

DFTA Case Management Standards of Operation

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Based on standards set by the New York City Department for the Aging and the New York State Office for the Aging.

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Introduction

These standards are required and apply to all DFTA-funded case management programs. Case management services help older persons with functional impairments gain access to appropriate services, benefits and entitlements needed to age safely at home and maintain their quality of life. Case managers do so by developing trusting relationships with clients and their caregivers and engaging them in a collaborative process of problem solving.

The core functions of case management are:

Intake and assessment. Identification of the client's needs and capabilities through intake and comprehensive strength-based in-home initial assessment and regular reassessments. The assessment includes financial assessment of clients who need home care, and, when permitted by the client, financial assessment to determine eligibility for city, state and federal benefits and entitlements.

Care planning. Development of a mutually agreed-upon care plan with clients and caregivers, based on the needs and goals identified during the assessment/reassessment(s) and specifying the interventions that will help the older person to age safely at home.

Implementation of the initial and subsequent care plan(s). Authorizing DFTA-funded home care services* and home-delivered meals, arranging for other services, linking clients to community resources, coordinating and negotiating with service providers for the delivery of service identified in the care plan, and coordination and collaboration with providers of counseling and assistance with long-term care planning.

**Note: DFTA-funded home care services are homemaker/personal care service and housekeeping/chore service. In these standards they will be referred to as home care services unless specified.*

Follow-up and monitoring. Ensuring the client's needs are being met as specified in the care plan through ongoing contact and coordination with service providers and clients.

Reassessment. A scheduled or event-based reassessment of the client conducted to identify changes in the client's situation and functioning since the most recent assessment/reassessment and to measure progress toward the service goals.

Services discharge. Discontinuation or termination of case management and other services at the client's request, when the client's goals have been met or if the client becomes ineligible for the service.

Examples of case management needs:

- A case manager visits the client at home to conduct a comprehensive assessment and discovers that the client cannot bathe herself or do housework. The client's son, her only relative, lives in Wisconsin.
- A case manager visits the client at home and determines that she needs help applying for SNAP benefits because she is eligible for this entitlement and it can help reduce her food bills. She also needs assistance paying her utility bills from Con Edison.
- A case manager determines that the client, who can self-direct, needs help linking to Medicaid and Medicaid home care in order to continue living at home safely.
- A case manager discovers that a client, who called asking for meals, may be a victim of elder abuse and needs case management services coordinated with services from a local elder abuse services provider.
- A client who is a recent immigrant needs home-delivered meals as well as friendly visiting service from an organization that helps immigrants from her country.
- A client who is recently widowed after 51 years of marriage needs support from the case manager and linkage to grief counseling from a local community center.

In order to provide quality case management and perform the above core functions effectively, the program maintains extensive information resources and linkages. Information resources include (1) key businesses serving community residents; (2) cultural, religious and educational institutions; (3) key health care and social service providers, (public and voluntary) including hospitals, ambulatory care clinics, community health centers, nursing homes; senior centers, social adult day programs, and other DFTA-funded service providers; and (5) non-DFTA-funded service providers serving the community.

DFTA also expects the program to identify, develop and maintain collaborative relationships with Medicaid programs; NY Connects; volunteer organizations; local banks; DFTA-funded caregiver programs, elder abuse services providers and senior center programs; APS and mobile crisis teams; community hospitals and clinics; and key civic and representative offices serving the community.

Unit of Service

Case Management unit of service: One Unit = 1 hour (including travel time).

Supplemental unit of service: One Unit = 1 friendly visit to a client, 1 hour of a support group, 1 client assisted in obtaining;

- Home remediation/services
- Legal services
- Medical, dental and mental expenses not covered by insurance
- Transportation for non-emergency appointments

Target Population/Eligibility

Standard 1: Participant Eligibility

The program provides case management to individuals who meet case management eligibility requirements.

Compliance 1.1. Individuals eligible for case management meet the following requirements:

- Are 60 years of age or older;
- Have at least one functional ADL limitation or two IADL limitations as shown by the need for assistance from another person. Note: The client may have a functional need that is being met – e.g. by an informal support, private home care agency or other source – but require other types of case management assistance.
- Need case management assistance;
- Are able to be safely maintained at home;
- Accept assistance from the case management agency and providers and cooperate with the care plan; and
- Are not eligible to receive similar case management services from any other government-funded program.

Note: The case management agency may provide case management services for the older client's caregiver(s) when such assistance enables the client to age safely at home. If the client's caregiver is 60 years of age or older, that caregiver is eligible for case management services and should be considered a client in her/his own right.

Standard 2: Home Care and Home Delivered Meals Authorization

The program authorizes home care and home-delivered meals services for eligible clients.

