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TITLE III-B Services

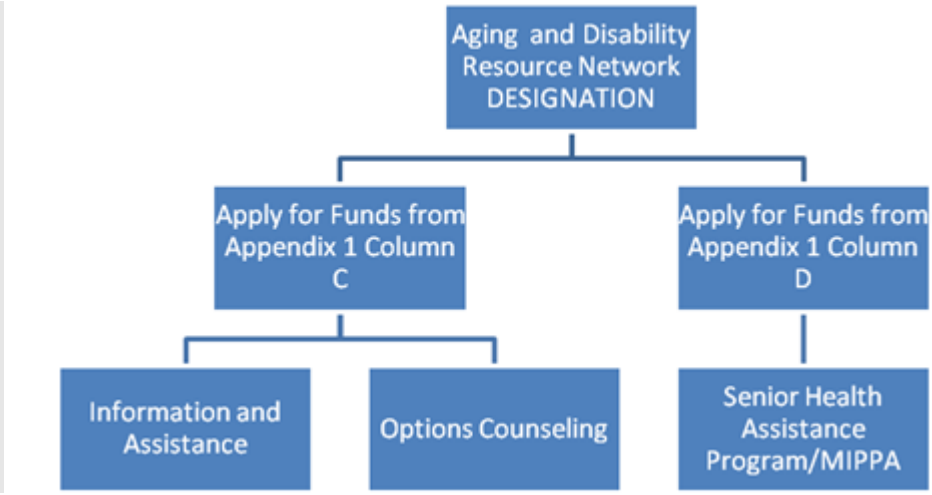
Applicants will apply for the designation of "Aging and Disability Resource Network (ADRN) for a specific township(s) and be responsible for implementing three programs and services under ADRN:

1. Information and Assistance
2. Options Counseling
3. Senior Health Assistance Program (SHAP)/Medicare Improvements for Patients and Providers (MIPPA)

Standards specific to Information and Assistance, Options Counseling and SHAP/MIPPA are highlighted separately. ADRNs are responsible for meeting the standards and definitions for all three program areas.

There will be an Aging and Disability Resource Network designated for all townships in suburban Cook County.

Available funds for this service:
Applicants should apply for the funding that is available for the Aging and Disability Resource Network (ADRN). Applicants may propose to use some of the area's distributive fund to supplement the available ADRN funds. Applicants must meet all the requirements of ADRN or partner/collaborate with another organization to meet the requirements. Each individual agency or partnership should have at least one full time equivalent Information and Assistance staff person. The following chart outlines the funding for each ADRN service:



Special Considerations: *If the Illinois Department on Aging releases standardized materials for the marketing, training, and administering of this program then all ADRNs will be required to comply with the requirements set forth by the Illinois Department on Aging.*

For Agencies designated as Aging and Disability Resource Network - Information and Assistance Service standards	
DEFINITION: There are two types of clients for ADRN services. Older adults over the age of 60 and adults with disabilities who are 18-59 years old. **Services on behalf of an older adult age 60 and over must meet the following:** A person centered, community-based service for older individuals and people over the age of sixty that promotes the independence and dignity that: (A) provides the individual with current information on opportunities and services available within their communities, including information relating to assistive technology; (B) assesses the problems and capacities of the individuals; (C) links the individuals to the opportunities and services that are available, particularly long-term support options; (D) to the maximum extent practical, ensures that the individuals receive the services needed by establishing adequate follow-up procedures; (E) serves the entire community of older individuals, particularly those with the greatest social and/or economic need, and those at risk of institutional placement; (F) provides resources and services that support the range of needs for family caregivers. "Family" includes individuals of the same sex who are lawfully married under the law of a state, territory, or foreign jurisdiction, regardless of whether the individuals are domiciled or reside in a state or territory that recognizes the marriage. **Services on behalf of an individual with disabilities ages 18-59 must:** Provide basic information and quality referrals to individuals with disabilities ages 18-59. An older person, person with a disability, caregiver or service provider, may initiate the service.	**UNIT OF SERVICE:** Each individual client contact made for information, referral, or assistance constitutes one unit of service. These units can include referral and follow-up on behalf of that client.

Clarifications on units of service:
For example: If an eligible client contacts the service provider requesting information on a benefit program, this contact constitutes one unit of service. If the service provider follows up with this same person to see if the application has been made to this program, this will constitute another unit.

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

Internet web site "hits" should be counted as units if there is an exchange of information with the client or representative. If the provider provides this information by e-mail, traditional mail or by telephone, this is one contact (one unit of service).

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

Note: There are several initiatives in Illinois that may affect the Aging Disability Resource Networks during this funding cycle. These include "No Wrong Door," "Universal Assessment Tool" and "Person Center Planning." If these programs are implemented, AgeOptions may need to adjust its standards to reflect new guidance, rules and/or tools.

Service activities may include:

Provision of specific information about appropriate community resources that meet the immediate expressed need;

Provision of assistance to older persons and persons with disabilities (or their regiver) to identify their needs and to place them in contact with appropriate community resources or rvice providers;

Assessment of the problems and capacities of the individual beyond the esenting problem;

Follow-up activities conducted with client and/or agency(ies) to determine ether services have been received and the identified need met following the formal referral;

Expansion of information and assistance services on a 24 hour (if needed) ergency basis during times of disaster (e.g., flooding, hot weather, tornadoes, severe weather, man-ade emergencies, etc.) in order to ensure older persons are safe and have access to services to meet eir needs.

STANDARDS

Staffing

1. The agency shall provide a setting for the ADRN staff to attend to each caller's questions/needs without interruption and in a confidential manner.
2. The staff of the ADRN shall be competent, ethical, qualified, and sufficient in number to implement the policies of stated programs and service objectives. All ADRN direct service staff must meet the following criteria:
   a. Certified by AgeOptions for the delivery of Information and Assistance. This certification involves attending training sessions and passing an accreditation test (staff that passed the former "Central Point of Entry" test meet this requirement).
   b. At least a B.S., B.A., RN, LPN degree from an accredited university, or equivalent.

c. Adhere to a standard training protocol for all current staff and new employees. When IDoA approves standardized training, the training must be utilized by all ADRNs.
d. Participate in all AgeOptions trainings for Information and Assistance service providers.
e. Participate in professional development and training opportunities beyond those offered by the AgeOptions. ADRN staff must complete 10 Continuing Education Units (CEUs) and/or 10 hours of AgeOptions trainings per year that focus on benefits for older people and people with disabilities. All CEUs must be submitted to AgeOptions for approval within one month of the date of the class, course, or workshop. These same hours can be counted towards the Options Counseling Training requirement.

3. ADRNs should have bilingual and bicultural staff that reflects the demographics of the area. In areas in which a significant number of older persons do not speak English as their principal language, the service provider must arrange for or have the capacity to provide information and assistance services in the language spoken by the older persons. The service provider should develop a language assistance plan in the PSA, if needed.
4. ADRNs must have at least one staff person certified by the Alliance of Information & Referral Systems (AIRS) (Certified Information and Referral Systems – Aging and Disability Certificate) that monitors and makes recommendations on the quality of service provided. Agencies should strive to have two staff (supervisor and specialist) trained.

Targeting of Services

1. The agency must arrange for or have the ability to provide information and assistance services in the language spoken by the older persons. As part of NAPIS program reporting, ADRNs will report the languages of the clients that are served.
2. The agency shall ensure that information and assistance services are provided with particular emphasis on linking services available to isolated older individuals and older individuals with Alzheimer's disease or related disorders with neurological and organic brain dysfunction (and the caretakers of individuals with such disease or disorders).
3. ADRN agencies shall serve the entire community of older individuals particularly targeting (i) older individuals with greatest social need; (ii) older individuals with greatest economic need; and (iii) older individuals at risk for institutional placement.
4. ADRNs must conduct outreach and public awareness of services that reach all individuals regardless of race, ethnicity, age, income, ability, sexual orientation, and gender identity. This outreach and public awareness work must be coordinated with the Senior Helpline and recognized disability support services. All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.
5. Grantees shall outreach to new populations in order to bring in “new” clients. The outreach should be in locations outside of their offices.

Tools

ADRN agencies will use the NAPIS software or approved interface as their data collection system for Information and Assistance calls. This system will have information about resources in the community. ADRNs will be expected to submit updates and corrections to AgeOptions as necessary to ensure accurate and up-to-date resource information is available.

ADRNs may be required to use a standardized intake form/process to identify the issues and capacities of the individual beyond the presenting problem. *This requirement relates to the potential implementation of the Universal Assessment Tool.*

ADRNs procedures must be compatible with Comprehensive Care Coordination systems, which may be a referral source for the client as appropriate.

ADRNs are encouraged to use the BenefitsCheckUp Consumer Edition as an assessment tool. ADRNS must have Internet access and email available to all staff and clients and/or their caregivers.

ADRNs will work with AgeOptions on information sharing and cross training of disability partners.

ADRNs must have the ability to provide quality referrals to callers with disabilities. This will include understanding issues and concerns of callers with disabilities and knowledge of the service provider for people with disabilities.

ADRN facilities must:

Provide an environment accessible to people with disabilities and the public.

Have phone and voicemail systems that meet the following requirements:

Sufficient phone lines so that callers may get through 90% of the time.

Preference will be given to agencies that have a live person answer calls rather than a voicemail system. In cases where a voicemail system is used, the system should be user friendly and accessible to potential client.

Phone systems that allow for three way calling (call conferencing) and the ability to forward calls.

Provide a disability accessible environment for meeting with clients and the public.

Service Activities

The ADRN must:

Maintain current information with respect to the services and opportunities available to older persons;

Develop current lists of older persons in need of services and opportunities; and

Employ a specially trained staff to inform older persons of the services and opportunities that are available and to assist older persons to take advantage of the services and opportunities.

The ADRN must provide basic information to clients, their families and to the public on aging and disability topics and issues.

The agency shall seek to maximize and streamline the eligibility determination for public programs and other needed services.

The ADRN must provide assistance in filling out applications, obtaining authorizations and follow up with clients to make sure that benefits and services are accessed. This will be done to ensure the ADRN maximizes the accessibility of other needed services for clients.

The agency shall have a plan in place that addresses its operations in the event of emergency and disaster conditions. In addition, the agency shall keep a list of older persons to contact in case of emergency or disaster.

ADRNs shall provide client advocacy to secure needed benefits.

ADRNs must provide community and/or group presentations about available resources and services.

a. ADRNs will outpost at least once per year in each municipality in their service area. The agency should strive to go to different locations within the municipality each year.
b. ADRNs will outpost at the Congregate meal sites at least once per year. This requirement is in addition to the annual outpost in each municipality.
c. ADRNs shall outpost at locations other than their own facilities or nutrition sites.

The ADRN must make referrals that are in the best interest for the client, and shall make efforts to avoid a conflict of interest.

ADRNs must use person-centered approach to providing referrals and advising clients, caregivers, or their families. The agency shall provide referrals to enable older people to attain and maintain physical and mental well-being through programs of physical activity, exercise, music therapy, art therapy and dance movement therapy.

ADRNs will develop the capacity to identify gaps in available services and develop alternatives to meet those needs. For example, affordable housing may not be available in the area but the caller will be assisted in other creative ways to help meet their needs or a referral will be made to the Care Coordination Unit for a comprehensive assessment.

ADRNs should have the capacity and advertise that they can make appointments for calls beyond traditional hours (evenings and weekends).

ADRNs must have procedures for the evaluation of service delivery to determine the effectiveness of the program.

ADRN services must be available at least five (5) days a week, for seven (7) hours a day.

Partnerships and Service Coordination

1. ADRNs must coordinate and make referrals to the local Care Coordination Unit, Managed Care Organizations, or No Wrong Door Agency as appropriate.
2. ADRNs will have working relationships with key organizations such as, but not limited to, hospitals, townships, municipalities, law enforcement, emergency response, local senior service agencies, disability related organizations, Care Coordination Units (CCUs), Managed Care Organizations, senior centers, Targeted Culturally and Linguistically Isolated Persons (TCLIP) and Caregiver Resource Centers (CRCs) and the local Progress Center for Independent Living.
3. ADRNs will coordinate with administrative agencies such as Social Security Administration, Department of Human Services and CEDA to work to develop streamlined application processes.
4. ADRNs will attend their local Community Quality Council at least twice a year and will strive to attend quarterly.
5. ADRNs must attend trainings and workshops on improving service delivery to culturally and linguistically diverse clients. AgeOptions, TCLIP providers or other agencies, may offer these.
6. ADRNs must follow statewide and regional protocol for coordination between the ADRN system and 211 providers, as this system is developed.

Record Keeping

1. The agency must have informed consent of the client or his/her authorized representative prior to disclosing the client's name. This consent must be documented in the clients' case file whether it is written or verbal consent and include who provided the consent (the client or authorized representative).
2. ADRNs are required to use a computerized client tracking system to report NAPIS information as required. This includes unit and client demographic data. AgeOptions will provide training and technical support to ensure all ADRN agencies are able to meet this requirement.
3. All grantees will meet the "Requirements for Recipients of Title III Older Americans Act Funds."
4. ADRNs must submit a separate SHAP report as required and maintain records for that program as required.
5. ADRNs must submit updates on Options Counseling as required and maintain case file records for those clients.

Quality Assurance

1. ADRNs must participate in statewide efforts to continuously develop the ADRN model and improve program systems.
2. ADRNs must have a continuous process in place to assess the quality of services through client feedback.

