screen for the caregiver requesting assistance.
3. Select the Purpose Code “one-time only funding” for the one-day event in TCARE® Case Notes and describe the service provided.
4. FCSP staff or a family caregiver may arrange with contracted licensed or certified, trained agency providers (e.g. home care, adult day services, and residential facilities) for the care needed by the care receiver in the caregiver’s absence.

REMINDER: If, in the course of completing the TCARE® Screen, a caregiver indicates in question 6 that the care receiver has memory loss or dementia, FCSP staff should offer referral information to a local Alzheimer’s resource (e.g., Alzheimer’s Association, Alzheimer’s Society).

TCARE® RESCREENING

A TCARE® rescreening can occur through a telephone or in-person interview or the Personal Caregiver Survey.

The following information relates to caregivers whose previous screen resulted in Step I or Step II eligibility and are due for a re-screening at six months.

For Caregivers at Step I or II

When caregivers are not requesting additional FCSP services, a rescreen (or the Personal Caregiver Survey) at the six-month follow-up should still be encouraged. The rescreening responses will enable the local and state FCSP staff to learn about the effectiveness of the program and caregivers will be able to see how they are doing as compared to prior screening (e.g., have different score ranges in areas such as burden, stress, depression, etc.). Those who choose not to be rescreened are to be encouraged to call back if their situation or needs change.

When caregivers wish to continue to receive FCSP short-term and limited services and have not reached the annual Step I or II financial cap, they can undergo a rescreen every six months.

If the caregiver's rescreen results in higher ranges, FCSP staff should consult the AAA's current eligibility threshold to see if the caregiver should be referred for a full TCARE® assessment.

PART 3: ASSESSMENT

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The third part in the TCARE® protocol is the TCARE® Assessment. The assessment includes all of the screening questions, as well as additional questions focused on both the caregiver's experience and the care receiver's situation. Some of the major areas covered in the assessment are: care receiver behaviors, memory issues, Activities of Daily Living (ADL), Instrumental Activities of Daily Living (IADL), Cognitive Performance questions and diagnoses/conditions. An Assessment and a Care Plan must be completed within 30 calendar days of the screening.

All questions are required to be answered except for the caregiver's monthly income. The question about the care receiver's monthly income is required to determine the participation fee for respite care. The results of the algorithm identify specific goals and strategies linked to caregiver support and services appropriate to address the caregiver's specific stresses and burdens.

One face-to-face visit during the TCARE® assessment or consultation process is required before services can be authorized during the initial assessment/consultation process as well as during subsequent annual TCARE® reassessments/consultations. If the caregiver and care receiver reside together, at least one home visit must occur in the home with both caregiver and care receiver present. This home visit allows the assessor to evaluate the living situation and must be completed before the Care Plan is created. When caregiver and care receiver don't live together, a home visit in the care receiver's home is strongly encouraged, though not required. If a care receiver is unwilling to have a home visit take place, an ETP should be noted within the TCARE® system.

The TCARE® Assessment is available both as an on-line and off-line tool. A TCARE® Assessment must be completed by staff persons who are certified TCARE® Assessors.

It is recommended an AAA Master Trainer, FCSP Coordinator or Supervisor review three TCARE® caregiver cases (which includes entering demographics through the completion of care plan) and provide feedback to each newly certified TCARE® assessor within their first six months. After the first year, it is recommended that a minimum of two TCARE® caregiver cases be reviewed for each assessor in order to ensure program quality. Examples of some case review templates will be available on the ALISA TCARE® resource page.

STEP III: LEVEL OF SUPPORT

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What is the current eligibility threshold for Step III for any new unpaid caregiver who enrolls in the FCSP?

- In order for a family caregiver to access the full TCARE® system (screening, assessment, consultation/care plan and services as recommended by the TCARE® algorithm) a family caregiver must have either:
 - One high score in any of the three burdens (relationship, objective, stress) or in depression or identity discrepancy; or
 - A total of three medium scores in the burden scales, depression or identity discrepancy as indicated in the TCARE® screen.
- Statewide eligibility thresholds may be changed in the future depending on available funding and/or demand.

NOTE: Please verify your AAA's threshold levels.

- If a AAA needs to vary its Step III eligibility criteria from that which is stated above, ALISA FCSP staff must be notified in writing of the reason for this change and approve it prior to the eligibility change being implemented.

As with Step II planning, FCSP encourages family caregivers to seek available supports (friends, family, faith communities) and other funding sources (e.g., Medicare, Apple Health, health and long-term care insurance, Veteran's benefits) to supplement state and federal FCSP funding.

If a caregiver's depression score is either medium or high, the Health Goal is to be addressed in the TCARE® Consultation.

The caregiver can remain active in the FCSP if their care receiver does not want to participate in the program. However, in order for the caregiver to receive respite care or other ongoing services, the care receiver needs to be willing to receive care from a respite provider agency that provides in- or out-of-home respite services.

To be eligible for Respite Services paid through FCSP, a caregiver must provide a minimum of 40 hours of care per week or live with the care receiver who needs ongoing help.

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with the selected strategies identified in TCARE®.



TCARE® ON-LINE SYSTEM: For an assessment to be complete, FCSP staff needs to move the assessment from pending to complete status in order for the TCARE® algorithm to run. **REMINDER:** In the TCARE® application a screen must be moved from pending status to complete within 30 calendar days to avoid repeating the screening process with the caregiver. A copy and create function is built into the TCARE® system so that responses in the screening can be populated into a new assessment.

[Refer to Appendix C for Step III for Level of Support.](#)

TCARE® STRATEGIES AND ASSOCIATED SERVICES

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This section illustrates the types of strategies utilized in TCARE® and examples of services that could be offered.

A	Strategies to change personal rules for care
B	Strategies to reduce or minimize workload
B1	Reduce care needs of care receiver
B2	Reduce difficulty of care and tasks
B3	Introduce alternate source for care to provide respite
C	Strategies to support positive self-appraisal (enhance or affirm current identity & behavior)
C1	Reject negative appraisal
C2	Reinforce positive aspects of identity
D	Strategies to reduce generalized stress
E	Strategies to improve overall health

Strategies A, C, and D (Defined above)

- Caregivers Workshop Series
- Powerful Tools for Caregivers
- Wellness Programs
- Caregiver Education
- Counseling*
- Legal, Financial, Health Care Planning

- Support Groups
- Caregiver Education

*Counseling within the FCSP is now defined as Individual or Family Counseling that can be provided by the following professionals who hold a current license with the Washington State's Department of Health:

- Psychiatrists
- Psychologists
- Psychiatric advanced registered nurse practitioners (ARNPs)
- Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
- Mental health counselors
- Independent clinical social workers
- Advanced social workers
- Marriage and family therapists

Strategy B (Defined above)

- Equipment and Supplies, PERS (e.g., Assistive Technologies)
- Caregiver Education – Information and Skills (including evidence-based (EB) interventions, e.g., STAR-Caregivers (STAR-C), RDAD (Reducing Disability in Alzheimer's Disease), Home Care Aide Training
- Care Receiver Education – Improve Health, Strength and Self Care, including Evidence Based interventions (e.g., Chronic Disease Self-Management /Living Well classes, Diabetes Self -Management Program and Chronic Pain Self -Management Programs)
- Financial and Legal Planning, setting up Bill Pay process
- Transportation
- Home Delivered Meals/Grocery Deliveries
- Pharmacy Delivery
- Rehabilitation Services (e.g., OT/PT)

Higher care needs: In TCARE®, services that provide a break from caregiving are identified under the categories of Informal Help Network, In-Home Supports and Services (Personal Care), Adult Day Services, Overnight Respite Services.

Examples of Services:

- Adult Day Services - Adult Day Health, Dementia and Social Day Care
- Chore/Homemaker Services – e.g., housework and errands type service
- Personal Care or Home Health Services
- Out-of-Home and In-Home Respite

Strategy E

Example of Services:

- Mental and Physical Health Evaluation
- Alcohol and Drug Abuse Evaluation
- Wellness Services – Services to keep caregiver healthy that do not include those services related to emotional health. Emotional Health services belong in Strategies A, B, C and D.

Consider other sources of payment such as Medicare and/or Apple Health/Medicaid, health and long-term care insurance or Veteran’s benefits for payment towards caregiver/care receiver services.

[See Appendix D for Service Names by TCARE® Service Categories](#)

FCSP Requirement: TCARE® Assessors employed by a community FCSP TCARE® subcontractor through an AAA are required to inform caregivers of all the relevant, available services in their community, including all FCSP services contracted by the local AAA. This is to ensure that caregivers have sufficient information to make well informed choices on services that may best suit them.