Compliance 2.1. DFTA-funded home care eligibility. Individuals authorized for DFTA-funded home care meet the following requirements:

- 60 years of age or older;
- Functional limitations, as shown by the need for the assistance of another person with at least (a) one Activity of Daily Living (ADL) such as bathing, grooming, dressing, washing, feeding, toileting, mobility, and transferring, or (b) two Instrumental Activities of Daily Living (IADLs) such as shopping, laundry, meal preparation, reheating meals and house cleaning (for housekeeping);
- Unmet needs for assistance with ADLs and/or IADLs;
- Able to be maintained safely in the home if support is provided;
- Ineligible for housekeeping or personal care under any other government program, including Medicaid (may receive DFTA-funded home care until Medicaid service begins);
- No other resources are available to fully assist the client or DFTA-funded home care services will supplement but not duplicate other services the client is receiving, such as Medicare-funded Hospice or Medicare-funded skilled nursing care following hospital discharge.

Compliance 2.2. DFTA Funded home care for clients with Medicaid or eligible for Medicaid. Authorizations of DFTA-funded home care meet the following guidelines:

- The client has been assessed by the case manager to have unmet ADL and/or IADL needs.
- The authorization of home care hours is as specified by DFTA.
- When the case manager determines that the client is eligible for Medicaid, learns from the client they are in receipt of Medicaid or based on an HRA data match learns that the client is in receipt of Medicaid, the case manager will follow up with the client to obtain Medicaid home care within a 2 month time frame.
- The case manager documents when the application for Medicaid home care (and Medicaid, where applicable) is submitted.
- Once Medicaid home care is approved and begins, DFTA-funded Home Care ends.

Compliance 2.3. Home Delivered Meal eligibility. Individuals authorized for DFTA-funded home-delivered meals meet the following eligibility criteria:

- The client is age 60 or older;
- The client is unable to attend congregate meal sites because of an accident, illness or frailty;
- The client lacks formal or informal supports (family, friends or neighbors) who can regularly provide meals;
- The client is able to live safely at home if home-delivered meal services are provided;
- The client is unable to prepare meals because of one or more of the following:
 - Client lacks adequate cooking facilities.
 - Client lacks knowledge or skills to prepare meals.
 - Client is unable to safely prepare meals.
 - Client is unable to shop or cook.

Example:

The client is 76 years old, lives alone, has difficulty walking, and is struggling to shop for food. She may be eligible for home-delivered meals.

Note: When it is in the best interest of the home-delivered meals client, as documented in case notes, DFTA-funded meals may also be provided to: (1) the client's spouse or domestic partner, regardless of the person's physical condition or age (under 60); (2) disabled individuals under 60 years of age living in the same household as the client. A case record for the non-case managed client (the case managed client's spouse or domestic partner, or disabled person under 60 living in the same household as the client) is opened in DFTA's client tracking system, and the NY Client Info section of the Client Profile is completed. A referral is also sent to the home delivered meal program. A six month follow-up is done with the non-case managed client and is documented in the case notes of this client's case file. The six month follow-up can be in the form of a home visit or a telephone contact.

However, if the spouse or domestic partner meets all the eligibility criteria for home delivered meals, that person is considered a case management client.

Example:

The client is 69 years old and cares for her 40 year old developmentally disabled son. In addition to her own difficulty in caring for herself, she is struggling to care for her son as well. Both persons may be eligible for meals.

Compliance 2.4. Home Delivered Meal ineligibility. Counseling about other resources such as congregate meals and food pantries is provided to clients who are reassessed as no longer eligible for DFTA-funded home-delivered meals, after which the case is closed.

Compliance 2.5. DFTA Funded Home-Delivered Meals for Adult Protective Services (APS) clients.

- Clients referred for home-delivered meals from APS have an APS referral form on file (required). In this situation, the case management agency is not required to conduct an in-home assessment or to make monitoring calls because APS works comprehensively with clients to meet their needs. CMAs, therefore, are not required to duplicate case management service. In possible emergency situations (e.g. client does not answer door to accept meal), APS is contacted before the close of the business day.
- Client information from the APS referral form is added to the client's electronic and physical record.

Scope of Services

Standard 3: Screening and Intake

The program screens each inquiry to determine whether to conduct an Intake or provide the client with needed information and referral.

The process typically starts with a phone call to the case management agency from a referral source or an individual, such as a senior, caregiver or neighbor. If, through screening, the individual is found to be appropriate for case management service, an intake is completed. If not, the staff conducting the screening addresses the client's information and referral needs.

Compliance 3.1. Screening and Intake are staffed daily, Monday through Friday, during normal business hours.

- Staff that conduct the screening/intake are competent in the main languages spoken by older residents in the program's service area, are knowledgeable about community resources, and skilled in eliciting information and deducing needs. Telephonic translation or interpretation services must be available if needed.

Compliance 3.2. Screening. The initial inquiry is screened to determine preliminary eligibility for the program in terms of age, functional and/cognitive impairment and need for case management assistance.

- Information and assistance is provided to persons who do not meet eligibility requirements and documented in DFTA's client data system through a service ticket. A client case file is not opened.
- An Intake is conducted on persons who appear to meet eligibility requirements (Compliance 3.3 Intake below).