For Agencies designated as Aging and Disability Resource Network – Options Counseling Standards	
DEFINITION: Options Counseling is a person-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values. Essential components of Options Counseling include: a personal interview assistance with the identification of choices available (including personal, public, and private resources) a facilitated decision-support process (weighing pros/cons of various options) assisting as requested and directed by the individual in the development of an action plan links to services (when services are requested) follow-up Options Counseling is a person-directed process where the individual controls the planning process, which includes: selection of goals; when and where meetings are held; who is a part of the planning meetings, and who is to be/not be in attendance; the topics to be/not be discussed; and decisions about supports and services the individual selects. Options Counseling will be available to all persons 18 and over with a disability and to older adult who request or require current long term support services and/or persons who are planning for the future regarding long term support services without regard to income or assets. If the Options Counseling program does not specifically address the following there must be a mechanism in place for a transfer if the individual requests assistance: short term assistance, long term assistance, assisting with applications for services, employment assistance, benefits counseling, futures planning, mobility assistance, and assistance with participant directed services.	**UNIT OF SERVICE:** Each individual client contact made as part of the Options Counseling service constitutes one unit of service. These units can include follow-up on behalf of that client.

STANDARDS

Service Activities

1. Providers of options counseling must utilize person centered planning procedures when advising clients and must demonstrate respect for the client's self-direction.
2. The agency must have and use a uniform screening process for receiving initial inquiries or that may lead to the initiation of the Options Counseling process.
3. Every attempt should be made to deliver Options Counseling in the setting and by the method desired by the individual client. Settings and modes of service delivery may include office or satellite office, by phone, by e-mail, by video conferencing technology, other electronic method, or in person at the individual's place of residence. Options Counseling is generally provided on the phone or electronically.
4. Options Counseling is usually provided prior to a Comprehensive Care Coordination (CCC) assessment; Options Counseling is not provided as part of case management (CCC).
5. Options Counseling activities will include the following:
    a. Personal interview or person-centered conversation to learn about the person's values, strengths, preferences, concerns, and available resources that they may use for long-term support services. This discussion is guided by the need to obtain specific information to assist the person in developing a long-term services and support plan.
    b. Exploration of resources to assist with long term services and supports, including informal support, privately funded services, publicly funded services and available benefits, among others.
    c. Decision making support to assist the person in evaluating the pros/cons of specific choices.
    d. Assisting the person to develop a written plan of action. The written plan serves as a guide for the individual for future work and/or steps necessary to obtain LTSS, as requested by the individual, that are important to the person in maintaining independence. The written plan should include a process for follow up.
    e. On-going contact with an individual to answer questions they have about their written/action plan implementation or to assist in the implementation of service. Written plans may be adjusted as determined by the client.
    f. The complexity, diversity, and/or quantity of needs and providers may necessitate the assistance in the coordination of short-term assistance. If short-term assistance is not provided directly by Options Counselors then there must be a process in place to link people to needed services or assistance.
    g. Determining financial eligibility, when appropriate
    h. Assisting with enrollment into public programs and benefits
    i. Encouraging future planning for long term care
    j. Providing a list of agencies, organizations, or facilities and questions to consider when looking at various options. Providers of Options Counseling must make unbiased referrals reflecting the best outcomes for the client and shall make efforts to avoid a conflict of interest. Providers of OC are prohibited from making referral to agencies that are unlicensed, unregistered, or uncertified, if such agencies are required to be licensed, registered or certified.

6. Options Counseling agencies must offer follow up to each individual. Follow-up may be conducted in person, by phone, or electronically as resources allow and the individual prefers. Follow up should be implemented no later than 60 days after the initial Options Counseling contact with the client.
7. Follow-up allows:
   a. The individual to clarify questions concerning their plan;
   b. The individual to receive assistance from the Options Counselor regarding the application and eligibility process, if requested;
   c. The individual the opportunity to request assistance regarding the implementation of long term supports;
   d. The individual and the ADRC to track the usefulness of the service.

Staffing

All Options Counseling staff must meet the following criteria:

Certified by AgeOptions for the delivery of Options Counseling. This will involve attending training sessions and passing an accreditation test (staff that passed the former "Central Point of Entry" or ADRN test meet this requirement).

At least a B.S., B.A., RN, LPN degree from an accredited university, or equivalent.

At least one year of Information and Assistance or equivalent experience.

Adhere to a standard training protocol for all current staff and new employees. When standardized training is approved by IDoA, the training must be utilized by all Options Counseling agencies.

Participate in all AgeOptions trainings for Options Counseling providers.

Participate in professional development and training opportunities beyond those offered by the AgeOptions.

Options Counseling staff must complete an additional 8 Continuing Education Units (CEUs) and/or 8 hours of AgeOptions trainings per year that focus on benefits for older people and people with disabilities. All CEUs must be submitted to AgeOptions for approval within one month of the date of the class, course, or workshop. These hours are IN ADDITION to the Information and Assistance hours. (A staff person who does I&A must have 10 hours of training and an additional 8 hours if they also are an Options Counselor).

Participate in all ADRN Options Counseling trainings

Options Counseling staff must demonstrate cultural competency and have measures in place to serve persons of Limited English Proficiency.

Supervisors of Options Counseling staff must be certified by AgeOptions to provide ADRN services and Options Counseling.

Record Keeping

1. The agency will maintain client files, electronic or paper, to document individual Options Counseling contacts. Documentation should at a minimum include: name of person(s) receiving OC, summary of contact(s), any written plan(s), the individual's stated goals, time spent with/ or on behalf of the person, and the counselor's name. Documentation may be in a paper and/or electronic format

2. The agency must have informed consent of the older person or his/her authorized representative prior to disclosing the client's name. This consent must be documented in the older person's case file whether it is written or verbal consent and include who provided the consent (the client or authorized representative).

Evaluation

The Options Counseling agency will develop a quality improvement/quality assurance program that involves making improvements to operations based on evaluation information. At a minimum, the plan will monitor customer satisfaction with outcomes (including the perceived seamless delivery of services) and effectiveness in linking people to home and community-based services when requested by the individual, as well as tracking transition and diversion activities. This may be done through phone, mail or internet surveys.

For Agencies designated as Aging and Disability Resource Network – Senior Health Assistance Program and MIPPA standards	
DEFINITION: A person centered, community-based service for older individuals and adults with disabilities that: Includes Information and Assistance services, outreach activities and educational programs, counseling about Medicare benefits and Medicare Part B Preventive Care Benefits, Low Income Subsidy (LIS/"Extra Help") and Medicare Savings Programs and prescription coverage available under the Medicare Part D drug plans or Medicare Advantage plans that offer a prescription drug benefit (MA-PD), and other public benefit and pharmaceutical assistance programs; Includes technical assistance, phone support, and counseling in order to help Medicare beneficiaries eligible for the Medicare Part D benefit select and enroll in Part D plans and eligible persons (including those under the age of 60) and other Pharmaceutical assistance programs when appropriate. Supports other activities that promote effective coordination of enrollment and coverage in Medicare Part D Plans. ADRNs are responsible for identifying and achieving benchmarks for the number of applications submitted for Seniors Ride Free, Persons with Disabilities Ride Free, License Plate discounts, Medicare Part De Enrollments, LIS applications, MSP applications, enrollment events for SHAP services, Information and Assistance contacts for SHAP related services, the number of persons counseled for SHAP services, and the number of SHIP sessions, and the community events conducted on SHAP services.	**UNIT OF SERVICE:** Each individual client contact made for information, referral, or assistance constitutes one unit of service. These units can include referral and follow-up on behalf of that client.

How to identify available funds for this service:
Applicants should apply for the funding that is available for the Senior Health Assistance Program (SHAP)/MIPPA

All ADRNs must be designated as a Senior Health Insurance Program (SHIP) site and retain the SHIP designation during the grant period.

Have at least one staff person certified as a SHIP Counselor and attend SHIP trainings. Agencies should strive to have two staff (supervisor and specialist) trained.

Participate in all AgeOptions quarterly conference calls and in-person meetings for SHAP service providers.

All ADRNs, as part of providing SHAP, must 1) attend the Avisery webinars in order to receive updates on SHAP related programs; 2) receive and review Avisery Alerts and Bulletins; and 3) disseminate the information to other SHAP staff.

Submit applications for Medicare Savings Programs, Extra Help, Medicare Part D, Benefits Access and other prescription assistance program for individuals over 60 and persons with disabilities regardless of age.

Conduct community outreach events, and/or group presentations, health fairs, and other community events to provide information about pharmaceutical assistance programs such as Extra Help, Medicare Savings Programs, Benefits Access and Medicare Part D.

Identify clients who are not currently receiving but may be eligible for Medicare Savings Programs, Extra Help, Medicare Part D, Ride Free, License Plate Discount, and other prescription assistance programs,

Grantees shall outreach to new populations in order to reach “new” clients. The outreach should be in locations outside of their offices or nutrition sites.

Grantees will outreach and coordinate with key referral sources:

Nursing Homes and other Institutions: The ADRN should be seen as a resource to discharge planners to help facilitate the transition of residents back to the community.

Acute Care Systems: The ADRN will work with hospitals to put in place protocols for person centered counseling to partner with hospital discharge planners with the common goal of supporting an individual through a transition that would help the person successfully return to the community, even if a post-acute nursing home stay was necessary.

Veterans Administration (VA) Medical Centers

Grantees must submit reports on a timely basis to AgeOptions. Reports should be electronic or may be paper if the electronic system is not working.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Chore Housekeeping	
DEFINITION: Assisting older adults having difficulty with one or more activities of daily living or instrumental activities of daily living (e.g., household tasks, personal care or yard work) under the supervision of the client or other responsible person.	**UNIT OF SERVICE:** One hour of staff time spent providing direct service to a client. Units of service include the time needed for preparation, travel and case documentation. Preparation of reports and grant applications are considered administrative activities, not activities directly on behalf of a client. Units are counted to the nearest quarter of an hour.

Service Activities may include:

Assisting with the uncapping of medication containers and providing water;

Preparing supplies for and monitoring non-medical personal care tasks such as shaving, hair shampooing and combing, assisting with sponge bath;

Assisting with tub bath or shower only when clients are able to enter and exit tub or shower themselves;

Assisting with dressing;

Brushing and cleaning teeth and/or dentures under specific direction of client or responsible individual;

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

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

Service Limits:

The agency's <u>average</u> unit to client ratio may not exceed 80 units per client per fiscal year.

STANDARDS

1. Grantee is encouraged to maintain at least one generic business email address for the sole purpose of exchanging information with the local Care Coordination Unit (CCU) about Chore Housekeeping referrals and/or status of current Chore Housekeeping clients. "Generic" is defined as an e-mail address that is labelled by purpose rather than by employee name (e.g., Chorereferrals@AgencyXYZ.org) and is accessible by a group of the Chore Housekeeping agency's employees. If established, the generic email address must support message encryption to ensure client confidentiality.
2. The Chore Housekeeping agency shall obtain an in-home assessment of client's chore-housekeeping needs from the local CCU prior to service. This assessment shall be kept in the client's file.
3. The Chore Housekeeping agency shall develop a chore/housekeeping plan in conjunction with the CCU including activities to be performed for each client and share with the client

and any significant family member(s). This plan shall be kept in the client's file and updated as necessary.

4. The Chore Housekeeping agency shall maintain individual client records that document the client's needs and the specific services provided.
5. Chore housekeeping services should not be provided on a "first come, first served" basis. The Chore Housekeeping agency (in consultation with the Care Coordination Unit) should prioritize and manage waiting lists based on clients need as well as targeting to low income older adults. Waiting lists should be reviewed quarterly to ensure the clients with highest needs are receiving services.
6. The Chore Housekeeping agency shall utilize chore services offered by the Community Care Program/Medicaid Waiver (including Managed Care) program for eligible participants.
7. The Chore Housekeeping agency shall promote the rights of each older person and shall assure that:
   a. The client is fully informed in advance of any change in service. The client shall participate in planning and changing an in-home service, unless they are judicially adjudged incompetent.
   b. The client is able to voice a grievance with respect to service without discrimination or reprisal;
   c. The client's record shall be kept confidential;
   d. The client's property shall be treated with respect by all staff;
   e. The client shall be fully informed (orally and in writing) in advance of receiving in-home service under Title III.
8. The Chore Housekeeping agency shall develop and follow written procedures for reporting changes in client functioning or needs to the CCU. In addition, the CCU will have procedures for reporting any changes in client function or needs to the chore provider.
9. The Chore Housekeeping agency shall ensure that continual service is provided regardless of staff turnover.
10. The Chore Housekeeping agency shall screen and train chore workers prior to their assignments to clients.
11. The Chore Housekeeping agency shall provide regularly scheduled training and supervision to chore workers.
12. The Chore Housekeeping agency must have an emergency/disaster plan for managing emergency/disaster situations both in the community and in the client's homes. Staff must be trained in these procedures.
13. The Chore Housekeeping agency shall maintain chore worker calendars and/or time sheets as documentation of actual service provision.
14. The Chore Housekeeping agency shall conduct criminal background checks on all staff whose salaries are paid wholly or partially through Area Agency grants/contracts. In addition, volunteers participating in Area Agency funded programs with in-home client contact, or access to confidential client information, should also complete a background check.
15. The Chore Housekeeping agency shall use the computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.
16. All grantees will meet standards outlined in the "Requirements for Recipients of Title III Older Americans Act Funds."

17. All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.

Funding available through the "Distributive Funding" –
This service is NOT required to be funded in each locality.

Counseling	
DEFINITION: Counseling services shall include personal counsel to help individuals and families cope with personal problems and/or develop and strengthen capacities for more adequate social and personal adjustments.	**UNIT OF SERVICE:** The unit of service is a session per participant. Client count should be unduplicated for the reporting period. Example: If there are 7 people attending a weekly educational session, then the unit count would be 7, the unduplicated count of people served is 7. If during the second weekly educational session, 4 people return from the first meeting and 4 new people join, then the unit count for the month to date would be 15 (7 sessions in 1st week +8 sessions in 2nd week), and the unduplicated count of people served is 11 (7 people in 1st week +4 new people in 2nd week).