PART 4: CONSULTATION AND PLANNING

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The purpose of the consultation meeting is to review with the caregiver the outcome of the assessment and to review the services available through the community, private resources (e.g., long-term care insurance) or other public funding (e.g., Medicare, Veterans Administration) to assist the caregiver in relieving their stress and burden.

A consultation worksheet is developed by the TCARE® assessor after an assessment is completed and used to facilitate service planning between the assessor and the caregiver. The consultation with a caregiver helps to determine which services will comprise the final care plan and helps to explain the potential benefits of the services to the caregiver.

What is the timeframe for staff to complete a TCARE® care plan for a family caregiver?

FCSP staff have 30 calendar days from the time the TCARE® screening is completed (and entered into the TCARE® system) until a care plan must be completed.

To consider a Caregiver Care Plan completed, an Agreement Date must be entered into the TCARE® system as the system will not allow the care plan to be moved to complete without this date. The agreement date is defined as when the caregiver verbally agrees to the services outlined in the Care Plan.

Available Resources: After completion of an assessment, a caregiver is eligible to receive services associated with the selected strategies identified in TCARE®.



TCARE® ON-LINE SYSTEM: For an assessment to be complete, FCSP staff needs to move the assessment from pending to complete status in order for the TCARE® algorithm to run. **REMINDER:** In the TCARE® application a screen must be moved from pending status to complete within 30 calendar days to avoid repeating the screening process with the caregiver. A copy and create function is built into the TCARE® system so that responses in the screening can be populated into a new assessment.

Completion of Caregiver Care Plan

The Caregiver Care Plan is developed from the TCARE® Consultation Worksheet. The plan will include the agreed upon services and expected outcomes. Outcomes need to be measurable and specific. For example, instead of stating that a caregiver will learn how to transfer the care receiver from the bed to wheelchair, the assessor might include a statement in the Care Plan that says “Caregiver will have less back strain upon receiving instruction on safe transfer skills.” This will promote conversation at next rescreen.

The TCARE® Assessor will request the caregiver’s signature on the Caregiver Care Plan. The caregiver’s signature signifies acknowledgment of services and of receipt of the Caregiver Care Plan. Do not delay services if caregiver’s signature has not been obtained. The TCARE® Assessor signature is required to acknowledge the agreement between the two parties.

Rescreening For Caregivers at Step III

All caregivers who have completed a full assessment, and wish to continue to receive services must have a completed rescreen at least every **six** months (following the completed care plan) through a self-screen (Personal Caregiver Survey), telephone or in-person interview.

NOTE: Refer to [Appendix E](#) for a diagram of the Flowchart for FCSP TCARE® Rescreen and Reassessment Process.

At the rescreen, scores are to be compared with previous screen or assessment. It is important to note if the ranges of high or medium scores changed.

For current Step III caregivers, if new ranges are lower than last screening/assessment, the TCARE® assessor must confirm that services are still useful and that the caregiver wishes to continue them. If it is not time for an annual assessment, a reassessment is not required. An update to the Consultation/Plan Caregiver Plan is required.

Update Status, Used, and Useful boxes

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- Offer previously declined services or new services to the caregiver and enter in the TCARE® computer application the updated estimated start and end dates.

- Create a new Care Plan. A verbal agreement is required to authorize and begin or continue services. The Care Plan must be sent to caregiver for signature, which acknowledges receipt of the agreed upon services.
- All TCARE® Care Plans are kept within the TCARE® system and there is an ongoing history for viewing and printing.

For current Step III caregivers, if the screen results in the same number of highs or mediums, but the highs or mediums are in different categories from the previous screen, consult the TCARE® Blue User Manual Decision Maps page to determine if the goal has changed. (A change in goal will not appear in the TCARE® system unless an assessment is conducted.)

If the goal has changed, a reassessment must be administered. This enables the algorithm to run, suggesting appropriate services.

If the goal has not changed:

- Update Consultation Worksheet, including new start and end dates for services that will be continued.
- Offer new services when appropriate.
- Complete the Service Plan tab for each service offered.
- Select “in plan” for those services that are to be appear on the Consultation Worksheet.
- Update the action steps and outcome boxes to reflect changes on the care plan.

If the caregiver wishes to continue a current service that is not one of the service options generated by the new TCARE® algorithm and there is no goal change, update that service in the care plan.

- This service will become part of the new care plan being created.
- Conduct the consultation with caregiver to obtain agreement for new plan.
- Print and mail the new care plan to caregiver for signature.
- If no reassessment is conducted at this time, a face-to-face visit is not required.

For what time period can an ongoing service be authorized?

It is possible to authorize ongoing services (e.g. respite care, housework and errands) for up to one year. However, any ongoing service must be updated in the care plan at the time of a **six** month rescreening in order to confirm and document that the service is working for the caregiver. If a rescreen does not take place according to the schedule (must be completed by seven months), any ongoing service(s) must be terminated and the care plan updated. It is recommended that a letter also be sent to the caregiver informing them that, without participating in a rescreen, they will be terminated from the program. If they want to continue to receive services, they must either participate in a re-screening or will need to pay the provider agency privately for the service. If a caregiver is no longer eligible for the service (e.g.

change in TCARE® Goal where the service is not recommended and the caregiver has gotten worse instead of better with services connected to previous Goal), the service must be terminated and other available services offered.

ANNUAL REASSESSMENT

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Caregivers who are at Step III and wish to continue services must receive an annual reassessment within 12 months of the most recent assessment regardless of the screening levels. At least one face-to-face visit must take place at some point during the reassessment or consultation process. As caregiving can change dramatically over time, it is important to see the caregiver and, if possible, the care receiver on at least on an annual basis. If a caregiver lives with the care receiver, an in-home in-person visit must take place before the new updated Care Plan is complete.

At the annual TCARE® reassessment, if a family caregiver is receiving respite care services and wants to continue to receive them and the TCARE® scores indicate that the caregiver has benefitted from the services, the TCARE® Assessor should determine if the family caregiver is still living with or providing 40 hours per week of care to the care receiver. If the family caregiver is providing less than 40 hours per week and it looks like the respite services are helping, the AAA, according to their own local policy, can decide whether or not to provide continued respite services. For example, the AAA may set the required number of unpaid caregiver hours at a lower lid; e.g., 25 hours a week, to still qualify the family caregiver for respite services. If a family caregiver still lives with the care receiver they would automatically still qualify for respite services depending on the outcome of the reassessment and if the TCARE® Assessor and family caregiver determine that respite services are still a benefit to the caregiver.

Refer to [Appendices G](#) - TCARE Screener and Assessor Training and [H](#) - TCARE® Assessor Qualifications and Recertification

RESPITE POLICIES

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The purpose of respite care is to provide relief for families or other unpaid caregivers of adults (age 18 and over) who are living with functional disabilities. Where available, in-home and out-of-home respite care options can be provided on an hourly and/or daily basis, including 24-hour care for several consecutive days. Staff providing respite care services provide supervision, companionship and personal care services that are usually provided by the primary caregiver. Services appropriate to the needs of individuals with cognitive impairment are also provided. Medically-related services, such as administration of medication or injections, are provided by a licensed health practitioner.

Respite providers require a contract. Check with your AAA FCSP Coordinator for a list of your current contracted respite providers before authorizing respite services.

The Washington Administrative Codes (WACs) which direct respite care services are WAC 388-106-1200 through 1230 and included here:

RESPITE CARE SERVICES WACs (Washington Administrative Codes)

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- [388-106-1200](#) What definitions apply to respite care services through the family caregiver support program?
- [388-106-1205](#) What are respite care services?
- [388-106-1210](#) Who is eligible to receive respite care services through the family caregiver support program?
- [388-106-1215](#) Who may provide respite care services through the family caregiver support program?
- [388-106-1220](#) How are respite care providers reimbursed for their services through the family caregiver support program?
- [388-106-1225](#) Are participants required to pay for the cost of their respite care services through the family caregiver support program?
- [388-106-1230](#) What determines emergent and non-emergent respite care services through the family caregiver support program?

AAA Respite Procedures

The AAAs must have written procedures for:

- Determining, with the caregiver and care receiver, the amount of respite care services authorized, when it will be provided, and the name of the respite agency provider. This information must be included in the caregiver's TCARE® Care Plan;
- Arranging for one-time or ongoing respite care with the agency provider and providing them with the TCARE® Respite Information form;
- Maintaining contact with caregivers to determine further needs and/or changes to the respite care plan;
- Providing a substitute respite care worker if the scheduled worker has to cancel;
- Attempting to provide respite care when a caregiver has an emergency; and
- Monitoring the respite care provider and assessing provider performance to ensure all regulations are followed, including training of staff.

NOTE: FCSP-funded respite services shall be terminated upon notification of a care receiver participating in COPES or Medicaid Personal Care, a Developmental Disabilities waiver, or living in an assisted living or nursing home facility.