Service Activities May Include:

Personal counseling; and
Formal and informal group experiences.

STANDARDS

1. Providers of Counseling must utilize person centered planning procedures when advising clients and must demonstrate respect for the client's self-direction.
2. Every attempt should be made to deliver Counseling in the setting and by the method desired by the individual client. Settings and modes of service delivery may include office or satellite office, by phone, by e-mail, by video conferencing technology, other electronic method, or in person at the individual's place of residence.
3. Direct interaction between a trained counselor and an individual to improve mental health or coping with personal problems.
4. Work may be short or long term, including brief crisis assistance. Topics to address can include but are not limited to: a) issues of life/role transitions; b) interpersonal relationships; c) dealing with anxiety or depression.
5. The agency should maintain separate files on Counseling clients. Documentation should at a minimum include: name of person(s) receiving Counseling, summary of contact(s), reason(s) for Counseling, the individual's stated goals, anticipated outcomes of the intervention, time spent with/ or on behalf of the person, and the counselor's name. Documentation may be in a paper and/or electronic format
6. The Counseling agency shall promote the rights of each older person and shall assure that the client's record shall be kept confidential.

7. The agency must have informed consent of the older person or his/her authorized representative prior to disclosing the client's name. This consent must be documented in the older person's case file whether it is written or verbal consent and include who provided the consent (the client or authorized representative).

General

1. Information about the Counseling program must be clearly visible on the agency webpage and there must be an email address on that webpage that individuals can use to request information.
2. The Counseling agency will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.
3. The Counseling agency must coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.
4. The Counseling agency must have an emergency/disaster plan for managing emergency/disaster situations both in the community and in the client's homes. Staff must be trained in these procedures.
5. The Counseling agency shall conduct criminal background checks on all staff whose salaries are paid wholly or partially through Area Agency grants/contracts. In addition, volunteers participating in Area Agency funded programs with in-home client contact, or access to confidential client information, should also complete a background check.
6. All grantees will meet standards outlined in the "Requirements for Recipients of Title III Older Americans Act Funds."

Funding available through the "Distributive Funding" –
This service is NOT required to be funded in each locality.

Education	
DEFINITION: Services which provide individuals with opportunities to acquire knowledge and skills suited to their interests and capabilities through formally structured, group-oriented lectures or classes. Subject areas for adult education may include nutrition, health, mental health, personal care, consumerism, crime prevention, legal rights/entitlement benefits, home maintenance and repair, retirement orientation and life enrichment, etc.	**UNIT OF SERVICE:** The unit of service is a session per participant. Client count should be unduplicated for the reporting period. Example: If there are 7 people attending a weekly educational session, then the unit count would be 7, the unduplicated count of people served is 7. If during the second weekly educational session, 4 people return from the first meeting and 4 new people join, then the unit count for the month to date would be 15 (7 sessions in 1st week +8 sessions in 2nd week), and the unduplicated count of people served is 11 (7 people in 1st week +4 new people in 2nd week).

Service Activities May Include:

Arranging and providing academic courses, classes, seminars, lectures and other presentations;
Developing teaching aids and/or informational materials;
Arranging for group tours of nutrition-related and other organizations as deemed appropriate;
Arranging and providing nutrition education. Nutrition education is defined as: Facts are made available about the kinds and amounts of food required to maintain good health and nutrition, foster good eating habits, and to develop better food purchasing practices, preparation, and selection. Nutrition education should be overseen by a dietitian or individual of comparable expertise.

STANDARDS

Publicize each educational program at least three (3) weeks prior to the date of the program, using outreach mechanisms including but not limited to provider website and newsletter.

Retain records of instructor, instructor credentials, and training materials.

Obtain case management/senior opportunities and services for those clients with additional needs. Pursue assessment for the Community Care Program or other services as appropriate.

Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.

All grantees will meet the “Requirements for Recipients of Title III Older Americans Act Funds.”

All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.

AgeOptions may require Grantee to ensure that all clients complete the UCLA loneliness scale assessment a total of two times during the fiscal year.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Friendly Visiting	
DEFINITION: Regular visits by staff or volunteers to socially and/or geographically isolated individuals for purposes of providing companionship and social contact with the community. The program is for the older person who is often unable to leave his/her own residence, if at all, and who has few to no friends, family, or neighbors that can visit them.	**UNIT OF SERVICE:** One hour of staff or volunteer time expended on behalf of a client constitutes one unit of service. Units should be measured to the nearest quarter hour. Units should be tracked within the client records.

STANDARDS:

The Friendly Visitor Agency will:

Have staff or volunteers visit older adults in their residences.

Arrange for and maintain the service.

Provide training and support to staff or volunteers to ensure competent, ethical and qualified service delivery.

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

Obtain case management/senior opportunities and services for those clients with additional needs. Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will meet standards outlined in the "Requirements for Recipients of Title III Older Americans Act Funds."

All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Home Repair	
DEFINITION: Minor modification of homes/apartments that is necessary to facilitate the ability of older individuals to remain at home and that is not available under other programs.	**UNIT OF SERVICE:** Each home repair or renovation constitutes one unit of service.

Service activities may include:

1. Arrangement for repairs or renovation
2. Follow-up provided to ensure that an older person receives satisfactory service
3. Allowable home repairs/renovations include but are not limited to:
   a. Purchase and/or installation of smoke detectors or changing batteries
   b. Purchase and/or installation of fire extinguisher
   c. Furnace cleaning and tuning
   d. Purchase and/or installation of grab bars
   e. Repair of windows and steps, including seasonal changing of storm windows or screens
   f. Purchase and/or installation of raised toilet seats
   g. Purchase and/or installation of ramps
   h. Widening doorways
   i. Repair cracked plaster
   j. Replace/correct door handles
   k. Repair electrical outlet/switches
   l. Addition of easy to use plumbing fixtures
   m. Purchase and/or installation of adjustable closet shelves
   n. Purchase and/or installation of delayed door closer
   o. Purchase and/or installation of safety strip for tub or shower
   p. Addition of phone amplifiers for hearing impaired
   q. Addition of large buttons for telephones
   r. Purchase of phones for visually impaired, other phone equipment to facilitate the ability of the senior to use the phone
   s. Purchase and/or installation of heating/cooling system
   t. Purchase and/or installation of dead bolts for doors
   u. Lowering a sink or installing an adjustable height sink to increase accessibility of sink for wheelchair-bound older adults

STANDARDS

1. Obtain case management/senior opportunities and services for those clients with additional needs. Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.
2. All repairs/renovations must conform to local laws and ordinances.
3. All assessments and client contacts must be kept in the client's file.
4. Client files must contain documentation of work performed and receipts from vendors with client signatures.

5. The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.
6. All grantees will meet standards outlined in the “Requirements for Recipients of Title III Older Americans Act Funds.”
7. All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Housing Assistance	
DEFINITION: Technical assistance to relocate or obtain more suitable housing which the client can afford. (Excludes direct financial assistance).	**UNIT OF SERVICE:** One hour of staff time expended on behalf of the client. Units should be counted to the nearest quarter hour. Units should be tracked within the client records. Units should include the time necessary for preparation, travel and case documentation. Preparation of reports and grant applications are considered administrative activities and should not be tracked as units of service.

Service activities include:

Actively assist older persons with the entire range of housing needs or problems.

Having a resource file that consists of an inventory of housing opportunities, resources, and services available to older persons.

Assistance in locating suitable and adequate housing which the individual can afford.

Relocation assistance.

STANDARDS

1. Housing Assistance agencies will use the Information and Assistance web-based program supplied by AgeOptions. This system provides information on services and referral sources for aging programs including housing options. Housing Assistance grantees shall submit updates/corrections to AgeOptions as needed to ensure accurate and up-to-date information is available.
2. Obtain case management/senior opportunities and services for those clients with additional needs. Pursue assessment for the Community Care Program or other services as appropriate.
3. Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.
4. All grantees will meet the "Requirements for Recipients of Title III Older Americans Act Funds."
5. All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.

Legal Assistance (Title III-B)	
DEFINITION: Legal Assistance shall include arranging for and providing assistance in resolving civil legal matters and the protection of legal rights, including legal advice, research and education concerning legal rights and representation by an attorney at law, a trained paralegal professional (supervised by an attorney), and/or a law student (supervised by an attorney) for an older person (or his/her representative).	**UNIT OF SERVICE:** **Representation by an Attorney, a Paralegal, and/or a Law Student:** One hour of time spent by one person working on a case. **Legal Information and Community Education:** One hour of staff time expended on behalf of a client(s). Units of service should include the time necessary for preparation, travel and case documentation. Preparation of reports and grant applications are considered as administrative activities and should not be considered units of service. Units should be measured to the nearest quarter hour, and tracked by client.

Service activities may include:

- Provision of legal advice and information;
- Legal research on behalf of client(s);
- Education concerning legal rights including community education;
- Representation by an attorney at law[1] or either a trained paralegal or a law student who are supervised by an attorney;
- Provision of client advocacy to secure needed and entitled benefits.

A **Client** is any person aged 60+ who is seeking legal services in suburban Cook County. No means testing is allowable for determining client eligibility.

STANDARDS

The Area Agency will enter into a grant with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance.

The legal assistance provider will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary of the Administration on Aging.

[1] Filing fees and related court costs are allowable expenses under a legal assistance grant.

The legal assistance provider will attempt to involve the private bar in legal assistance activities authorized under the Older Americans Act, including groups within the private bar furnishing services to older persons on a pro bono and reduced fee basis.
The legal assistance provider must administer a program designed to provide legal assistance to older person with social or economic need.
If the legal assistance provider is unable to assist a potential client, the legal assistance provider must provide referrals (and preferably forward the caller) to the local Aging and Disability Resource Network (ADRN) or Care Coordination Unit for additional assistance.
If the legal assistance agency is not a Legal Services Corporation project grantee, the agency will coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under the Older Americans Act on individuals with the greatest social or economic need.
The legal assistance provider will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. Examples include legal assistance to:

Access public benefits including SS/SSI/SSDI, Medicaid, Medicare, veterans' benefits and unemployment compensation.
Advance directives and designation of surrogate decision makers who will effectuate their wishes if they become incapacitated
Foreclosure and eviction proceedings that jeopardize an older adult's ability to stay independent in their homes and communities
Access to the full benefit of appropriate long term care private financing options
Elder rights protections

Based on standards from 45 CFR Section 1321.71 (Legal Assistance) from the Older Americans Act rules and regulations, the legal assistance provider must:

a. Have staff with expertise in specific areas of law affecting older persons in economic or social need, for example, public benefits, institutionalization and alternative to institutionalization;
b. Demonstrate the capacity to provide effective administrative and judicial representation in the areas of law affecting older persons with economic or social need;
c. Demonstrate the capacity to support other advocacy efforts, for example, the long-term care ombudsman program;
d. Demonstrate the capacity to provide legal services to institutionalized, isolated, and homebound older persons effectively; and
e. Demonstrate the capacity to provide legal assistance in the principal language spoken by clients in areas where a significant number of clients do not speak English as their principal language.

Demonstrate capacity to outpost services to better increase access to legal services in high need areas.
The legal assistance provider may not require an older person to disclose information about income or resources as a condition for providing legal assistance.
The legal assistance provider may ask about the older person's financial circumstances as part of the process of providing legal advice, counseling and representation, or for the

purpose of identifying additional resources and benefits for which an older person may be eligible.

The legal assistance provider and its attorney may engage in other legal activities to the extent that there is no conflict of interest nor other interference with their professional responsibilities under the Older Americans Act.

The legal assistance provider shall not use Older Americans Act to provide legal assistance in a fee generating case unless other adequate representation is unavailable or there is an emergency requiring immediate legal action. The legal assistance provider shall establish procedures for the referral of fee generating cases. "Fee generating case" means any case or matter, which, if undertaken on behalf of an eligible client by an attorney in private practice, reasonably may be expected to result in a fee for legal services from an award to a client, from public funds, or from the opposing party.

Other adequate representation is deemed to be unavailable when:

i. Recovery of damages is not the principal object of the client; or
ii. A court appoints a legal assistance provider or an employee of a legal assistance provider pursuant to a statute or a court rule or practice of equal applicability to all attorneys in the jurisdiction; or
iii. An eligible client is seeking benefits under Title II of Social Security Act, 42 U.S.C. 401, et seq., Federal Old Age, Survivors, and Disability Insurance Benefits; or Title XVI of the Social Security Act, 42 U.S.C. 1381, et seq. Supplemental Security Income for the Aged, Blind, and Disabled.

The legal assistance provider may accept a fee awarded or approved by a court or administrative body, or included in a settlement. If fees are awarded or approved by a court or administrative body due to a case funded by Title III of the Older Americans Act, such fees must be considered as program income that will be used to expand legal assistance services in the service area.

When a case or matter accepted in accordance with this section results in a recovery of damages, other than statutory benefits, the legal assistance provider may accept reimbursement for out-of-pocket costs and expenses incurred in connection with the case or matter.