GUIDELINES FOR DETERMINING FINANCIAL PARTICIPATION FOR RESPITE CARE SERVICES

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The department requires eligible care receivers to pay part or all of the cost of respite care services based on their monthly income (above 40% of the State Median Income (SMI)). The FCSP staff will administer a sliding fee schedule, (same as the Sr. Citizens Services Act (SCSA) schedule) which is updated annually, to determine the share of the cost of these services. The related income question is asked in Question #25(a) in the TCARE® Assessment.

How is the participation fee determined?

- 1) There is no charge to the care receiver whose income is at or below 40% of the SMI, based on family size.
- 2) If the care receiver's gross income is above 40% of the SMI, then, utilizing the SCSA sliding fee scale, the TCARE® assessor will determine the percentage rate the participant is required to pay towards the cost of the respite care services; and
- 3) If the care receiver's gross income is 100% or more of the SMI, the participant must pay the full cost of the respite care services.
- 4) If the care receiver is experiencing extreme financial hardship (e.g., high medical expenses) and cannot pay for their share of the cost of the respite care services, the AAA's FCSP Coordinator or Supervisor may grant an ETP and then the Assessor must document this situation in the caregiver's TCARE® assessment case notes under the ETP purpose code. At the next reassessment the care receiver's income will be once again reviewed for financial participation if respite care services are continued.

How is income defined?

An updated general definition for income includes, but is not limited to, all the money received which the participant can use to meet his/her needs, such as cash, pension, wages, Social Security benefits, Veteran's benefits (e.g. , Aid and Attendance), dividends and interest paid on bank accounts.

The cost of respite care is determined by the numbers of hours or days of respite care service authorized and used, and the rate for the service.

Listed below are examples of how FCSP staff shall determine the care receiver's income:

- A.1 If the caregiver and eligible care receiver are married, all the monthly income received in either or both names shall be combined and one-half of the total shall be considered the participant's income. Refer to Column One on the SCSA sliding fee scale.
- A.2 If the caregiver and eligible care receiver are married to each other and there are dependent children in the home, all the monthly income received in either or both parents' names shall be combined and one-half of the total shall be considered the care

receiver's income. Refer to the fee scale column which represents the number of persons in the household less one (ex. for family of 4, use column 3).

Example: One spouse is the care receiver, the other is the caregiver, and they have two children under 18. The couple's combined monthly income is \$3,000. One-half the total is \$1,500. The monthly income for column 3 (total of persons in the household less one because the husband and wife are counted as one) on the fee schedule is less than 40% of the SMI, so the care receiver does not have to pay participation.

- A.3 In a case where both members of a married couple are respite care receivers and the unpaid caregiver is a friend or relative, all monthly income received in either or both names of the married couple shall be combined and then divided in half. Refer to Column One to determine what percentage of cost each spouse would pay.
- A.4 If the care receiver is single, and the caregiver is a friend or relative, the only monthly income counted toward participation would be that of the care receiver. Refer to Column One.
- A.5 In a case where there are two non-spousal, care receivers living in the same household and are cared for by a relative or friend, each care receiver's income will be considered separately when determining the percentage rate of participation amounts. The cost of the respite service will be pro-rated among the two care receivers. They will share in paying for a percentage of the service (if their income is above 40% of SMI).

Refer to the fee schedule, Column One for the appropriate percentage of cost each participant will pay.

NOTE: Under no circumstances is the combined multiple care receivers' contributions to exceed the cost of the respite service.

- A.6 In a case where the care receiver is the head of household and the caregiver is a relative or friend, only the monthly income received by the care receiver would be considered for financial participation. Refer to the fee schedule for the number of persons (care receivers and dependents) in the household.
- A.7 In the case of a care receiver who is a veteran receiving Veteran's Aid and Attendance benefits for their long term care needs, these benefits are recognized as income and therefore counted. It is important to keep in mind that the caregiver cannot be receiving pay through the VA program and also receive FCSP respite care. That caregiver would be considered a paid caregiver and therefore ineligible for FCSP funded-respite.

AAA Respite Billing Requirements:

1-The AAA's National Family Caregiver Support Program (NFSCP) funding for Respite Care Services is to be used **only** when the care receiver's income is at or below the 40% SMI or when participation is a financial hardship. All other respite care charges must be billed to the State funded FCSP.

For more information go to [MB# H12-056 – Procedure, August 9, 2012. Respite Care Services and Other Non-Core Personal Care Services Funding Source Billing Options Related to Participant Contributions](#)

2-As part of the monthly invoicing to ALTSA, the AAAs must report all funds received from respite care participants by the agencies collecting them. These funds shall only be used within the provider agencies for purposes of the Family Caregiver Support Program.

SPECTRUM OF RESPITE CARE SERVICES

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What types of Respite Care providers are to be involved in FCSP?

Respite care services are to be contracted with the local AAA. The types of possible respite agency providers that can be contracted include available residential facilities: licensed boarding homes, adult family homes, assisted livings, nursing homes, along with adult day services, home care/home health agencies, and any other providers such as Senior Companion, Volunteer Services, etc. Provider agencies shall be monitored for compliance according to the ALTSA/AAA Policy and Procedures. Respite services may be also provided through an unpaid, network of family, friends and community members.

Family caregivers will be able to choose from available contracted agency providers in their service area. Special requests may be made for cultural, ethnic and language considerations. Caregivers may request a change in agency providers at any time. The array of respite care providers (volunteer and/or paid services) should cover all levels of care including:

- A. Companionship, supervision and meal preparation,
- B. Help with activities of daily living (e.g., personal care, lifting, turning, transferring, dressing, eating, walking, medication reminders, etc.),
- C. Tasks such as catheter care, injections, pressure ulcer care, that require licensed medical or health professionals for respite type care such as a Licensed Practical Nurse or Registered Nurse, and
- D. Out of home services: Adult day services where available (socialization, nursing services, rehabilitation, classes and many other activities) or short-term residential facility stays (nursing homes, assisted living, boarding homes and adult family homes).

There may be instances during a respite episode when transportation to a medical appointment or essential shopping* may be provided to the care receiver by the home care agency worker. (This would apply if the family caregiver would normally be providing transportation, but is

unavailable during this episode(s) because s/he is taking a respite break.) This service is allowable if the TCARE® Assessor communicates this need in a written form (this could be included in the caregiver's care plan, Respite Care Information Sheet or AAA/Respite Care Authorization form) to the home care agency ahead of time. The home care agency worker will use 1) public transportation (if appropriate) or 2) insured private vehicle, provided the home care agency worker has a valid driver's license/insurance coverage.

*The Medicaid agency home care rate already includes parity for transportation to medical appointments and essential shopping. Because respite care services utilize this same home care rate, it's reasonable to expect transportation to medical appointments or essential shopping can be included in the respite service package.

Transportation for essential shopping would also be permissible under FCSP Supplemental Services when a home care agency is contracted to do housework and errands type services if the TCARE® Assessor communicates this need in a written form and follows the same procedures for the home care agency worker as stated above.

The following WAC pertains to nursing facilities that provide respite care. [WAC 388-97-1880](#).

Respite Care Provider Staffing and Monitoring Standards Licensing and/or certification of any respite staff are the responsibility of the Home Care/Home Health agencies, Adult Day Services and Residential Services. Check with AAA contract staff on the required certification, licensing, training and background checks needed for all contract respite providers.

If a AAA is unable to provide the array of respite services as listed in this section A through D, above, the AAA must contact AL TSA Program Manager for technical assistance regarding adequate provider network.

The AAA must ensure they are utilizing the current respite provider rates and the Annual SMI Schedule (SCSA) to determine care receiver cost contribution/participation.

RATES FOR RESPITE PROVIDERS AGENCIES

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Rates for In-Home Respite Service Providers

In-home respite care workers shall be paid according to the labor standards and applicable legislation (RCW 74.39A.310). Rates for Home Care Respite Provider Agencies are governed by the following legislation:

[RCW 74.39A.310](#) which requires that the contribution rate for caregiver compensation, paid leave, training and AWHI be paid by the department to home care agencies at the same rate as negotiated and funded in the Collective Bargaining Agreement (CBA) for Individual Providers (IPs) of home care services. This contribution rate is connected to the CBA and is communicated in an MB as changes occur.

Respite care services can contract with home care or home health agencies that employ Nursing Assistant Certified (NAC) staff at their established rate. Nurse delegated tasks are not included within the respite care services.

AAA staff will utilize the latest Management Bulletin on home care rates to determine applicable respite care rates.

Rates for Out-of-Home Respite Providers

Each AAA shall negotiate for an hourly and/or a daily rate with providers whenever possible.