The legal assistance provider, employee of the provider, or staff attorney shall not engage in the following prohibited political activities:

The legal assistance provider or its employees shall not contribute or make available Older Americans Act funds, personnel or equipment to any political party or association or to the campaign of any candidate for public or party office; or use in advocating or opposing any ballot measure, initiative, or referendum;

The legal assistance provider or its employees shall not intentionally identify the Title III program or provider with any partisan or nonpartisan political activity, or with the campaign of any candidate for public or party office;

While engaged in legal assistance activities supported under the Older Americans Act, no attorney shall engage in any political activity;

No funds made available under the Older Americans Act shall be used for lobbying activities, including but not limited to any activities intended to influence any decision or activity by any non-judicial Federal, State or local individual or body. Nothing in this section is intended to prohibit an employee from:

Communicating with a governmental agency for the purpose of obtaining information, clarification, or interpretation of the agency's rules, regulations, practices, or policies;
Informing a client about a new or proposed statute, executive order, or administrative regulation;
Responding to an individual client's request for advice only with respect to the client's own communications to officials unless otherwise prohibited by the Older Americans Act, Title III regulations or other applicable law. This provision does not authorize publication of lobbying materials or training of clients on lobbying;
Techniques or the composition of a communication for the client's use;
Making direct contact with the Area Agency for any purpose;
Providing a client with administrative representation in adjudicatory or rulemaking proceedings or negotiations, directly affecting that client's legal rights in a particular case, claim or application;
Communicating with an elected official for the sole purpose of bringing a client's legal problem to the attention of that official; or
Responding to the request of a public official or body for testimony, legal advice or other statements on legislation or other issues related to aging; provided that no such action will be taken without first obtaining the written approval of the AgeOptions.

While carrying out legal assistance activities and while using resources provided under the Older Americans Act, the legal assistance provider nor its employees shall:

a. Participate in any public demonstration, picketing, boycott, or strike, except as permitted by law in connection with the employee's own employment situation;
b. Encourage, direct, or coerce others to engage in such activities; or
c. At any time engage in or encourage others to engage in:
    i. Any illegal activity; or
    ii. Any intentional identification of programs funded under the Older Americans Act or recipient with any political activity

The legal assistance provider shall not use Older Americans Act funds to pay dues exceeding $100 per annum to any organization (other than a bar association).
All grantees will meet the "Requirements for Recipients of Title III Older Americans Act Funds."
Reporting- Legal Assistance requires paper reports of client demographics and units provided.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Multi-Purpose Senior Center	
DEFINITION: The Older Americans Act defines Multi-Purpose Senior Center as "community facility with regular operating hours and staff that provide a broad spectrum of health, social, nutritional and educational services and recreational activities for older persons". Funds may be awarded to a public or non-profit organization for the operation of a facility that meets federal, state, and local regulations and/or ordinances, which serves as a multipurpose senior center.	**UNIT OF SERVICE:** None.

ALLOWABLE ACTIVITIES WHICH MAY BE IDENTIFIED FOR SENIOR CENTER FUNDING: The costs associated with the day-to-day physical operation of a facility that serves as a multipurpose senior center, including equipment and the professional and technical personnel of a multipurpose senior center necessary for its operation. Funds may not be used for facility development, alterations, renovations, or construction at the senior center.

STANDARDS

Preference for funding will be given to facilities located in communities with the greatest incidence of older persons with the greatest economic or social need, with particular attention to low-income minority individuals.

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

The agency must install, in consultation with state or local fire authorities, an adequate number of smoke detectors in the facility.

The agency shall have a plan for assuring the safety of older persons in a natural disaster or other safety-threatening situation.

In a facility that is shared with other age groups, funds received under Title III may support only:

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

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

Any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the facility will be paid wages at rates not less than those prevailing for similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276A-5, commonly known as the Davis-Bacon Act). and the Secretary of Labor shall have, with respect to the labor standards specified in this clause, the authority and functions set form in reorganization plan numbered 14 of 1950 (15 CFR 3176; 64 Stat. 1267) and Section 2 of the Act of June 13, 1934 (40 U.S.S. 276c).

Maintain regular hours defined as seven (7) or more hours at least five (5) days a week.

Senior Centers must host one educational presentation conducted by the AgeOptions Countywide Health Promotion Coordinator grantee.

Senior Centers should strive to be a dynamic, accessible, and appealing community resource. Programming and activities should be inclusive for all ages and abilities.

Senior Centers should provide educational and community events, preferably with other local agencies or groups.

Senior Centers should actively collaborate with other community organizations such as universities to offer educational and recreational opportunities for older adults.

Senior centers should strive to provide job training and placement programs, volunteer opportunities, and health and fitness programs.

Senior Centers should strive to be accredited through the National Senior Center Accreditation Program.

Senior Centers should strive to act as a resource for the community; developing innovative approaches to address aging issues in the community.

Senior Centers should strive to use the skills and services of older adults in paid and unpaid work at the centers.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will meet standards outlined in the “Requirements of Title III Funded Agencies.”

All grantees will ensure services are available and advertised to the general over sixty population and not restricted to any ethnic group.

Funding available through the "Distributive Funding" –
This service is NOT required to be funded in each locality.

Recreation	
DEFINITION: Activities which foster the health and social well-being of individuals through social interaction and constructive use of time. In determining and developing recreational activities older person's needs and interests should be considered.	**UNIT OF SERVICE:** Each hour of staff, volunteer or consultant time spent on behalf of a client constitutes one unit of recreation service.

Service Activities May Include:

Recreational activities for individuals and groups may include instructions and discussions in arts, crafts, hobbies, travel, games, sports, physical activities and other activities;
Group tours and outings.

STANDARDS

1. Publicize each recreational program at least three (3) weeks prior to the date of the program, using outreach mechanisms including but not limited to provider website and newsletter.
2. Obtain case management/senior opportunities and services for those clients with additional needs. Pursue assessment for the Community Care Program or other services as appropriate.
3. Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.
4. All grantees will meet the "Requirements for Recipients of Title III Older Americans Act Funds."
5. All grantees will ensure services are available, advertised to the general over sixty population, and not restricted to any ethnic group.
6. AgeOptions may require Grantee to ensure that all clients complete the UCLA loneliness scale assessment a total of two times during the fiscal year.

Funding available through the "Distributive Funding" –
This service is NOT required to be funded in each locality.

3b Respite Care (Paid or Volunteer)	
DEFINITION: The provision of appropriate, temporary substitute care or supervision on behalf of the caregiver for functionally impaired persons aged 60 and over who score 28 or more points on the Community Care Program Determination of Need. The purpose is to provide relief from the stresses and responsibilities accompanying constant care to enable the caregiver to maintain care of the older person(s).	**UNIT OF SERVICE:** One hour of respite worker's/volunteer's time spent providing direct care or supervision to a functionally impaired older person. Units should be measured to the closest quarter hour. Clients may receive respite services during the day if they do not receive Title III-B Chore.

Service activities may include:

Homemaker Services
Chore Housekeeping Services
Home Health Services
Senior Companion Services (Sitter Services)
Adult Day Services
Other activities to support caregiver(s)

Service Limits: Clients may receive up to 80 hours of service per fiscal year.

STANDARDS

The agency shall have clear identification of staff responsible for the provision of evening and weekend respite care service.

The agency shall describe the plan for allocation of units of service over time to ensure that service is provided throughout the grant period (at least ten months of the year).

The agency shall provide sufficient training for homemakers who provide the respite service. Training will include a component of caring techniques for clients with Alzheimer's disease or related dementias.

The agency shall obtain an in-home, face-to-face, assessment of the potential client's respite care needs from the Care Coordination Unit or Managed Care Organization prior to the delivery of respite service.

The agency shall develop the respite care plan, including activities to be performed for the client, in conjunction with the Care Coordination Unit or Managed Care Organization and the caregiver(s).

The agency shall have trained supervisors available any and every time that respite care is delivered.

The agency shall provide for health and safety emergencies in the client's home.

The agency shall have procedures for respite care workers to report back to the agency any concern about the client's service needs or emergency situations.

The agency shall document all aspects of the provision of service and maintain this information in the clients file.

The agency shall make provision for evaluating staff and delivery of service.

The agency shall follow up the service with an evaluation process measuring client/family satisfaction and receive feedback on service provided.

The agency shall promote the rights of each older person. The agency shall have written policies and procedures to ensure that:

The client is fully informed in advance of any change in service. The client shall participate in planning and changing an in-home service, unless they are judicially adjudged incompetent.

The client is able to voice a grievance with respect to service without discrimination or reprisal;

The client's record shall be kept confidential;

The client's property shall be treated with respect by all staff;

The client shall be fully informed (orally and in writing) in advance of receiving in-home service under Title III.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will meet standards outlined in the “Requirements for Recipients of Title III Older Americans Act Funds.”

All grantees will ensure services are available and advertised to the general over sixty population and not restricted to any ethnic group.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Senior Opportunities and Services	
DEFINITION: A special program designed to identify and meet the needs of older at risk individuals through effective referral to existing health, employment housing, legal, consumer, transportation, mental health and other services; and/or development and provision of new volunteer services; and/or stimulation and creation of additional services and programs to remedy gaps and deficiencies in present existing services and programs.	**UNIT OF SERVICE:** One hour of staff time spent on behalf of the client, including preparation and travel time. Units are counted to the nearest quarter hour.

Service Activities may include:

- Translation services
- Interpretation
- Outreach to the target population
- Personal escort
- Public Education
- Telephone reassurance
- Referral to public assistance/public aid
- Referral to a Care Coordination Unit (CCU) for Comprehensive Care Coordination assessments, the Community Care Program
- Referral to a nutrition program (home delivered meals, congregate dining)
- Referral to a Caregiver Specialist agency for caregiver support services including Respite and gap filling
- Referral and assistance with Medicaid/Medicare & other insurance benefits
- Referral for transportation, respite, chore/housekeeping, and/or legal assistance
- Referral to a senior center
- Referral to a mental health services organization
- Referral to an employment program
- Referral to legal services supports
- Assistance with Immigration Issues
- Assistance applying for public assistance/public aid
- Assistance applying for Circuit Breaker, LIHEAP, etc.
- Assistance applying for other benefits not listed

STANDARDS

1. The agency shall develop procedures for intake and follow up of each client.
2. The agency must maintain client files and keep record of all communications and services provided on behalf of the client. The individual records shall include a complete intake form that includes the clients' primary language and complete case notes outlining the

contacts with the older person, family, neighbors, friends or others involved with the case, all collateral calls, arrangements and follow-up provided on behalf of the older person.

3. A plan that includes the following must be developed:
    a. The specific group of at risk older persons that will be served must be identified according to where they reside, what ethnic and/or minority group they represent and why the group has been selected
    b. The barriers or gaps in services that prevent the group from using existing services must be explained.
    c. Methods for reaching the specific groups must be identified and targeted to the selected group.
    d. The methods for using the identified services to assist the selected group in accessing and using services must be clearly stated.
    e. The method of evaluating the effectiveness of the provision of service must be identified in advance and approved by the Area Agency.
4. AgeOptions shall offer and may require SOS agencies to attend training and coordination meetings such as:
    a. Benefit and Service update meetings
    b. Caregiver Specialist meetings
    c. Quarterly Funded Agencies Meetings
    d. Aging and Disability Resource Network coordination meetings
    e. Other meetings as required
5. Agency will be in regular contact with the designated Care Coordination Unit(s), Elder Abuse provider(s), Aging and Disability Resource Network, Targeting to Culturally and Linguistically Isolated Persons (TCLIP), and Caregiver Resource Center (CRC) in the service area.
6. Refer clients to the Care Coordination Unit (CCU) for access to services such as Community Care Program (CCP) and Home Delivered Meals.
7. Refer clients to the Caregiver Specialist agency if caregiver needs are identified including Respite and Gap filling.
8. All SOS-funded agencies are encouraged to explore the possibility of utilizing the ***BenefitsCheckUp*** Consumer Edition web-based benefits screening tool to enhance the delivery of service.
9. The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.
10. All grantees will meet standards outlined in the “Requirements of Title III Funded Agencies.”

How to identify available funds for this service:
Applicants may apply for this service under the Targeting to Culturally and Linguistically Isolated Older Persons (TCLIP) Set-aside Funds. Applicants should apply for these funds from the TCLIP set-aside amount. If an applicant applies for these special set aside funds, they will not be eligible for other Title III-B or E funding

Targeting to Culturally and Linguistically Isolated Older Persons	
DEFINITION: A special program designed to provide effective referral to existing health, employment, housing, legal, consumer, transportation and other services that are culturally and linguistically specific and appropriate to Limited English Proficient older adults and/or development and provision of new volunteer services; and/or stimulation and creation of additional services and programs to remedy gaps and deficiencies in present existing services and programs.	**UNIT OF SERVICE:** One hour of staff time spent on behalf of the client, including preparation and travel time. Units of service are counted to the nearest quarter hour.

Translation and interpretation are required activities for agencies serving limited English proficient populations.

Service Activities may include:

- Translation
- Interpretation
- Outreach
- Personal Escort
- Public Education
- Telephone reassurance
- Referral to public assistance/public aid
- Referral to a Care Coordination Unit (CCU) for Comprehensive Care Coordination assessments, the Community Care Program.
- Referral to a nutrition program (home delivered meals, congregate dining)
- Referral to a Caregiver Specialist agency for caregiver support services including Respite and gap filling
- Referral for assistance with Medicaid/Medicare & other insurance benefits
- Referral for transportation, respite, chore/housekeeping, and/or legal assistance
- Referral to a senior center
- Assistance applying for public assistance/public aid
- Assistance applying for Circuit Breaker, LIHEAP, etc.
- Assistance with Medicaid/Medicare and other insurance benefits
- Assistance with Immigration Issues
- Assistance applying for other benefits not listed

STANDARDS

1. The agency must have culturally and linguistically diverse staff and leadership, including the board, at all levels of the organization that reflects the community being served.

The agency must have signage and instructional material in the clients' language(s) and consistent with their cultural norms.

The agency must provide for culturally specific service settings and methods.

The agency shall develop procedures for Intake and follow-up of each client.

The agency must maintain client files, and keep record of all communications and services provided on behalf of the client. The individual records shall include a complete intake form that includes the clients' primary language and complete case notes outlining the contacts with the older person, family, neighbors, friends or others involved with the case, all collateral calls, arrangements and follow-up provided on behalf of the older person.