- If an agency provider has only an hourly rate, this rate shall be paid for each hour of respite care used, including 24 consecutive hours of respite care.
- If an agency provider (such as an adult day or residential service) has only a daily rate, the rate shall be paid for 24 consecutive hours or less of respite care used.
- If an agency provider has both an hourly and daily rate, the AAA shall reimburse the provider whichever rate (hourly or daily rate) is lowest.

When a respite episode warrants an exceptional rate for a non-Medicaid funded, out-of-home provider, (e.g. only one facility is available in the area and requires a higher rate and is still more cost effective than some other type of facility), then the AAA may negotiate an exceptional rate and document it with the subcontractor's contract.

The department shall pay Medicaid facilities the Medicaid rate approved for that facility (e.g., nursing homes, etc.). It shall be unlawful for any facility which has a Medicaid contract with the department to charge any amounts in excess of the Medicaid rate for services covered, except for any supplementation permitted by the department pursuant to RCW 18.51.070. The participant shall pay for services not included in the Medicaid rate.

The agency provider shall not be paid for more service hours than authorized by the FCSP. Annually, ALTSA will notify AAAs of the current rates paid by the department to providers offering a same level of service by respite care providers.

How should respite care episodes be scheduled for emergent and non-emergent situations?

TCARE® Assessors shall encourage eligible caregivers to schedule episodes of respite care in advance.

Requests for respite care which are of an emergent nature shall have first priority. An example of such an emergent need for respite would be when the caregiver becomes ill or injured to the extent that the caregiver's ability to care for the care receiver is impaired. It is understood that emergencies may not be able to be resolved if respite resources (e.g. providers) are not available to meet a given caregiver's needs.

In-non emergent situations, respite care is available on a first-come first-served basis provided that sufficient financial resources are available to fill the requests each month. Respite care services are not part of an entitlement program. The amount of respite allotted is based on funding availability along with the needs of the particular caregiver and can vary from time to time. If respite care cannot be provided, refer to the waiting list criteria noted on page 28. If a cancellation occurs, respite care shall be made available to those on the waiting list according to the service priority categories.

AAA FCSP SPECIAL CIRCUMSTANCES

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Caregivers in Crisis

AAA policies will determine how best to serve caregivers in crisis. A caregiver must be screened, assessed, and have a completed care plan within 30 calendar days following the crisis if ongoing services exceeding \$500 were authorized.

EXCEPTIONS TO POLICIES (ETP) AND DOCUMENTATION

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Each AAA must develop an ETP process to be followed when exceptional cases arise within FCSP and the TCARE[®] process. The process must include a written approval process between the assessor and their supervisor or the AAA FCSP program coordinator before authorizing the ETP. For tracking purposes, staff must enter the demographics on the caregiver and care receiver, use Case Notes and select “ETP-Exception to Policy” as the Purpose code. Staff shall discuss ETPs with a supervisor and/or the FCSP Program Coordinator. In addition, a short description of the exception and what action was taken to address the situation is needed in case notes. The date and name of authorizing party’s approval of the ETP (e.g., supervisor or FCSP Coordinator) must also be included in the case notes.

Examples of possible ETPs include:

- A caregiver who needs a certain service that is not included in the list of TCARE[®]’s 15 service categories in Step III and the service is approved by the AAA;
- A caregiver who is in a crisis can be served with Step II or III FCSP services without first going through a screening or assessment. A TCARE[®] screening and/or assessment/care plan must be completed within 30 calendar days if ongoing services are needed;
- A caregiver who needs some supplies or a piece of equipment within Step I (if a TCARE[®] screen has been completed) or II that exceeds the dollar amount;
- For a caregiver who has Limited English Proficiency (LEP) and is requesting services, supplies or equipment, FCSP screeners and TCARE[®] assessors are asked to conduct a TCARE[®] screening/assessment using interpreter services. If this is not feasible, follow the documentation procedures for an ETP;
- If the screener has a “gut feeling” that an existing caregiver who rescreens at less than the eligibility threshold is truly in need of a higher level of service such a Step II to Step III, discuss with supervisor or FCSP Program Coordinator.

- There may be those instances where a family caregiver who is struggling with the caregiving role provides unpaid care to an adult who is receiving Medicaid long term care services (e.g., COPES). An exception can be made if there are no other resources available to help caregiver. This individual can also be served without an ETP at Step I with resources like support group referrals, conferences etc. but if other needs occur (e.g. consultation, counseling) an ETP is needed. Respite care services are not permitted;
- In certain situations (e.g., ethnic/cultural communities), a primary caregiver may not be distinguishable from another family member/unpaid caregiver providing care to the same care receiver. In these circumstances, the total service package for these multiple caregivers should not exceed (in hours or funding) the AAA's limit for one caregiver.

WAITING LIST CRITERIA FOR RESPITE & SUPPLEMENTAL SERVICES

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If an AAA needs to implement a waiting list for FCSP respite care, please use the criteria below. The criteria can also be used for other FCSP ongoing services, e.g., Housework and Errands. Only caregivers for respite care need to meet the criteria of either providing 40 hours per week of care or living with the care receiver.

The TCARE® ranges (low, medium, and high) will be used to prioritize caregivers on a waiting list. **Uplift scores do not count for any of the priorities.** Priority one is considered the highest priority.

Priority 1 – All 5 highs

Priority 2 – 4 highs in Depression, Objective, Stress, and Relationship burdens

Priority 3 – 4 highs; Objective burden must be either medium or high

Priority 4 – 3 highs and 2 mediums. One of the highs must include Depression; Objective burden must be either medium or high

Priority 5 – 3 highs and 1 medium. One of the highs must include Depression; Objective burden must be either medium or high

Priority 6 – 3 highs, no mediums. Highs must include Depression and Objective burdens.

Priority 7 – 2 highs to include Depression and Objective burden

Priority 8 – 2 highs. Objective burden must be either medium or high.

Priority 9 – 3 mediums. Objective burden must be one of the mediums.

The waiting lists are established for caregivers who are new to TCARE®/FCSP. There may be multiple caregivers on a waiting list who are in the same priority category. When an opening becomes available, the caregiver who has been on the list the longest will be served first.

WAITING LIST CRITERIA FOR COUNSELING SERVICES [return to top of document](#)

If a AAA needs to implement a waiting list for FCSP funded counseling* services, please use the criteria below. The TCARE® ranges (low, medium, and high) will be used to prioritize caregivers on a waiting list. Uplift scores do not count for any of the priorities. Priority one is considered the highest priority.

Priority 1 – All 5 highs

Priority 2 – 4 highs in Depression, Objective, Stress, and Relationship burdens

Priority 3 – 4 highs in Depression, Relationship, Stress, and Identity Discrepancy

Priority 4 – 3 highs and 2 mediums. Highs must include Depression and Relationship burden

Priority 5 – 3 highs and 1 medium. Highs must include Depression and Relationship burden

Priority 6 – 3 highs, no mediums. Highs must include Depression and Relationship burdens

Priority 7 – 2 highs to include Depression and Relationship burden

Priority 8 – 2 highs. One must include Relationship burden

The waiting lists are established only for caregivers who are new to TCARE®. There may be multiple caregivers on a waiting list who are in the same priority category. When an opening becomes available, the caregiver who has been on the list the longest will be served first.

FCSP FREQUENTLY ASKED QUESTIONS [return to top of document](#)

Are there restrictions on purchasing goods or services under the FCSP Steps I-III?

Yes, funding from the FCSP cannot be used to pay for rent, car repairs, computers, entertainment items, vacation expenses, major appliances, gift cards or utility bills. If staff are unsure of allowable items or services, contact ALTA FCSP Program Managers.

Can a caregiver receive FCSP services if the care receiver lives in an Assisted Living Facility, paid for privately?

The state and federal funding sources have different viewpoints on this question:

The State FCSP RCW 74.41, states that the program is to “encourage family and other nonpaid individuals to provide care for adults with functional disabilities at home, and thus offer a viable alternative to placement in a long-term care facility”.

For National FSCP (NFSCP), the Older Americans Act defines a caregiver as: An adult family member or another individual, who is an “informal” provider of in-home and community care to an older individual.

Based upon the different definitions, the state FCSP funding should be limited to family caregivers who care for adults at home, whereas the NFSCP can include caregivers who’s loved ones live in an Assisted Living Facility. When applying the NFSCP funding, ALTA staff cautions

AAAs about using costly services for caregivers whose care receivers are living in long-term care facilities.

Can an AAA provide services to caregivers who live in WA State but care for family member living outside of the state?

AAAs can provide services to caregivers, on a case-by-case basis, as determined by the local FCSP policy.

How should caregiver and care receiver privacy and confidentiality be protected?

By its nature, the Family Caregiver Support Program involves collecting sensitive, private information from caregivers and care receivers. Such information must be treated with the utmost care. The Family Caregiver Support Program (which is a non-Medicare and non-Medicaid program), is not considered a Health Care Component under HIPAA and therefore is not subject to its rules, oversight and penalties. However, such information is still confidential and subject to RCW 42.56.590 and RCW 19.255.010 if a breach occurs. If the TCARE® Assessment and Care Plan involves the sharing of caregivers' responses of any health related information (e.g., results of the depression scale) AAAs shall get signed consent forms (the AAA can choose the DSHS 14-012 form or similar one) from the caregivers so they are aware that the FCSP staff may share the minimum necessary information with contracted partner programs in order to help provide effective caregiver services. The TCARE® database is controlled by DSHS, and is protected under strict security protocols and AAA security contract language. Only those staff with the proper security clearance and covered by confidentiality oaths have access to it.

For activities of daily living needs and health-related information on the care receivers that will be shared with providers (e.g., respite care providers), a signed consent form (the AAA can choose the DSHS 14-012 form or similar one) should also be utilized and signed by the care receiver or their designated representative.

What documentation is needed in the family caregiver file when purchases are made?

Staff that authorize services under the FCSP are responsible to ensure that, when purchasing goods/services or one-time set-up fees on behalf of an eligible family caregiver, documentation within a family caregiver file (e.g., copies of authorization and billing tracking documents) must include:

- A caregiver's name,
- A description of the goods and services including purchase price,
- Proof (can be verbal verification with caregiver) the goods were purchased, and
- Goods or services were received, the costs verified, and purchase is consistent with needs identified in the TCARE® care plan.
- No cash or gift cards may be offered to family caregivers.

It is important to also consult local AAA policies for additional documentation that may be required.

Can a care receiver receive general case management at the same time their family caregiver receives FCSP?

Yes and the FCSP staff should coordinate with the General Case Management staff to optimize service delivery and avoid duplication of efforts and resources.

Can a caregiver receive services through a kinship care program (Kinship Caregivers Support Program or Kinship Navigator Program), and simultaneously from the Family Caregiver Support Program?

Yes, as these programs serve different primary care receiver populations (adults versus children), the needs of the caregiver can vary based on their role. The FCSP staff should coordinate with the kinship care staff to optimize service delivery.

TCARE® APPLICATION

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How does one change the Caregiver Status?

In the TCARE® system you can change Caregiver Status from Active to Inactive and back again. The TCARE® system records the date, time, user and reason for inactivation or reactivation when the caregiver's status changes.

What is the process for Family Caregiver TCARE® Inactivation?

It is important for FCSP staff to accurately mark the reason for an inactivation of a family caregiver from the TCARE® system. This information is used to help determine the outcome of the caregiver's participation in the FCSP.

A single response option can be selected from the Caregiver Status Inactivation drop down menu. Listed below are the response options:

- Caregiver (CG) current needs addressed
- CG Death
- CG Health Issues
- CG no longer available
- CG Change
- CG receiving wages (for caregiving)
- CG did not meet eligibility level
- Care Receiver (CR) Death
- CR on Medicaid LTC Services
- CR Placed in any LTC facility
- Declined Screening/Assessment
- Duplicate
- Lost contact
- Moved out of state

- Other
- Refused service
- No activity in nine months (Display only. System generated for automated inactivation)

What if there has not been any TCARE® activity for a caregiver in many months?

The TCARE® online system will automatically inactivate a family caregiver if there has been no activity within a nine-month period. This means that if there have been no screenings, assessments, care plans (or updates) or case notes provided in the caregiver's file, the caregiver will move to inactive status. This action is least desirable; when the system inactivates a family caregiver, it is not possible to get outcome information to understand what is happening with the family caregiver or their care receiver.

For staff to change status from Active to Inactive, all incomplete or pending Screenings and Assessments must be completed or deleted. Once caregiver is Inactive, all information in their folder will be read-only.

If caregiver wants to stay connected to FCSP through Step 1, staff should not inactivate this individual in the TCARE® system. Contact with these caregivers, at least every six months, will inform staff of caregiver's desire for more or less involvement with the FCSP. Either create or update the Step I TCARE® Application Planning Screen.

What are the TCARE® Purpose codes to use in the case notes?

PURPOSE CODE DEFINITIONS

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Advocacy: Use to document advocacy activities on behalf of client.

Assessment: Use to document when the purpose of the contact is to complete the initial assessment.

Caregiver Care Plan Signature Date: Use to document the receipt of the signed Care Plan signature page from the caregiver.

Case Closed: Use to document that you have inactivated the caregiver in the TCARE® tool.

Clerical: Use to document any clerical function such as payment authorization, mailing of forms, or scheduling appointments.

Collateral contact: Use to document contact made to gain or share information with a collateral contact, such as medical provider, service provider, family members, mental health provider, etc.

Consultation: Use to document the discussion you had with the caregiver about the screen scores, strategies and support services that may reduce burden, and services that the caregiver believes will be beneficial.

Dementia Consultation: Use to document implementation of a structured intervention designed to help family caregivers who are caring for someone with Alzheimer's disease or a related dementia to resolve dementia-specific challenges. Would include STAR-C, Skills2Care, and Reducing Disability in Alzheimer's disease (RDAD).

External Consultation: Use to document discussions with individuals outside your organization.

ETP (Exception to Policy): Use to document the Program Manager's approval of an ETP.

Follow-Up: Use to document calls to providers or the caregiver verifying that services have been started or that equipment that has been purchased is working effectively.

Information: Use to document the gathering of information for the caregiver or others.

Intake: Demographics: Use when initially gathering demographic information from the caregiver for level 1&2. There are times when intake: demographics info is gathered on someone who is not screened at that time and who, when screening occurs, is a level 3.

Internal Consultation: Use to document discussions with individuals inside your organization. Ex: staffing with your Supervisor, Program Manager, or to consult with your AAA consulting nurse.

Medicaid LTC Services Pending: Use to document when caregiver's care receiver has submitted a Medicaid LTC request/application for services to Home & Community Services and is awaiting a final determination.

One-time only funding: This choice is used to indicate that the contact is related to a request for a one-time payment and that there may or may not be a TCARE® Screening or Assessment for this caregiver's case.

Plan Agreement/Changes: Use to document verbal approval of the Care Plan.

Planning: Use when discussing services and options before care plan is finalized.

Provider Issues: Use to document issues with the provider. (Ex: notification that a Respite provider cannot be found for the schedule requested, caregiver would like to switch providers, etc.).

Referrals Made: Use to document referrals to providers, Nurse Consult, etc.

Re-Screening: Use to document the 6 month re-screen.

Reassessment: Use to document assessments completed annually. (If completing an initial assessment select Assessment for purpose code)

Screening: Use to document an initial screen.

Schedule change: Use to document a change in the agency provider schedule.

Other: Use to document activity that does not fit under the other purpose codes.

TCARE® Application Workarounds and Processes [return to top of document](#)

How does one complete cases involving one caregiver caring for 2 care receivers that come into the system at the same time?

An assessment needs to be completed for each dyad relationship: You will create only one caregiver in TCARE®. A separate assessment will be conducted for each dyad: caregiver (CG) and associated care receiver (CR) 1 and CG with associated CR 2. Keep both of the assessments in pending status until you are ready to move one or the other to complete status.

To get two Care Plans, (e.g., one caregiver Care Plan associated with care receiver #1), the assessor needs to first ensure that the appropriate care receiver (CR #1) is chosen from the care receiver drop down menu on the care receiver screen.

For the assessment associated to the CG and CR #1, you need to first move this pending assessment in the tree to complete and then work it through the consultation and care plan process.

Leave the CG/CR #2 assessment in pending status until you have completed all the steps for developing a care plan for CG and CR # 1.

DO NOT move the assessment between CG and CR #2 to complete before finishing the consultation and care plan on CG and CR #1.

Once you have worked all the way through the process so that the care plan for CR #1 is complete, the Assessor would then do the same process with CG and CR #2. Now that CR #1 process is complete, you can move the pending assessment for care receiver #2 to complete and continue the process for CR #2, consultation through care plan.

If you do not follow the steps above, it will result in creating the care plan associated with the last assessment that was moved to complete.

You can choose which services are most appropriate on the consultation for that particular dyad instead of doubling up on the same service units for each CG/CG (e.g. mental health counseling, Powerful Tools for Caregiving) would only need to be on one care plan as it would benefit the caregiver in both instances. Another example would be if the CG has a higher relationship burden score associated with CR#1 than with CR#2, counseling would be most appropriate in the care plan related to CR#1. This should only appear on the care plan of the CR #1.

Once you have the two care plans (for CR #1 and CR #2), you will not be able to combine the two care plans into one single care plan.

How does one complete a Case involving ONE care receiver and more than one caregiver?