The specific group of at risk older persons that will be served must be identified according to where they reside, what ethnic and/or minority group they represent and why the group has been selected. The barriers or gaps in services that prevent the group from using existing services must be explained. A plan that includes the following must be developed:

Methods for reaching the specific groups must be identified and targeted to the selected group.

The methods for using the identified services to assist the selected group in accessing and using services must be clearly stated.

The method of evaluating the effectiveness of the provision of service must be identified in advance and approved by the Area Agency.

AgeOptions shall offer and may require TCLIP agencies to attend training and coordination meetings such as:

Benefit and Service update meetings

Caregiver Specialist meetings

Quarterly Funded Agencies Meetings

Aging and Disability Resource Network coordination meetings

Other meetings as required

Agency will be in regular contact with the designated Care Coordination Unit(s), Elder Abuse provider(s), Aging and Disability Resource Network and Caregiver Resource Center (CRC) agency in the service area.

Agencies must provide in-services and trainings to the AgeOptions network to provide education on culturally appropriate and sensitive service delivery.

Partner with ADRN to conduct cross trainings on organizational development and service delivery to culturally and linguistically diverse clientele.

Report to AgeOptions on the languages of the clients served.

Refer clients to the Care Coordination Unit (CCU) for access to services such as Community Care Program (CCP) and Home Delivered Meals.

Refer clients to the CRC agency if caregiver needs are identified including Respite and Gap filling.

TCLIP agencies are encouraged to use web based ***BenefitsCheckUp*** Consumer Edition web-based benefits screening tool to enhance the delivery of service.

For agencies targeting limited English proficient populations, culturally-appropriate agency staff must be available to provide interpretation/translation services to Title III clients served by other Area Agency funded providers.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will meet standards outlined in the “Requirements for Recipients of Title III Older Americans Act Funds.”

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Telephone Reassurance	
DEFINITION: Telephone calls at specified times to or from individuals who live alone, to determine if they require special assistance, to provide psychological reassurance and reduce isolation.	**UNIT OF SERVICE:** Each telephone reassurance call placed or received by a client constitutes one unit of service.

STANDARDS

The Telephone Reassurance Agency will:

Have procedures for supervising calls and for the caller to report a client's need for services.

Establish an emergency plan for client(s) if a telephone call is unanswered.

Have activities planned for each telephone call relative to the individual's needs

Place telephone calls to each client at specified times; and

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

Telephone Reassurance Agencies will obtain case management/senior opportunities and services for those clients with additional needs. Coordinate with the local Care Coordination Unit to assure assessment for Community Care Program when deemed appropriate.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will meet standards outlined in the "Requirements for Recipients of Title III Older Americans Act Funds."

All grantees will ensure services are available and advertised to the general over sixty population and not restricted to any ethnic group.

Funding available through the "Distributive Funding" – This service is NOT required to be funded in each locality.

Transportation	
DEFINITION: Transportation services include activities which enable individuals to travel to and from community resources in order to receive services, reduce isolation, or otherwise encourage independent living. These services may be provided through projects designed specifically for older persons, or through the utilization of public transportation systems or other modes of transportation.	**UNIT OF SERVICE:** Each one-way trip to or from community resources per client. (A round trip equals two units).

Service Activities May Include:

- Door to door or scheduled route;
- Assistance in making travel arrangements;
- Provision of or arrangement for special modes of transportation when needed;
- Coordination with similar and related transportation in the community; and
- Provision of transportation for medical and social service appointments, shuttle service for senior centers, and shopping and congregate meals on a priority basis.

Transportation does not include the delivery of Home Delivered Meals.

STANDARDS

Eligible Clients – transportation services are available to:
Older adults over the age of 60
Grandchildren being raised by grandparents, family caregivers, and adult children with developmental disabilities when they accompany persons age 60 and over on a van or bus funded under the Older Americans Act
Adult children with developmental disabilities (e.g., doctor's appointment for a school exam) if services will directly benefit the older adult as the caregiver or the care recipient.

Contributions – All clients must have the opportunity to voluntarily contribute to the cost of the transportation service.

The transportation agency adheres to all applicable state/local laws regarding vehicle licensure and inspection and the drivers. (Reference material is available at AgeOptions - Ill. P.A.82-532 and Ill P.A. 82-957).

a. (Ill. P.A. 82-532): Drivers of senior transportation vans must:
   i. be 21 years of age or older;
   ii. have a valid and properly classified driver's license;
   iii. have had a valid driver's license for three years prior to the application;
   iv. have demonstrated ability to exercise reasonable care in the safe operation of a motor vehicle on a driving test; and
   v. have not been convicted of reckless driving within three years of the date of application.

b. (Ill. P.A. 82-957)

i. Any vehicle of 12 or more passengers used in the transportation of senior citizens shall bear placards on both sides indicating it is being used for such purposes. The placards may be permanently or temporarily affixed to the vehicle. The size of the letters must be at least 2 inches high and the stroke of the brush must be at least 1/2 inch wide. Any such vehicle used for such purposes shall be subject to the inspections provided for vehicles of the second division and its operation shall be governed according to the requirements of the Illinois Vehicle Code.

The transportation agency has appropriate insurance coverage for facilities, vehicles and staff.

The transportation agency publicizes service availability to eligible clients.

The transportation agency assures service is accessible to the physically disabled.

Transportation agencies that own and operate their own vehicles must provide orientation and training to staff and volunteers regarding service to older persons, especially those with physical disabilities.

Transportation agencies must have written emergency procedures that will be followed in case of emergency or accident while the vehicle is in service.

Transportation agency coordinates service with similar and related transportation in the community.

Transportation agency shows evidence of efforts to develop coordination agreements with transportation service providers in adjacent service areas to fill gaps in service.

The transportation agency has a system is in place to track the number of clients and units served.

The transportation agency may partner with other programs. The cost of the program/service will be prorated based on program usage if used for other federal programs (such as youth services).

The transportation agency may sell advertising space on their vehicles.

All Title III transportation providers must abide by the Illinois Vehicle Code, as amended.

The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.

All grantees will ensure services are available and advertised to the general over sixty population and not restricted to any ethnic group.

All grantees will meet the “Requirements for Recipients of Title III Older Americans Act Funds.”

Title III-D Services

How to identify available funds for this service:
Applicants should apply for the funding that is available for the Countywide Health Promotion Coordinator

Title III-D Health Promotion/Disease Prevention Countywide Health Promotion Coordinator	
DEFINITION: Provides older adults and their caregivers with evidence based programming and information related to the diagnosis, prevention, treatment and rehabilitation of age related diseases and chronic disabling conditions, including, but not limited to, osteoporosis, cardiovascular diseases, Alzheimer's disease and related disorders with neurological and organic brain dysfunction.	**UNIT OF SERVICE:** The unit of service is a session per participant. If there are 7 people attending a weekly health promotion session, then the unit count would be 7, the unduplicated count of people served is 7. If during the second weekly health promotion session, 4 people return from the first meeting and 4 new people join, then the unit count for the month to date would be 15 (7 sessions in 1st week +8 sessions in 2nd week), and the unduplicated count of people served is 11 (7 people in 1st week +4 new people in 2nd week).

Countywide Health Promotion Coordinator

Service activities include:

Title III-D funds may only be used for services meeting the Highest-level criteria for evidence based programs including falls prevention programs . Examples include but are not limited to Active Living Every Day, A Matter of Balance, Enhance Fitness, Healthy Eating for Successful Living Among Older Adults, Healthy IDEAS, Health Moves for Aging Well, Diabetes Self-Management Program, Arthritis Self-Management Program, Programa de Manego Personal de la Arthritis, and Programa de Manego Personal de la Diabetes. See RFP Resources for a list of Evidence Based Programs.

STANDARDS

1. Meet annually with AgeOptions to develop priorities for the year and determine targeting and locations of programs.
2. Provision of at least one evidence based health promotion activity to each Congregate Dining sites and Senior Center funded by AgeOptions at least ONCE every 3 years of the grant cycle.
3. Clients must be given information on follow-up/referral as necessary.
4. Agency must submit a quarterly report to AgeOptions of all programs conducted, dates, locations and number of attendees.

5. Agency will have policies and procedures for identifying major languages other than English in the service area and developing a plan for providing service to persons proficient in languages other than English. This plan must include the components outlines in Guidance to Assistance to Persons with Limited English Proficiency.

Title III-E Services

Caregiver Resource Center Designation

How to identify available funds for this service:
Applicants should apply for the funding that is available for the Caregiver Resource Centers. Applicants may propose to use some of the area's distributive funding to supplement the available Caregiver Resource Center funds. Applicants must meet all the requirements of Caregiver Resource Center or partner with another organization to meet the requirements. Each individual agency or partnership should have at least one full time equivalent Caregiver Specialist staff person. Each agency must have staff identified to attend AgeOptions meetings and develop special expertise on caregiver issues so they may be a resource for other care managers.

Caregiver Resource Center Designation/Caregiver Specialist	
DEFINITION: The Caregiver Specialist at each Caregiver Resource Center (CRC) links older persons, caregivers of older persons, grandparents or other non-parent relatives raising children (who are not more than age 18) and parents or other relatives raising children age 19-59 who has a severe disability, social services staff, and community members with training and educational opportunities, emotional, financial, and physical resources (including respite and gap-filling services) to support the work of caregivers. The Caregiver Resource Center will provide nine (9) services for caregivers of older adults (see below for specific service definitions): • One-on-One Outreach • Information & Assistance • Case Management/TCARE Screener • Case Management/TCARE Assessment	**UNIT OF SERVICE (counted to nearest quarter hour):** 1. **One-on-One Outreach:** A unit of service is one contact between a service provider and an older adult or caregiver who is not already a CRC client. Outreach units are based on one-on-one contacts by an outreach provider. Client follow-up is counted as another Outreach unit of service. 2. **Information & Assistance:** A unit of service is one contact between a service provider and a caregiver or a grandparent or other non-parent relative who is raising children. 3. **Case Management/TCARE Screener:** A unit of service is one contact between a service provider and a caregiver client. 4. **Case Management/TCARE Assessment:** A unit of service is one contact between a service provider and a caregiver client. 5. **Counseling:** A unit of service is a session (per participant). For example, if 7 people attended a counseling session, the unit count would be 7). The care recipient should not be included in the count.

• Counseling • Group Training and Education (including ADRD) • Support Groups/Memory Cafe • Respite (except for relatives raising children age 18 and under) • Gap Filling The CRC may use approximately 7% of their funding for either Counseling, Group Training and Education or Support Groups and Gap Filling for "Relatives Raising Children" (RRC or GRG). Service provided to RRC by the CRC must be broken out from service to caregivers of older adults and adults with Alzheimer's/related condition. A same-sex spouse who is lawfully married to a parent under the law of a state, territory, or foreign jurisdiction (regardless of whether the individual is domiciled or reside in a state or territory that recognizes the marriage), is considered a relative of a child by marriage.	6. **Group Training and Education (including ADRD Training & Education):** A unit of service is one session multiplied by the number of attendees. 7. **Support Groups/Memory Café:** A unit of service is a session per participant. For example, if 7 people attend a weekly support group, then the unit count would be 7 for each session. If a caregiver and their care recipient attend two (2) sessions, that will count as four (4) total units of service. **CLIENT:** A caregiver (of any age) who is caring for a care recipient (who is age 60 or over, or someone of any age who has Alzheimer's Disease or a related disorder (ADRD) with neurological/organic brain dysfunction) will be counted as a client. A relative caregiver who is at least 55* years or older and lives with, is the informal provider of in-home and community care to, and is the primary caregiver for, a child or an individual with a disability. In the case of the caregiver of a child, the caregiver is the primary caregiver and is the grandparent or nonparent relative raising a child who is not more than age 18. The caregiver may have legal custody, adoption, guardianship or is raising the client informally and needs to live with the child. In the case of an individual who is 19-59 with a disability, the caregiver may be the parent or other relative by blood, marriage or adoption. Priority for service is given to family caregivers who provide care for individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and for older relative caregivers who provide care for children with severe disabilities. Memory Café Client: A caregiver (of any age) who is caring for a care recipient who has concerns about their memory (regardless of a dementia diagnosis) may use this service.

	See below for respite and gap filling units of service definitions. **Note: Title III-E GRG caregiving clients are relatives age 55+ years. State GRG caregiving clients (for the State GRG Gap program) are relatives of any age.*

SERVICE DEFINITIONS:

Caregiver Resource Center (CRC) Designation: The CRC must be a clearly identifiable resource center that serves as a point of entry to a broad range of services and resources for caregivers and relatives raising children. The CRC's Caregiver Specialist will act as an expert resource person to provide consultation to case managers and other aging network staff as well as provide the following services:

In areas in which a significant number of older persons do not speak English as their principal language, the Caregiver Resource Center must arrange for or have the capacity to provide Caregiver services in the language spoken by the caregivers. The CRC should develop a language assistance plan in their service area, if needed.

Caregiver Client Assessment Tool: TCARE is the mandated caregiver assessment tool to be utilized by all CRCs to assess caregivers' needs and stress/burden levels. The TCARE platform is to be used for caregivers of older adults (60+) and caregivers of those with Alzheimer's Disease or Related Dementias.

- TCARE assessments are required for caregiver clients receiving counseling, gap filling and respite services.
- TCARE Screeners, otherwise known as the shortened version of the assessment, are required for caregiving clients and are the starting point of a full TCARE Assessment. TCARE Screeners should be offered to all caregiving clients receiving all other caregiver services.

The collaborative process of case management, which involves the coordination of services, monitoring of services, and continuous evaluation of services rendered, will be completed by using the TCARE platform (screener and assessment.)

One-on-One Outreach: Interventions initiated by an agency for the purpose of identifying potential caregivers and encouraging the use of an agency's services and benefits. One-on-One Outreach does not include program publicity (e.g., preparation of newsletters and press releases) and the development of interagency agreements. Outreach to groups is not to be counted as units of service.

Information & Assistance: Refers to cases where caregiver clients contact the service provider to directly request information on available resources and access to services. This

service does not include giving advice or guidance but may include a referral. These units can include referral and follow-up on behalf of the caregiver.

This may include cases where caregiver clients call, email, chat or send a text message to ask questions requesting simple guidance that can be answered in a limited number of quick exchanges. The Caregiver Specialist is to clearly delineate the "closure" of the interaction, signifying an end/resolution or needed follow-up to the conversation.

Case Management - TCARE Screener: Assistance to caregivers in obtaining access to services and resources, using the TCARE platform, and referring the caregiver client to services as indicated by the assessment scores. Case management services may include referrals to support groups, memory cafes, and training and education sessions. This service may include providing advice, guidance, or a referral.

The TCARE screener is the first step in conducting case management, the starting point of a full assessment, and coordinating caregiver services. The summary provided by the assessment scores may provide insight into the caregiver client's burden levels and indicate that a full TCARE assessment is necessary.

Case Management - TCARE Assessment: Assistance to caregivers in obtaining access to services and resources, using the TCARE platform and creating a care plan based on the assessment scores, reviewing the care plan with the caregiver and—when possible—the care recipient, and coordinating services as indicated. Case management services may include counseling, gap filling and respite services. This service may include providing advice, guidance, or a referral.

Follow-up assessments are to be completed at regular intervals as required by AgeOptions for caregiver clients who have completed the TCARE Assessment in full. The follow-up assessment may be completed via the TCARE Screener (shortened assessment) and as needed may proceed to the TCARE (full) assessment, depending on the caregivers' individual needs and stressors.at that time.

Counseling:
Assistance to caregivers considered most at-risk, in the areas of health, nutrition, financial literacy, and in making decisions and solving problems relating to caregiving (including crisis management, role changes, etc.). This includes:

- One-on-one therapeutic counseling sessions for individual caregivers, for emotional or mental health difficulties to achieve mental health and wellness. This may include conversations related to decision making and problem solving related to caregiver role.
- Family sessions for families caring for an older adult
- Tailored training for an individual caregiver or family of caregivers

These clients need to have a completed TCARE assessment on file prior to the counseling session.

Counseling also includes time spent providing expert consultation to other aging network staff regarding their caregiver clients.

Counseling is much more than assessing for respite services. Caregiver Specialists are encouraged to consider evidence-based interventions such as Healthy IDEAS.

Group Training and Education: Services which provide family caregivers and grandparents raising grandchildren with opportunities to acquire knowledge and skills which address their caregiving roles through formally structured, group-oriented lectures, classes, workshops, or conferences. *Powerful Tools for Caregiving* is the recommended curricula for group training and education for general caregivers (not caregivers of ADRD specific populations). *Savvy Caregiver* and *Stress Busting for Family Caregivers* are the required curriculum for group training and education for caregivers of persons with Alzheimer's Disease and Related Disorders (ADRD).

1. **Caregiver (including ADRD) training topics may include but are not limited to the following:**
   a. Personal care training
   b. Assistive technology training
   c. Emotional/family dynamics of caregiving situations
   d. Home safety
   e. Coping with the transitions from health to increased infirmity
   f. Progression of different diseases and conditions
   g. Financial planning
   h. Legal and insurance issues
   i. Long-term care options
   j. Planning and advocacy for the caregiver and/or care recipient.

2. **Relatives Raising Children group training topics may include but are not limited to the following:**
   a. Health of self (including recognizing and dealing with memory loss)
   b. Community resources (e.g. respite and housing options, faith-based organizations, family, community-based agencies)
   c. Working with schools
   d. Advocating for self and child
   e. Tutoring and available tutoring services
   f. Child development
   g. Children with special needs (e.g. physical, learning or mental disabilities, emotional or behavioral problems)
   h. Financial assistance programs
   i. Alcohol and drug abuse among children
   j. Sexuality
   k. Legal issues such as guardianship, custody and insurance

Support Groups: Ongoing group counseling for caregivers provided by the Caregiver Specialist, for the purpose of facilitating mutual support between caregivers, increasing coping and problem-solving skills, improving participants' understanding of caregiving issues, grief support and coping suggestions, etc. CRCs are encouraged to consider alternative formats for support groups such as lunch discussion groups, or afternoon tea for caregiver groups.

Memory Cafe: Memory Cafes are informal, stigma free gatherings for those with concerns about their memory (regardless of a dementia diagnosis) and their caregivers.

Respite: All CRCs will provide respite according to AgeOptions Title III-E Respite Standards and Definitions.

Gap-Filling: All CRCs will provide gap-filling according to AgeOptions Title III-E Gap-Filling Standards and Definitions.

STANDARDS

Caregiver Resource Center (CRC) Designation:

1. Target Population for CRC:
    a. Individuals who are an informal provider of in-home and community care to an older individual over the age of sixty or those with Alzheimer's Disease or Related Disorders (ADRD) of any age.
    b. Parents or other non-parent older adult relatives age 55 and older caring for children ages 18-59 with severe disabilities.
    c. Non-parent biological relatives who are at least 55 years of age or older and are living with children ages 18 and under (i.e., grandparents raising grandchildren).
    d. Caregivers with greatest social and economic need, with particular attention to low-income minorities.
2. Preferred service mix is 37% counseling, 17% outreach, 33% group training and education, 5% support groups, and up to 8% on gap filling (any variation must have prior approval from AgeOptions); CRC partnerships must ensure that there is adequate Caregiver Specialist presence in all towns of the service area. CRCs may use up to 7% of their funding for relatives raising children programming. The caregiver to older adults services should be budgeted separately from the relatives raising children programming.
3. Information about the Caregiver program must be clearly visible on the agency webpage and there must be an email address on that webpage that caregivers can use to request information.
4. TCARE Screener must be clearly visible on the agency webpage so that caregiver clients can complete the screener on their own.
5. The Caregiver Specialist must be available either after hours or on weekends and this schedule must be publicized, including availability for counseling sessions (may be in the client's home or over the phone) and outreach events as well as periodic support group and group training sessions.

6. CRCs must have methods to evaluate services. AgeOptions will provide standard questions for an evaluation tool and approve the final evaluation method. These methods can include surveys, public forums or other means to solicit annual feedback from caregivers and the community regarding caregiver service needs and concerns. The results will be shared with the Countywide Caregiver Programs Coordinator.
7. CRCs must maintain an inventory of books, movies, recommended websites and other resources to help clients gain insight into common caregiving difficulties.
8. The agency shall use a computerized client tracking system to provide required National Aging Program Information System (NAPIS) data.
9. All grantees will meet the "Requirements for Recipients of Title III Older Americans Act Funds."

Caregiver Specialist: Each III-E applicant agency or partnership must have a minimum of one full-time equivalent Caregiver Specialist. If applicants choose to share a Caregiver Specialist through a partnership, the costs associated with staffing must be broken down according to functions at each site, and not based on geography. Additional staff (e.g., case aide, part-time Caregiver Specialist) may be required for larger service areas. **Caregiver Specialists may not perform Comprehensive Care Coordination (CCC) assessments or carry a CCC caseload as part of their Caregiver Specialist role. However, the Caregiver Specialist may complete a Determination of Need on a care recipient as part of arranging respite care to relieve a caregiver**.

Qualifications and responsibilities for the Caregiver Specialist are as follows:

Well-developed clinical skills (formal clinical degree or significant clinical job experience), including counseling and support group facilitation experience. At least a BA, BSW, BSN, or RN degree and one year of experience in social service provision to older persons.

Working knowledge of the Illinois Department on Aging (IDoA) Adult Protective Services program and resources and programs available for older adults and children (attending IDoA Adult Protective Services training is highly encouraged).

Working knowledge of technology and assistive devices related to caregiving.

Coordination with the Countywide Caregiver Programs Coordinator--meet with the Countywide Caregiver Programs Coordinator before the start of each fiscal year to develop program goals

Meeting and Training Attendance--attending all Caregiver Program meetings called by AgeOptions, training sessions offered by AgeOptions as required

Coordination-The Caregiver Specialist will cultivate relationships with respite vendors and serve as expert for Aging and Disability Resource Network and Targeting to Culturally and Linguistically Isolated Persons (TCLIP) staff in their service area.

One-on-One Outreach:

The CRC, with the Caregiver Programs Coordinator, will create an outreach plan that targets all types of caregivers (e.g., spouses/life partners, adult children and grandchildren, working caregivers, grandparents, family, friends, and neighbors; all ethnicities and communities within the service area). Allowable outreach activities include the following:

a. Search and find activities (e.g. canvas door to door and personal contact with caregivers and/or relatives raising children whose names have been solicited from community resources) which seek out and identify hard to reach populations

Education/encouragement to utilize benefits and programs

Follow-up activities with caregivers and/or agency(s) to determine whether services have been received and the identified need met following the formal referrals

Places where outreach activities may occur include (but are not limited to):

A. Religious organizations
B. Medical Providers
C. Schools (including Parent Teacher Associations and other similar groups)
D. Community-based agencies
E. Senior Centers
F. Businesses
G. Libraries
H. Stores

2. Outreach activities should increase the awareness of caregiver issues (both for older adult caregivers and relatives raising children). The activities should be more than advertising Caregiver Resource Center services.

Information & Assistance:

1. The CRC will develop and implement methods for communicating with clients via telephone, email, text messaging, and etc.
2. Caregiver specialists will be responsible for delineating the closure of communications, coordinating a referral, or setting up a follow-up with the client.
    a. The delineation of the closure of the interaction to signify the end of a conversation, a resolution, or needed follow-up to the conversation.
3. The CRC will implement a procedure for record keeping of all communications with caregiving clients.
    a. The CRC will keep record of commonly asked questions and themes of received communications with clients.
4. The CRC will report caregiving clients as “Caregiving I&A” and grandparents raising grandchildren, or relatives raising children, as “GRG I&A” into the online database.
5. The CRC must use person-centered approach to providing referrals and sharing resources with clients, caregivers, or their families.

Case Management/TCARE Screener:

1. The CRC will use the TCARE platform required by AgeOptions to complete the TCARE Screener for all Title III-E caregiver clients to assess and document needs.
2. The CRC may conduct the TCARE Screener by telephone, but a face-to-face (in-person) screening is preferable, when it can be conducted safely.
3. The CRC will coordinate referrals and services based on the scores and recommendations provided by the screener.
    a. The caregiver specialist may proceed to full assessment or, depending on the individual situation of the caregiver, may stop at the screener to complete the full assessment at a later date.

   b. The completion of the full TCARE Assessment is required to be completed within 30 days of completion of screener.
4. The CRC will complete follow-up assessments at regular intervals, as required by AgeOptions for all Title III-E caregiving clients.
5. The CRC will actively check the TCARE platform to monitor case load, including active cases, pending assessments and follow-up assessments.
   a. Best Practice: Each CRC will ensure email notifications via the TCARE platform are set in place to receive notifications of follow-up assessments, received screeners, and etc.

Case Management/TCARE (Full) Assessment:

1. The CRC will use the TCARE platform required by AgeOptions to complete the TCARE (full) Assessment for all Title III-E caregiver clients to assess and document needs.
   a. The caregiver specialist may proceed to complete the full assessment after completion of the TCARE screener or, depending on the individual situation of the caregiver, may stop at the screener to complete the full assessment at a later date.
   b. The completion of the full TCARE Assessment is required to be completed within 30 days of completion of screener.
2. The CRC may conduct the TCARE full assessment by telephone, but a face-to-face (in-person) assessment is preferable when it can be conducted safely.
3. The CRC will create a care plan and coordinate services based on the assessment scores and platform recommendations.
   a. The caregiver specialist will review the care plan with the caregiver and care recipient, when possible, and coordinate services as indicated by the TCARE Platform (caregiver assessment tool).
4. The CRC will complete follow-up assessments at regular intervals, as required by AgeOptions for all Title III-E caregiving clients.
5. The CRC will actively check the TCARE platform to monitor case load, including active cases, pending assessments and follow-up assessments.
   a. Best Practice: Each CRC will ensure email notifications via the TCARE platform are set in place to receive notifications regarding the need for follow-up assessments, received screeners, etc.

Counseling:

1. A TCARE assessment must be completed by all clients (except RRCs) prior to a counseling session (or within 30 days for emergency situations). The CRC may conduct counseling by telephone, but a face to face (in-person) session is preferable when it can be conducted safely.
2. The Caregiver Specialist will provide counseling as needed with the most complex caregiver cases. CRCs should maintain separate files on caregiver counseling clients, including a counseling care plan (sample included in RFP attachments) which outlines the caregiver's reasons for counseling, his/her goals and anticipated outcomes of the intervention.
3. The Caregiver Specialist will also provide expert consultation to case managers, other aging network staff and the community on caregiver issues.

4. CRC Counseling requires a TCARE Assessment and may include:
5. **Life Coaching**: Direct interaction between a trained counselor and an individual to assist the caregiver to cope with personal problems relating to the caregiving situation or relationship between caregiver and care receiver.
    a. Topics to address can include but are not limited to: a) issues of life/role transitions; b) interpersonal relationships; c) dealing with anxiety or depression; d) guardianship issues; e) health; f) nutrition; g) financial literacy; h) problem-solving; or i) decision making.

    b. **Purposeful therapeutic assistance**: Direct interaction between a trained counselor and an individual to improve mental health or coping with personal problems relating to the caregiving situation or inter-relationship between caregiver and care receiver. The therapeutic nature of the client/ counselor relationship is to be particularly stressed and should be adapted to meet the unique needs of the family caregiving relationship. Work may be short or long term, including brief crisis assistance. Topics to address can include but are not limited to: a) issues of life/role transitions; b) interpersonal relationships; c) dealing with anxiety or depression; or, d) guardianship issues.