In those instances where there is more than one caregiver, the Assessor must complete an assessment for each caregiver/care receiver dyad. NOTE: Keep in mind RCW FCSP language 74.41 focuses on primary family caregivers. Under the FCSP RCW 74.41 (5) "Unpaid caregiver" means a spouse, relative, or friend who has primary responsibility for the care of an adult with a functional disability and who does not receive financial compensation for the care.

In these instances where there is no primary caregiver, each caregiver may feel differently about their role as it relates to providing care for the care receiver. Assessors can distribute services (e.g.; respite care, etc.) between the multiple caregivers, not to exceed total number of hours authorized by AAA policy per caregiver. The assessor can designate a variety of services for each caregiver, or when appropriate, offer similar services to each (attend trainings, Powerful Tools for Caregiving, etc.). They should reference in the Additional Notes section at the end of the care plan that another caregiver is also providing care to the same care receiver.

How can an assessor create a Health Goal if the option does not appear in the Goal dropdown after the TCARE® algorithm has run? Instructions for Work Around are:

The Health Goal only comes up in TCARE® if the caregiver scores medium or high in depression. There may be times when an assessor determines that a health-related service would be beneficial, despite a low depression score. The TCARE® main service categories (1-14) found in the TCARE® User Manual contain "z" subcategories labeled "Other" under the Guide for Selecting Support Services. The z subcategory can be used to add health-related services. Then note this in Case Notes using the purpose code "Other."

TCARE® REPORTS AND FCSP REPORTING

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A number of TCARE® Management Reports are available to AAAs on the ADSA Reporting web page, <http://adsareporting.dshs.wa.gov/>. These reports include:

- TCARE® 1503 – Active Caregiver Summary
- TCARE® 1504 – Care Plan Service Summary
- TCARE® 1505 – Worker Activity AAA
- TCARE® 1506 – Worker Caseload Tickler
- TCARE® 1063 – Inactive Caregivers by AAA

AL TSA recommends that FCSP Coordinators/Supervisors review this report regularly to gather information on caregiver case status.

AAAs are to provide quarterly FCSP reports to ALTSA FCSP Program Manager until the CLC-Get Care system takes over this function. Currently, the reports are due six (6) weeks after the end of each quarter. The units of service and unduplicated caregiver count are required for each of the core FCSP services. Detailed demographic information on caregivers who are entered into the TCARE® system will be obtained from the TCARE® system by ALTSA staff for both state and federal reports.

[See Appendix F for FCSP Core Service Definitions for reporting](#)

Changes have been made to several definitions of FCSP core services. These changes include:

- **Access Assistance – Intake** includes Intake (e.g. demographics inputted into TCARE® (Step I))

- **Counseling** – is now defined as Individual or Family Counseling that can be provided by professionals who hold a current license with the Washington State’s Department of Health:
 - Psychiatrists
 - Psychologists
 - Psychiatric advanced registered nurse practitioners (ARNPs)
 - Psychiatric mental health nurse practitioners-board certified (PMHNP-BCs)
 - Mental health counselors
 - Independent clinical social workers
 - Advanced social workers
 - Marriage and family therapists

- **Training/Consultation** – is defined as: one to one consultation or group training, through a single event or series to help caregivers with coping and/or to build caregiving skills or provide the care receiver with training. Examples include a six-week Powerful Tools for Caregiving series, caregiver conferences, caregiver consultation or hands-on training, Enhanced Dementia Options Counseling and evidence-based STAR-C and RDAD models.

Step I Level of Support	Step II Level of Support	Step III Level of Support
TCARE® demographics required	TCARE® screening required	TCARE® assessment, consultation, care plan required

1

Part 1 : TCARE® Demographics

Reminder–Caregivers must be:

Unpaid and providing care to an adult age 18 or over

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Part 1 : TCARE® Demographics

Caregivers may receive:

- Information and brief assistance.
- FCSP support groups and trainings.
- One consultation. Consultant should encourage caregiver to do TCARE® screening if he/she wants more service.

Caregivers may NOT receive:

- Respite (except in emergencies)
- Mental health counseling
- Supplemental services; e.g. housework/errands

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Part 1 : TCARE® Demographics

Benefits:

- Begins building trust/rapport
- Accommodates caregivers with simple requests
- Encourages referrals
- Opportunity to assess caregiver “readiness”
- Educate caregivers about next step: Screening

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APPENDIX B - STEP II LEVEL OF SUPPORT

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Step I Level of Support	Step II Level of Support	Step III Level of Support
TCARE demographics required	TCARE screening required	TCARE assessment, consultation, care plan required

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Part 2: TCARE® Screening

Completed TCARE® Screening or Personal Caregiver Survey required

- ▶ Must be in the electronic TCARE® system, not just paper version.

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Part 2: TCARE Screening

Caregivers may receive:

- Information and brief assistance.
- FCSP support groups and trainings.
- Several consultations/mental health sessions.
- Supplemental services of up to **\$500*** per year.

Caregivers may NOT receive:

- Respite, other ongoing services; e.g. housework and errands

* Rates may vary by AAAs

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Part 2: TCARE Screening

Benefits:

- Screening tool can be accessed in different formats and settings
- Easy to score manually or through TCARE® IT system.
- Training is brief and accessible to screeners

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Part 2: TCARE Screening

Limitations:

- Screening does not allow access to supplemental funds of more than \$500 per year*
- Respite care/other ongoing services not included
- The algorithm that recommends services is not available in the screening – caregivers do not get the benefit of a full TCARE assessment and care plan.

* AAAs may have lower rates established.

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Step I Level of Support	Step II Level of Support	Step III Level of Support
TCARE demographics required	TCARE screening required	TCARE assessment, consultation, care plan required

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Part 3 : TCARE Assessment & Care Plan

Caregiver must have:

- A TCARE Screening that results in...
 - **One high score** in Relationship, Objective, Stress burdens, Identity Discrepancy or Depression
- OR**
- **Three medium scores** in Relationship, Objective, Stress burdens, Identity Discrepancy or Depression

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Part 3: TCARE Assessment & Care Plan

Caregiver may receive:

- One or more services offered by the FCSP or other local resources including respite care, mental health counseling, training, etc.
- Use TCARE care plan to determine most appropriate services.

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Part 3: TCARE Assessment & Care Plan

Benefits:

- Informs consultation/care planning process
- Helps to develop a plan of services tailored to caregiver's specific needs
- Helps AAAs service gaps in local communities

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Part 3: TCARE Assessment & Care Plan Procedures

- ▶ Conduct a TCARE assessment
 - Either in person or by phone
- ▶ Complete a TCARE Consultation Worksheet
 - Either in person or by phone
- ▶ Complete a TCARE Care Plan
 - Either in person or by phone

Either the assessment or consultation must be face-to-face in a location convenient for the caregiver (often their home).

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Part 3: TCARE Assessment & Care Plan Procedures

- Caregiver Care Plan (continued)
 - Get verbal agreement
 - Mail it to the caregiver
- ▶ Verbal agreement required to begin FCSP services
- ▶ Caregiver signature encouraged

AND...

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Are there restrictions for purchasing goods or services under FCSP?

Supplemental service funds from FCSP **cannot** be used to pay for:

- ✓ rent,
- ✓ car repairs,
- ✓ utility bills,
- ✓ major appliances,
- ✓ vacation expenses,
- ✓ entertainment items,
- ✓ gift cards



When in doubt, think of expenses directly related to caregiving services/supplies (RCW 74.41).

5/21/2015

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What is timeframe for staff to complete a TCARE® care plan with family caregiver?

- ▶ FCSP staff have 30 days from time TCARE® screening is completed (and entered into TCARE® system) until caregiver care plan must be completed.
- ▶ To complete care plan, Agreement Date must be entered into TCARE® system.
- ▶ Agreement Date = when caregiver verbally agrees to services outlined in plan.



4/30/2015

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A resource question is required as part of the TCARE® Assessment.

Question #25(b) is related to care receiver's resources!

- Assessors must ask question(s) about available **financial resources** (e.g.: bank /savings accounts, CDs, trusts & annuities, stocks/bonds, property other than residence) belonging to Care Receiver.
- The answer **does not** affect the family caregiver's eligibility for FCSP services. Only monthly income is considered for respite care sliding fee scale.



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APPENDIX D: SERVICE NAMES BY SERVICE CATEGORY [return to top of document](#)

Service Names by Service Category

Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
(0) Other (This service category can only be selected through the Health Goal. It only appears as a subcategory within service category 1-14.)	a) Comfort Therapies(under Health Goal Other), z) Other	Massage
(1) Adult Day Service (Experience time away from care responsibilities)	a) Health model, b) Social model, c) Dementia model, z) Other	Adult Day Care-dementia model Adult Day Health-dementia model Adult Day Health Services Adult Day Care
(2) Assistive technologies (Promote safety and functional abilities of care receiver)	a) Emergency response system (medical alert, in home monitoring), b) Home modifications (e.g. ramps, walk in showers, grab-bars), c) Home safety features (e.g. lighting, locks, exit door alarms), d) Assistive devices and care supplies (e.g. low beds, mobility devices, commodes, protective garments), z) Other	Electronic locator bracelet Durable Medical Equipment Home Safety Evaluation Occupational Therapist Evaluation Adaptive Equipment Personal Emergency Response System Care Supplies Physical Therapy Evaluation
(3) Counseling (Develop new perspective and practice skills with feedback)	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing positive aspects of caregiving, l) Problem solving skills, z) Other	Individual counseling Caregiver Counseling
(4.1) Education for caregiver to obtain information about services and assist with planning for the future	a) Available support services and how to obtain them, b) Disease and disease processes (provide basis for accurate assessment of care needs), c) End-of-life planning, decision and care, d) Legal, financial and/or health care planning, e) Safe-guarding care receiver in his/her	Online Caregiver resources Caregiver Advocate Family Caregiver Specialist Dementia Consultation Caregiver Consultation Family Caregiver Training/Education Long Term Care Planning

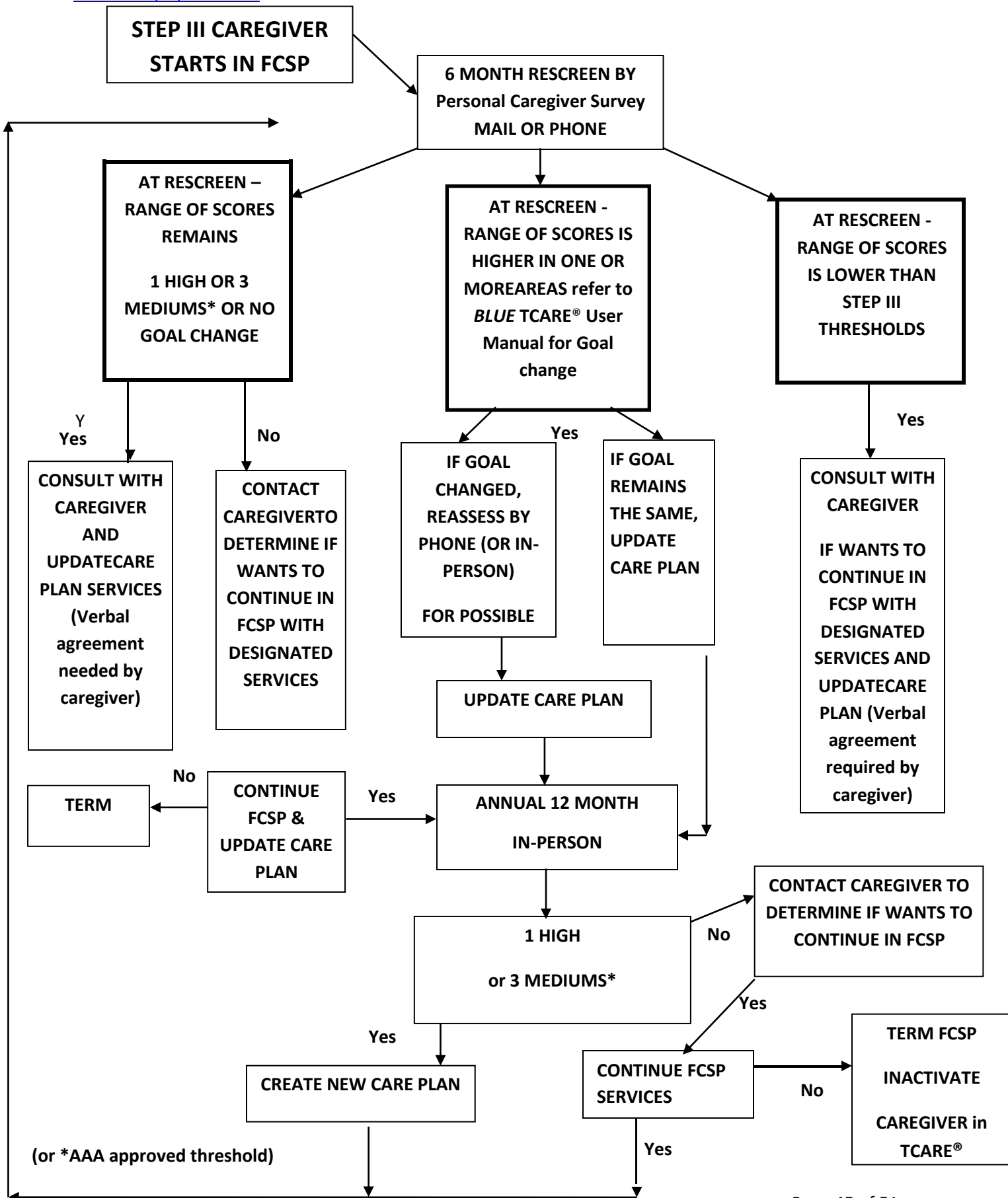
Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
	home (e.g. wander alert services, personal/home safety tips), f) Selecting a suitable living environment, z) Other	Veteran's Benefits Consultation Caregiver Conference
(4.2) Education for caregiver focused on psycho-social issues and coping skills	a) Alternative ways to express anger and frustration, b) Increase level of mastery or confidence, c) Caregiver journey/identity change, d) Develop new way of viewing current situation (Cognitive Reframing), e) Coping Skills, f) Family communication and relationships, g) Understanding and coping with guilt, h) Self-care techniques, i) Stress management techniques, j) Understanding loss and grief, k) Valuing positive aspects of caregiving, l) Problem solving skills, z) Other	Early Memory Loss Support Group Caregiver Consultation Family Caregiver Training Alzheimer's Support Group Powerful Tools For Caregivers Caregiver Conference
(4.3) Education to build caregiving skills (e.g. direct care and communication)	a) Direct care skills (e.g. bathing, dressing, transfer), b) How to ask for help from informal sources (e.g. family, friends, neighbors), c) Skills to communicate with care receiver, d) Skills to communicate with service providers, e) Skills for responding to mood and behavior changes, z) Other	Caregiver Consultation Family Caregiver Training Caregiver Training Caregiver Conference Dietician Consultation
(5) Education for care receiver (Facilitate self-care and/or reduce need for assistance)	a) Improve physical strength, coordination or mobility, b) Skills to increase self-care and independence, c) Reduce expectations for care, z) Other	Falls Prevention Workshop Chronic Disease Self-Management Program Medication Management
(6) Financial and/or Legal Services and Protection (Obtain assistance or counsel)	a) Automatic bill pay (e.g. utility, rent, mortgage), b) Financial assistance or voucher programs (e.g. prescriptions, care supplies, services, housing), c) Legal Services (e.g. estate planning, legal counsel, elder law attorneys), d) Consumer advocacy and protection services (e.g. adult protective services), e) Benefit entitlement programs and/or health insurance plans (e.g. Medicaid, Medicare, LTC Insurance), z) Other	Estate planning/Elder Law Services Benefits Check-up Elder Law Attorney VA Aid and Attendance Advance Medical Directive Information Packet Estate Planning Protective Payee Services
(7) Informal Help Network (Enlist or increase current amount of help)	a) Family and friends (includes family meetings), b) Religious affiliation groups, c) Ethnic/Cultural social club, d) Civic or fraternal organization (e.g. Rotary Club, Lions Club, Jaycees), e) Student group/organizations (e.g. high schools,	Faith based community Religious community In-home respite care (unpaid) Meal Sites Family support Help from Friends

Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
	universities, fraternities), z) Other	Home maintenance/Yard Work Volunteer/Community Service
(8) In-home Supports and Services (Reduce responsibility or workload)	a) Chore/Homemaker services, b) Home delivery of meals/groceries, c) Home health care (e.g. nursing, care attendants), d) Personal care, e) Pharmacy delivery, f) Sitter/Companion services, g) Volunteer/Friendly visitor services, z) Other	Housework and Errands In-home Personal Care In-home respite care (paid) Grocery Delivery Service Meals-On-Wheels Bath Aide Home Delivered Meals Volunteer Chore Services Caregiver (private pay)
(9) Living Environments (Introduce alternate source of 24-hour supervision/care)	a) Assisted living or other community based setting b) Nursing home c) Home of another family member or friend z) Other	
(10) Overnight Respite Services (Experience time away from care responsibilities)	a) Facility-based respite, b) Home-based respite, c) Home of another family member or friend, z) Other	Overnight In home Respite Overnight in home of friend/family Overnight Facility-Based Respite
(11) Palliative and/or Hospice Care (End-of-life supports and services)	a) Facility-based hospice, b) Home-based hospice, c) Palliative care consultation/ services, z) Other	Palliative care Hospice Services
(12) Rehabilitation Services (Identify and promote functional abilities of care receiver)	a) Occupational Therapy, b) Physical Therapy, c) Speech Therapy, d) Respiratory Therapy, z) Other	Occupational Therapist Consultation Physical Therapy Consultation
(13) Support Groups (Expand and sustain networks of support)	a) Condition or disease focused (including early stage groups for care receiver), b) Emotional support/release, c) Friendship/Peer support, d) Skill development, z) Other	Family Caregiver Support Group Support Group for Adult Children Early Memory Loss Support Group Alzheimer's Support Group Online Support Group Disease-based Support Group
(14) Transportation (Introduce alternate source of transportation)	a) Transport Service, b) Volunteer/Escort Service, c) Voucher Programs, z) Other	Dial-A-Ride Transportation (Paratransit Service) Medical Transportation Specialized Transit
(15) Medical or Behavioral Health Services	a) Alcohol and other drug abuse (AODA) evaluation, b) Medical evaluation, c) Mental health evaluation, d) Wellness programs, z) Other	Chronic Disease Self-Management Program Massage Depression screening/Medical evaluation Stress reduction class Fall Prevention Workshop Maintain regular medical appointments