Group Training and Education:

1. The CRC will provide a minimum of one (1) series of training and education activities per year (not required to be evidence-based series). The Caregiver Specialist should notify the Caregiver Programs Coordinator of tentative training and education plans at their annual meeting. Final training plans should be communicated to the Coordinator at least one month in advance of any program publicity. *Powerful Tools for Caregivers* is the preferred series.
2. The CRC will develop and implement methods of evaluating the effectiveness of training and/or educational activities. Examples of evaluation methods include pre- and post-tests, evaluation forms, and client satisfaction surveys. The Caregiver Specialist will share summaries of the qualitative and quantitative results with the Caregiver Programs Coordinator at their annual meeting, during which plans will be developed to incorporate the results into future trainings.
3. If CRCs would like to use a training curriculum other than Powerful Tools for Caregivers, Making Sense of Memory Loss, the Caregiver Survival Guide curriculum, REACH or the Red Cross modules, Savvy Caregivers, Stress Busting for Family Caregivers, or Paths to Faithful Caregiving, it must be approved by AgeOptions at least one month prior to program publicity in order for it to meet the standards for Group Training and Education.
4. If the CRC proposes to create a training curriculum other than listed in #3, the program should include one of the following:
    a. **Self-Care Skills**: individual or group instruction to caregivers about skills to take better care of themselves, to reduce stress and increase confidence in their caregiving ability.
    b. **Caregiving Skills**: individual or group instruction to caregivers about skills needed to take care of the care receiver. Skills include but are not limited to: a) lifting and transferring the care receiver; b) disease specific characteristics; c)

current parenting skills; d) health nutrition and financial literacy; and, e) legal options.

c. **Caregiver Training Sessions** may be provided in the workplace for employers and their caregiving employees. The CCC should carry out distinct actions to reach out to family caregivers in the workplace.

5. The CRC is required to provide at least one Caregiver Training session per year on legal options for family caregivers and/or non-parent relative caregivers.
6. For ADRD Group Training and Education:
   a. The CRC will provide a minimum of two (2) series of *Savvy Caregiver* and/or *Stress Busting for Family Caregivers* training and education activities per year. The Caregiver Specialist should notify the AgeOptions Caregiver Programs Coordinator of tentative training and education plans at their annual meeting. Final training plans should be communicated to the Coordinator at least one month in advance of any program publicity.
   b. The CRC will develop and implement methods of evaluating the effectiveness of training and/or educational activities. Examples of evaluation method include pre- and post-tests, evaluation forms, and client satisfaction surveys. The Caregiver Specialist will share summaries of the qualitative and quantitative results with the Caregiver Coordinator at their annual meeting, during which plans will be developed to incorporate the results into future trainings.

Support Groups:

1. Each CRC or CRC partnership must have a Caregiver Support Group for older adults. Support groups for relatives raising children (GRG) are encouraged but not required. If the CRC does not offer a support group for relatives raising children, it must maintain a list of such support groups in the area. CRC may request a waiver to the Support Group requirement. The waiver request will require a strong rationale and list of nearby support groups for caregivers. CRCs may consider providing an opportunity for caregivers to share information and stories with each other in a less formal group such as “caring crew lunch group” or “tea and talk”.
2. Best Practice: Each CRC or CRC partnership should provide an Early Stage Dementia Support Group or an informal opportunity to share information and stories.
3. The CRC must also maintain a list of nearby support group alternatives for caregivers whose schedules conflict with the CRC group. At least one caregiver support group option (either at the CRC or locally) should be during evening or weekend hours to accommodate working caregivers.

Memory Cafe:

1. The Caregiver Resource Center providing this service will enter monthly clients and units into the NAPIS system by the 15th of the following month using the IIIE CRC Memory Café code.
2. The agency providing this service will ensure that all participants complete the UCLA loneliness scale assessment and follow-up assessments throughout the fiscal year.

GOAL:

VOLUNTEER FACILITATION

As opportunities arise and time allows, the Caregiver Resource Center will encourage the recruitment and utilization of volunteers for the caregiver program. For example, the Caregiver Specialist may recruit volunteers for caregiver activities, which may include respite, mentoring, friendly visiting, and transportation. Volunteer recruitment may also emphasize outreach to the faith community.

Priority Service – Countywide via AgeOptions Respite Registry
Title III-E Respite Registry

How to identify available funds for this service:
*Applicants should **not** include Title III-E Respite Funds in their budgets unless they self-manage the funds and are directed by AgeOptions to budget the funds. Successful Caregiver Resource Center applicants will be responsible for the authorization and prioritization of clients for use of these funds.*

III-E Respite	
DEFINITION: The provision of temporary substitute supports and/or living arrangements to provide a brief period of relief or rest for family caregivers of persons age 60 or over or caregiver over the age of 55 who cares for child with a disability 19-59 who have two (2) or more Activities of Daily Living (ADL) impairments. The supports and/or living arrangements may be in the form of Adult Day Service, In-home Respite (including Companion/Friendly Visitor, bathing services, dressing, or "tuck-in" services), or Institutional/Out-of-Home respite selected from the Vendors included in the Enhanced Services Program (ESP) Respite Registry. Respite should be offered as part of a package of services.	**UNIT OF SERVICE**: One hour of staff time expended on behalf of the care recipient. Units should be reported to the closest quarter hour. **CLIENT:** The client is the caregiver who is an adult family member or other individual, who is an informal provider of in-home and community care (Caregiver) to either an adult age 60 and over (care recipient) OR to an individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction (care recipient) of any age.

SERVICE DEFINITIONS

Caregiver Resource Center (CRC)—A CRC is defined as an agency that is funded to provide Caregiver Resource Center Activities.
Respite Vendor—A Respite Vendor is defined as an agency that has an agreement with AgeOptions to provide Title III-E respite services and is included on the AgeOptions Respite Registry (Respite Registry).
Care Coordination Unit (CCU)—A Care Coordination Unit is defined as a community-based agency designated by the Illinois Department on Aging to administer the Comprehensive Care Coordination instrument.

SERVICE PRIORITIES

CRC shall give priority for service to:

1. Family caregivers who provide care for individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction;
2. Parents over the age of 55, Grandparents or older individuals who are relative caregivers who provide care for children with severe disabilities;
3. Caregivers who are older individuals with greatest social need, and older individuals with greatest economic need (with particular attention to low-income individuals); and
4. Older individuals providing care to individuals with severe disabilities, including children with severe disabilities.

STANDARDS

Program Coordination

AgeOptions must approve any Caregiver Resource Centers (CRC) that wish to also be a Respite Vendor.

Respite Vendors and CRCs providing Title III-E Respite will attend meetings as requested by AgeOptions.

Vendors providing Title III-E Respite will coordinate services with Caregiver Specialists at the CRC. Reimbursement for respite services will only be available for Title III-E referrals from the CRC.

CRCs will work with AgeOptions to make use of trained volunteers to expand the provision of available services 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 and Community Service) in community settings.

Respite Coordination-Respite Assessment and Arrangement – Caregiver Resource Center (CRC) and Care Coordination Unit (CCU)

All potential caregivers requesting Title III-E Respite Services must be assessed by the CRC using the TCARE Platform (caregiver assessment tool) before receiving those respite services (assessment within 30 days of receipt of services is allowable only in the case of emergency).

To be eligible for Title III-E Respite services, a family caregiver must be providing in-home and community care to a care recipient (older adult, or child 19-59 whose caregiver is over the age of 55) who is determined to be functionally impaired because the individual:

Is unable to perform at least two (2) Activities of Daily Living without substantial human assistance, including verbal reminding, physical cueing, or supervision, as recorded on the Determination of Need (DON); or

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.

A copy of the DON will be kept in the client (caregiver and/or care recipient) file. A copy of the care plan will also be kept in the client file and given to the client (caregiver and/or care recipient).

CRCs must obtain a copy of all completed assessments and keep such assessments on file.

Care recipients may receive an average of up to $3,000 of service per fiscal year based on availability. Agencies may choose to impose a lower cap per year to allow more clients to receive services.

a. On a case-by-case basis in accordance with assessed and documented needs, the CRC may increase a care recipient's yearly maximum amount to $3,500 with no waiver or approval from AgeOptions.
b. In all cases, a request to spend over $3,500 on any one care recipient in a fiscal year requires discussion with and approval by AgeOptions.

For each month, the CRC must submit a complete and accurate monthly service delivery report to reports@ageoptions.org by the 10th working day of the following month.

The CRC must submit reports from client satisfaction evaluations for respite service to the AgeOptions County-wide Caregiver Programs Coordinator as requested.

CRCs must document all aspects of provision of service in case notes and care plans, including referrals. This information will be kept in the client's file.

The CRC will be responsible for ensuring that respite recipients are given the option of a minimum of 3 (three) different Vendors and/or types of respite service.

The CRC will ensure that all respite recipients receiving out-of-home respite service receive the AgeOptions "Caregiver Checklist for Out-Of-Home Respite," which includes information on what caregivers should look for when choosing a vendor and contact information for the Illinois Department of Public Health (IDPH).

The CRC will fully inform respite recipients in advance of any change in service in writing.

The CRC will ensure that respite recipients are able to voice complaints about respite services they received without discrimination or reprisal.

Must meet the "Requirements for Recipients of Title III Older Americans Act Funds."

CRCs providing respite must ensure the following:

1. Staff must be trained, especially for providing care to persons with Alzheimer's disease or related dementias.
2. Trained supervisors will be available any and every time that respite care is delivered.
3. Health and safety emergencies in the client's home are addressed.
4. Procedures for respite care workers to report back to the agency any concern about the care recipient's service needs or emergency situations are followed.
5. Procedures for evaluating staff are followed.
6. Client property is treated with respect by all staff.
7. Caregiver signatures are collected after receiving respite service. Signatures must be kept on file.
8. AgeOptions will not reimburse a Vendor whose reimbursement request is received after the AgeOptions closeout process for the previous Fiscal Year.
9. CRCs that also serve as a Respite Registry Vendor will ensure that respite recipients receive a minimum of three (3) options.
10. CRCs and Vendors providing Title III-E Respite must adhere to the Respite Vendor Agreement.

11. Respite Vendors and CRCs will adhere to complaint procedures established by AgeOptions.

Respite Vendor Requirements

To be on the Respite Registry, Vendors must provide application materials that support the following requirements:

Provide services to the community for at least one year before applying.

Prove fiscal solvency by providing a copy of the most recent audit and/or most recently filed tax return.

Be insured with general liability and general comprehensive and 1) insurance covers against employee dishonesty or 2) workers are bonded. Vendors must communicate any updated insurance information (including annual renewal) to AgeOptions.

Notify AgeOptions when the insurance policy is renewed.

Complete criminal and reference checks of all staff.

Provide services without regard to race, color, religion or national origin

Have procedures for ensuring client confidentiality.

GOALS- Volunteer Facilitation

Vendors providing Title III-E Respite Service may work with AgeOptions to encourage the use of and recruitment for volunteer respite services.

Title III-E Priority Service—Countywide via Caregiver Resource Center

How to identify available funds for this service:
Applicants may budget up to 8% of their Caregiver funding for Gap Filling Funds. Successful Caregiver Resource Center applicants will be responsible for the distribution of these funds.

III-E Gap Filling	
DEFINITION: Gap Filling Services assist caregivers with unmet needs to maintain a care recipient's independence, safety, and well-being by providing limited financial assistance. Alzheimer's Disease and Related Disorders (ADRD): Person-centered Supportive Gap filling services are provided on a limited basis and will address the unique needs of individuals with dementia and their primary caregivers. Gap Filling Services may also assist grandparents or other non-parent relatives who are at least 55 years of age or older raising relative children (who are not more than 18 or who are 19-59 with a disability).	**UNIT OF SERVICE**: 1. **CRC and GRG Gap Filling:** One eligible request is the equivalent of one unit. The total amount(s) requested shall not exceed $250 per eligible care recipient or child per fiscal year. 2. **ADRD Gap Filling:** One person will constitute one unit of service, no matter what form of Gap-Filling Service is provided. **CLIENT:** A caregiver (of any age) who is caring for a care recipient (who is age 60 or over or who has Alzheimer's Disease or related disorder with neurological and organic brain dysfunction) may use this service. A grandparent or other non-parent relative (55* years of age or older) raising a child (who is not more than 18 or who is 19-59 with a disability) may use this service. **Note: Title III-E GRG caregiving clients are relatives age 55+ years. State GRG caregiving clients (for the State GRG Gap program) are relatives of any age.*

STANDARDS
Coordination and Service Linkage

Gap Filling Services will be available through Caregiver Resource Centers (CRCs).

The CRC's Caregiver Specialist will attend quarterly (or as requested) meetings called by AgeOptions.

The CRC may send representatives to attend trainings sponsored by AgeOptions.

The CRC will have specific written plans for assisting caregivers, RRCs, care recipients and/or children in an emergency or disaster situation and must demonstrate an ability to comply with the plans.

The CRC will have policies and procedures for identifying the major languages other than English in the service area and developing a plan for providing service to caregivers and RRCs, who are Limited English Proficient. This plan must include the components outlined in the Guidance on Assistance to Persons with Limited English Proficiency.