Category	Service Type Not included in Selection/ Display of Service Name INFORMATION ONLY	Service Name
		Mental Health evaluation Exercise Program Medication Management

APPENDIX E- FLOWCHART FOR RESCREEN & REASSESSMENT PROCESS

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APPENDIX F – FCSP CORE SERVICES DEFINITIONS FOR REPORTING

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Family Caregiver Support Program Core Services	Service Definitions
1. Information Services	Specific outreach to caregivers, advocates and community at large regarding caregiver information/resources. These activities directed to large audiences of current or potential caregivers such as disseminating publications, conducting media campaigns, and other similar activities.
<i>a. Group Presentations</i>	
<i>b. Dissemination of Publications</i>	
<i>c. Publicity/Media campaigns</i>	
2. Access Assistance-Intake	Includes activities: caregiver demographics/ intake, screening, assessment, consultation and care planning in the TCARE® (Tailored Caregiver Assessment and Referral) system, as well as other times when a caregiver contacts a FCSP staff member for assistance. Captures caregivers who are at FCSP Step I, II and III.
3. Counseling	Counseling for an individual caregiver or family by a mental health licensed practitioner.
4. Training/ Consultation	One to one or group, single event or series to help caregivers with coping and/or to build caregiving skills or provide the care receiver with training. Examples include six-week Powerful Tools for Caregiving series, caregiver conferences, caregiver consultation or hands-on training, STAR-C, RDAD, and Enhanced Dementia Options Counseling.
5. Support Groups	Caregiver or condition/disease specific focused groups.
6. Respite	In-home care, adult day services, overnight in nursing homes, etc.
7. Supplemental Services	Examples include; assistive devices, care supplies, home safety features, transportation, home modifications, medical or behavioral services, housekeeping and errands, etc.

APPENDIX G– TCARE® SCREENER and ASSESSOR TRAINING

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SCREENER TRAINING

To be eligible to conduct a TCARE® screening, FCSP staff must complete the following (not in any given order):

- Screener webinar, (See ALTSA intranet TCARE® online resource page site: <http://adsaweb.dshs.wa.gov/TCARE>® for calendar of scheduled trainings);
- On-line TCARE® computer application training up through Section 4: Screening;
- Review this FCSP policy document; and
- View the DVD of Dr. Rhonda Montgomery's TCARE® Theory DVD, (a copy has been provided to each AAA).

All of these training components must be completed before the AAA notifies ALTSA FCSP TCARE® staff of the name and contact information for the potential TCARE® Screener. Once ALTSA is notified, the Screener will then be granted security access to the TCARE® application system. NOTE: A TCARE® Screener does not require certification in order to conduct screenings.

TCARE® ASSESSOR TRAINING

A TCARE® Assessor must participate in TCARE® training in order to be certified by Tailored Care, Inc., to use the licensed TCARE® Assessment Tool. There are two versions of the training.

A. Traditional TCARE® Two Day Training

The training consists of two days of formal instruction by no less than two Certified TCARE® Master Trainers. The two-day session covers a series of PowerPoints that provide an overview of family caregiver stress and burdens and detailed instruction on the TCARE® Assessment process and tool. On day two of the training, trainees participate in class/group work that affords them the opportunity to put into practice what was presented in day one of instruction. Following the two-day training session, each trainee must complete two case assignments and submit them to their session's Master Trainers. The case assignments are reviewed by the Master Trainers to ensure the trainee has a working knowledge of the process and all of the elements of the assessment, consultation and care plan. Following each case assignment, participants must attend two webinars. The purpose of these webinars is to review the TCARE® tool and process and provide feedback on their case assignments. Upon successful completion of the Assessor training, the trainee is eligible to take the TCARE® Certification examination that is self-administered and scored by Tailored Care, Inc. Trainees must score 90% or better to be certified.

B. TCARE® eLearning Version

Tailored Care Enterprises is now offering a blended training curriculum format. Instead of the current two-day in-person training format, trainees are provided access to an eLearning

site two to three weeks prior to one-day in-person training. Trainees are responsible for: viewing ten video presentations about the TCARE® program and implementation; completing short quizzes after each presentation, enabling the trainer to determine if the trainee understands the information presented; and completing one short activity. The eLearning portion takes approximately eight hours to complete and is available to the trainee 24 hours a day, seven days a week. During the one-day in-person training, trainees are provided manuals and are given the opportunity to practice the process twice using a TCARE® case study example and one of their own case studies. Trainees must then complete one case study assignment, one review webinar, and the TCARE® Certification exam. For the blended training format, only one trainer is required for every eight trainees with a minimum requirement of two trainees per training. This training option may be available based on the assessor trainee and/or Master Trainer's circumstances. There is an additional fee for this eLearning training and AL TSA will pay for individual assessors for the initial training cost. AAAs will be responsible if training needs to be repeated.

Besides the education and experience piece, all assessors must complete a minimum of five assessments in a year and participate in one, two-hour webinar to maintain certification as a TCARE® Assessor. The time period for when the 5 assessments are to be completed starts October 1st of each year and coincides with AL TSA's annual contract renewal date with Tailored Care, Inc.

It is recommended an AAA Master Trainer, FCSP Coordinator or Supervisor review three TCARE® caregiver cases (which includes entering demographics through the completion of care plan) and provide feedback to each newly certified TCARE® assessor within their first six months. After the first year, it is recommended that a minimum of two TCARE® caregiver cases be reviewed for each assessor in order to ensure program quality. Examples of some case review templates will be available on the AL TSA TCARE® resource page.

APPENDIX H- TCARE® ASSESSOR QUALIFICATIONS AND RECERTIFICATION

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TCARE® ASSESSOR QUALIFICATIONS

Staff administering the full TCARE® assessment/consultation and service planning must meet the minimum qualifications of an AAA Case Manager. These qualifications include the following minimum education and experience requirements:

1. A Master's degree in behavioral or health sciences and one year of paid on-the-job social service experience; or
2. A Bachelor's degree in behavioral or health sciences and two years of paid on-the-job social service experience; or
3. A Bachelor's degree and four years of paid on-the-job social service experience.

If a FCSP assessor staff does not meet these minimum requirements, a waiver in form of a letter needs to be submitted to ALTSA FCSP Program

RECERTIFICATION OF TCARE® ASSESSORS

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Beginning October of each year, TCARE® Assessors must complete a minimum of five (5) or more assessments/care plans per year. This is stipulated in the ALTSA/DSHS contract with Tailored Care®, Inc. This does not apply to assessors who were certified mid-year.

Who keeps track of the five required assessments/care plans per year for each TCARE® Assessor?

Each AAA FCSP Coordinator must check the TCARE® Assessor's care plan activity annually to confirm that each Assessor has completed a minimum of five Assessment/Care Plans annually. Each AAA's FCSP Coordinator needs to submit to ALTSA FCSP Program Manager yearly, the names and email addresses of Assessors who did not meet the five assessments/care plan minimum and need to be re-certified. AAAs may devise their own system for tracking this information. It must include: Name of assessors, phone number and email address, their assigned offices, certification date, number of assessments/care plans completed within the prior year.

What steps are needed to be recertified?

The Tailored Care, Inc., staff will contact assessors to schedule and conduct a two-hour refresher webinar and will provide three to four possible dates and times to accomplish this activity. Once assessors complete the refresher webinar, they will immediately have access to take the on-line re-certification exam. The exam is similar to the current Assessor initial certification exam. Assessors will have two weeks to complete the exam.

How quickly can a TCARE® Assessor be recertified?

The recertification process takes no more than one month to complete. The timing depends on the individual assessor's availability to participate in webinar and complete their recertification.