Case Management

Service Eligibility

a. A caregiver must be caring for a care recipient who is age 60 or over and living in a non-institutional setting. The care recipient must be assessed to require substantial human assistance with two or more Activities of Daily Living (ADLs), including verbal reminding, physical cueing, or supervision; or 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.
b. For ADRD Gap Filling, any person with Alzheimer's disease or a related dementia or their primary caregiver (of any age), is eligible for Supportive Gap Filling services.

Person with Dementia (PWD) - the person with diagnosed or undiagnosed Alzheimer's disease or a related dementia. Related dementias include: Vascular Dementia, Dementia with Lewy Bodies, Frontotemporal Dementia, Parkinson's Dementia, Normal Pressure Hydrocephalus and Creutzfeldt-Jakob Disease.

Primary Caregiver - the person who provides the most care of a person with dementia or who is responsible for directing and managing the care of a person with dementia. This definition refers to informal caregivers, such as family or friends, NOT formal caregivers, such as paid healthcare professionals. While some persons with dementia have more than one caregiver, for the purposes of this data collection, only collect data from the one person who most closely fits the role of primary caregiver.

Additionally, individuals (person with dementia) participating in the ADRD Gap Filling service must reside or will reside in the geographic service area of the Caregiver Resource Center. ADRD Gap Filling funds may be used if a person with dementia will be moving to the PSA to reside closer to the primary caregiver. The use of such funds may be necessary for the person with dementia to remain living in the community.

Participants in the ADRD Gap Filling service are not required to receive Community Care Program (CCP) services or Title III services.

c. A grandparent or other non-parent relative client (aged 55 years or older) must be living with and raising a relative child (aged 18 or younger; or 19-59 with a

disability) and due to a cognitive or other mental impairment, has a need that poses a serious health or safety hazard to the individual or to another individual.

Assessment and Applications

All caregivers (except RRCs) seeking gap filling services must have undergone the full TCARE assessment prior to receiving gap filling (or within 30 days for emergency gap filling situations).

All caregivers and care recipients who are age 55 and over must complete the ***Benefits Checkup*** Consumer Edition and apply for any services to which they are entitled.

Caregivers must complete the AgeOptions "Application for Gap Filling Service for Caregivers of Older Adults" noting alternate sources of assistance (Elder Abuse Intervention, Public Assistance, Township/Municipality programs, etc.).

Relatives raising children (RRCs) must complete AgeOptions "Application Form for Gap Filling Service for Grandparents and Other Non-Parent Relatives Raising Grandchildren" noting alternate sources of assistance (Child Only Grant, KidCare, Legal Assistance Foundation, etc.).

Caregiver Specialists must submit all "ADRD Gap Filling Client Applications" to the Countywide Caregiver Programs Coordinator for approval each quarter.

Usage of funds

Requests may not exceed $250 per care recipient or child per fiscal year without prior AgeOptions approval. Requests must be kept to a minimum, meeting a specific transitional need of the caregiver, RRC, care recipient or child.

Clients must have a specific need. Cash assistance and gift cards for clients are not allowable. The CRC must get a receipt for any payment.

Requests must be approved by a case manager supervisor. Gap-filling purchases must be made in accordance with good business practices including appropriate internal controls.

Requests for prescription medication or durable medical equipment must receive physician verification. Requests for consumable medical supplies should receive physician verification wherever possible. There must be a clearly stated plan to identify funds for continued supply after the emergency period.

Payment for back bills is not encouraged. Gap filling funds may not be used to pay for items purchased prior to the date of approval.

Gap Filling Services funds may not be used to cover co-payments, to meet deductible requirements, or to go towards items or services covered under other programs. For items or services covered through public benefits. Gap Filling Services funds may be used for interim assistance while waiting for benefits approval.

Gap filling funds may not be used for legal assistance. In addition, gap-filling funds may not be used for child care/respite services, except for any AgeOptions special demonstration projects.

Additional ADRD Guidance:

ADRD Gap Filling Services: (see "APPENDIX A" for allowable goods and services)
ADRD Gap Filling Services have been divided into four broad categories:

1. Medical Care and Supplies;
2. Environmental and Material Aids;
3. Community Access; and
4. Other goods or services related to improving the client's health, safety, and/or welfare needs that are not identified in "APPENDIX A" must be approved by the Caregiver Resource Center (CRC).

ADRD Gap Filling Service Purchasing Requests:

1. Home Modifications and Repairs: All Home Modifications and Repairs must be approved by AgeOptions and are limited to $2,000 during the fiscal year funding period. Home modifications are only allowable for residences where the person with dementia (PWD) resides.
2. All Other Allowable Goods and Services: All purchases (other than Home Modification and Repair), are limited to a maximum of $1,500 during the fiscal year funding period. Any purchase above $1,500 must be approved by AgeOptions.

Allowable Expenditures for ADRD Gap Filling Services must be:

Required to meet the identified needs of the person with dementia and/or their primary caregiver to ensure their health, safety and welfare of the individual with dementia;

The least costly alternative that reasonably meets the person's identified needs;

For the sole benefit of the person with dementia, or to assist the primary family caregiver to perform his or her caregiving responsibilities (e.g., for Respite); and,

Not already covered under insurance policies, Medicare, Medicaid, Community Care Program (CCP), Older Americans Act services and local community services. This guideline does not apply to Older Americans Act Title III-B or Title III-E Respite and Gap-Filling services and other Title III-E Supplemental services.

Persons with dementia and/or their primary caregivers are both eligible for up to the maximum amount of funds allowed per individual if both individuals have an unmet need for the Supportive Gap Filling Service.

Unallowable Expenditures for ADRD Gap Filling Service:

Services covered in 4 above;

Personal assistant services;

Services, goods, supports or gifts provided to or benefiting persons other than the person with dementia and/or primary caregiver;

Bills or fees outside of the allowable goods and services as categorized in "Appendix A" (e.g., credit cards, monthly telephone bills, monthly rent/mortgage payments, annual property taxes, etc.);

Vacation or recreational expenses; and

Alcohol, tobacco and lottery tickets.

Procedures for ADRD Gap Filling Services:

1. Persons with dementia and primary caregivers may be identified through Older Americans Act and Community Care Program client file reviews, referrals, community

outreach efforts or through the completion of the assessment tools utilized by the Care Coordination Unit (CCU) and Title III service providers.
2. Participation in the Supportive Gap Filling service must be documented by completing the *"Client Application form"* for all project participants.
3. It is the role of Caregiver Resource Center to identify the Supportive Gap Filling Service needs of a person with dementia or their primary caregiver.
4. The Caregiver Resource Center will purchase the goods or services and provide a timely and accurate accounting of the purchases. Reimbursement of the purchase will be made by the AAA.
5. A *"Landlord/Mortgage Holder Approval form"* must be signed and witnessed by the Caregiver Resource Center to document that any modifications to the client's home has been discussed with the landlord/mortgage holder and approved prior to any work being performed. The form must be retained at the Caregiver Resource Center.
6. Upon receipt of goods and services, the client must complete the Supportive Gap Filling *"Receipt for Appliances, Merchandise and Supplies form."* The form must be retained at the Caregiver Resource Center.
7. ADRD Gap Filling Service forms and receipts associated with each project participant's case must be organized and filed in a consistent manner.

Payer of Last Resort:
Reimbursement for ADRD Gap Filling Services to person with dementia and/or primary caregivers shall be **payment of last resort**. If funding under local community resources, Community Care Program, Older Americans Act, Medicare, Medicaid, or private insurance is available, no reimbursement shall be made. Note: Clients receiving ADRD Gap Filling Funds may also receive all other Older Americans Act services for which they are deemed eligible such as Respite and Gap-Filling services (and all other Title III services).

Procurement:
1. The CRC should conduct a price or cost analysis to compare price quotations or market prices.
    a. For items or services with a purchase cost (including installation, shipping and other associated costs) of $2,000 up to $10,000, the Agency shall solicit at least three written competitive bids. (Reminder that any request over $2,000 for Home Modification and $1,500 for other items requires a waiver from AgeOptions).
    b. For items or services with a purchase cost (including installation, shipping and other associated costs) of $300 up to $2,000, the Agency shall solicit at least three competitive bids by phone or in writing.
2. CRC files shall include the basis for procurement selection.
3. The CRC must ensure that the vendor is itemizing bids.

Conflict of Interest:
CRCs must follow CCP guidelines regarding conflicts of interest as referenced in *Section 240.1400 (f), 220.600 (a) and Subsection C* in the CCP rules. "No organization having any other conflict of interest in the performance of case management service activities shall serve as a CCU. Conflict of interest means any entity or individual uses an official position for private gain (other than salary), gives preferential treatment to any entity or individual in the

conduct of official duties because of personal interest, impedes or adversely affects governmental efficiency or economy because of personal interest, fails to act impartially in the conduct of official duties because of personal interest, or engages in conduct that could adversely affect the confidence of the public in the integrity of the Department on Aging and its programs. The term also means that the circumstances are such that the Department might reasonably conclude that an entity's or individual's judgment could be influenced by the nature of the circumstances."

APPENDIX A

Illinois Department on Aging
ADRD Gap Filling Service Demonstration Project
Allowable Goods and Services Authorized
Under ADRD Gap Filling Services

Medical Care and Supplies
Dentures
Eye Glasses
Health Screening
Hearing Aids
Home Health and Home Health Aides
Medication (up to 60 days)
Wanderer Alarm Systems/GPS Tracking Devices
Medication Management Screening
Behavioral Health Assessment & Intervention
Other types of medical care and supplies

Environmental and Material Aids
Assistive Technology
Chore/Housekeeping
Emergency Utility Assistance
Emergency Rent/Mortgage
Nutrition Services
Housing Assistance
Material Aid (food, clothing, furniture)
Minor Household Modifications
Minor Repairs and Weatherization
Respite Care
Sanitation Assistance
Others types of Environmental and Material Aids

Community Access
Assistive Transportation

Transportation
Vehicle Adaptation
Other types of Community Access

Other
Other goods/services as needed

Volunteer Facilitation

1. The CRC will utilize any source of volunteer assistance that will aid the caregiver and/or RRC and reduce dependence on this source of funds.

Priority Service—Countywide

How to identify available funds for this service:
Applicants may apply for this service under the Title III-E Legal Assistance funds.

Legal Assistance for Relatives Raising Children (Title III-E)	
DEFINITION: Caregiver Legal Assistance (CLA) shall include arranging for and providing assistance in resolving non-criminal, non-income generating civil legal matters and the protection of legal rights for matters directly relating to a grandparent (or other non-parent relative) who is at least 55 years or older raising a child who is either not more than 18 or 19-59 with a disability.	**UNIT OF SERVICE:** One hour of staff time expended on behalf of the non-parent relative raising a child (RRC). **CLIENT(S):** A grandparent or other non-parent relative (aged 55 years or older) living with a child (who is not more than age 18 or is 19-59 with a disability) will be counted as a client or parent or raising a child who is 19-59 with a disability) will be counted as a client.

Service Activities May Include:

- Provision of legal advice and information;
- Legal research on behalf of clients;
- Education of older adult caregivers and/or social service professionals about their legal rights and responsibilities;
- Provision of representation by an attorney at law, a trained paralegal professional, and/or a law student (supervised by an attorney) to caregivers;
- Provision of client advocacy to secure needed and entitled benefits.

STANDARDS
Coordination and Service Linkage

1. The agency providing legal assistance to grandparents or other non-parent relatives will work in coordination with AgeOptions, the Countywide Caregiver Coordinator, Caregiver Specialists at each Caregiver Resource Center, Aging and Disability Resource Network (ADRN) agencies, Elder Abuse Intervention Agencies, Ombudsmen programs, and other service providers in assuring services are provided to targeted caregivers.
2. The agency providing Caregiver Legal Assistance will attend meetings (quarterly or as requested) conducted by the Area Agency.
3. If the agency providing Caregiver Legal Assistance is not a Legal Services Corporation project grantee, the agency will coordinate its services with existing Legal Services Corporation projects in the service area.
4. The grantee providing Caregiver Legal Assistance will have information available in various forms, such as having a web page or listing an email address potential clients can contact to receive information.
5. The agency will refer caregiver clients to AgeOptions for other caregiver services.

Training and Education

1. The agency providing Caregiver Legal Assistance will be available for training activities for aging network staff and/or caregivers estimated at four (4) days per year.
2. The agency providing Caregiver Legal Assistance must be responsive to the needs of caregivers in the community by having methods for developing, identifying, and distributing literature that can assist with common legal issues.

Client Assistance

1. The legal assistance provider will give priority to legal assistance related to guardianship, adoption, back-up child care plans, school advocacy, income, health care for both adults and children, housing, utilities, nutrition, protective services, abuse, neglect and age discrimination.
2. The agency providing Caregiver Legal Assistance will maintain individual records on cases where direct services involving one or more personal contacts are provided.
3. Filing fees and related court costs are allowable expenses under this grant.

Volunteer Facilitation

1. The agency providing Caregiver Legal Assistance will involve private bar organizations in caregiver legal assistance activities, including asking groups within the bar to furnish services to caregivers on a pro bono basis.

Policies and Procedures

1. The agency providing Caregiver Legal Advice will submit reports to AgeOptions as required.
2. The agency providing Caregiver Legal Advice will develop written procedures to ensure client confidentiality.
3. The agency providing Caregiver Legal Advice will adhere to all regulations pertaining to legal services as defined in Section 307(11)A of the 2006 Older Americans Act Regulations[2].
4. The agency providing Caregiver Legal Advice will have policies and procedures for identifying the major languages other than English in the service area and developing a plan for providing service to persons who are Limited English Proficient. This plan must include the components outlined in the Guidance on Assistance to Persons with Limited English Proficiency.
5. All grantees will meet the “Requirements for Recipients of Title III Older Americans Act Funds.”

[2] Available upon request