Compliance 3.3. Intake

- Sufficient information is collected during the Intake process to register the client in the case management program. Note: If both individuals in a "couple" are to receive services, two Intakes are completed.
 - Sufficient information is also obtained from the client or client's collateral contacts to make a reasonable determination that the client is not at-risk. An in-home assessment is scheduled as soon as possible if the client's risk status cannot be ascertained. The Intake is then completed during the initial in-home assessment.
- During Intake, the worker asks about whom the client lives with, whether someone with a mental illness is present in the home and whether there is any current substance abuse in the home.
 - If there is reason to suspect safety issues, the assigned case manager calls before making the in-home visit to inquire of the client whether she/he is fearful of anyone who comes into the home; whether the police have ever been called to the home and why; presence of weapons in the home. The case manager discusses how to proceed with his/her supervisor if she/he feels uncomfortable or unsafe.

The Intake process results in one of the following actions: (1) scheduling of client's in-home assessment; or (2) client's placement on a wait list for in-home assessment if an in-home assessment cannot be conducted within ten days; or (3) decision that client does not require an in-home assessment and provision of information and assistance when there are other needs. Note: At intake, a client may be authorized for home-delivered meals on the presumption that the client is eligible.

Standard 4: Assessments and Reassessments

The program conducts an initial assessment and annual (at minimum) reassessment of each client's needs, strengths, and assets.

In conducting an assessment/reassessment, the case manager uses the skills of observation, deduction, exploration and inquiry to obtain in-depth information about the client's current strengths, resources (including formal and informal support systems), problems, needs, and quality-of-life goals. The purpose of the assessment is not simply to "certify" the client's need for the services that she or he has requested, but to evaluate all aspects of the client's current functioning and situation in order to develop a comprehensive care plan. The purpose of the reassessment is to again review all aspects of the client's current functioning in order to develop a new care plan or continue the existing

plan. The case manager also uses the reassessment as a fresh opportunity to engage or re-engage the client in meaningful activities and interests and to measure progress toward care plan goals since the last assessment.

To facilitate doing a comprehensive evaluation, the case manager:

- Takes time to get to know the client as a human being.
- Explains the purpose for asking personal questions.
- Seeks the client's input and listens to what the client has to say.
- Uses skills of observation and deduction.
- Evaluates all aspects of the client's functioning and situation.

- Compliance 4.1. Case manager assignment.** The program assigns a case manager to the client who is, and who remains, the primary contact for the client and who coordinates contact with the client by other agency staff.
- Compliance 4.2. Location of Assessment/reassessment.** The case manager assigned to the client conducts the assessment/reassessment face-to-face with him/her and, if applicable, his/her authorized representative. It takes place in the client's home or usual residence.
- Compliance 4.3. Assessment/reassessment instrument.** The case manager completes (or updates at reassessment) all relevant sections of the Assessment. These include:
- All Assessment/COMPASS forms, with particular attention to the following: emergency contact(s); housing status; home safety; health status; assistive devices used; nutritional status; psychosocial status; health care events; medications; ADL/IADL status; services currently receiving; informal supports and specific tasks they perform; benefits and entitlements; and monthly income.
 - Note: The client may refuse to provide the information requested without loss of services. (See Cost Share Determination for exception).
 - COMPASS Supplemental Form
 - PHQ2/9
 - Strengths and Accomplishments
 - Financial Information.
- Compliance 4.4. Elder abuse and imminent risk detection.** Where elder abuse is known or suspected, the case manager assesses the client's imminent risk of serious physical harm and brings the situation immediately to the attention of her/his supervisor.
- Compliance 4.5. Client need for accommodation.** The client's communication difficulties (e.g. due to vision or hearing impairment or limited English proficiency) are accommodated – for example, by reading documents out loud to the individual with a vision impairment (documents should be in large print); use of a TTY device for hearing impaired elders; use of an interpreter service; having a family member or friend present during the assessment to aid in communication; enlisting assistance from another agency that specializes in assisting persons with a special need.
- Compliance 4.6. Obtaining information from others.** To obtain as complete as picture as possible of the client's needs, the case manager seeks information relevant to the client's presenting problems, recent care issues and informal supports from others engaged in the client's care.

- If the client does not object, and if it is feasible, formal and/or informal caregivers are involved in the assessment process (except for questions related to elder abuse and neglect which must be asked of the client in private). If informal caregivers provide assistance with ADLs and/or IADLs, the type of assistance they provide is documented.

Example:

The client was recently discharged from the hospital and is being assessed at home. The case manager asks for the most recent discharge package and, if needed, follows up with the client's physician/social worker/care coordinator.

Compliance 4.7. Determination of contribution/cost-share status for home care clients. If a client is eligible for DFTA-funded home care, the client provides documentation of income to enable the case manager to determine whether he/she is above the current threshold for contribution status (thresholds are provided annually by the NY State Office for the Aging) and will be required to pay a cost share. Note: Although the case manager determines the cost share based on client documentation, the home care provider collects the cost share.

- A Cost-Share Worksheet is completed in DFTA's client tracking system for every home care client prior to home care authorization. If the client lives alone or with another person who is not willing to divulge financial information (and who is not a recipient of DFTA-funded home care), the column for single-person household is completed. If the client lives with a spouse or other party who contributes to expenses and is willing to provide information, the column for couples is completed.
 - The following sources are excluded from income determination: food stamp allotments; income from job programs established to foster employment of lower income elderly or to support volunteer efforts; unearned income from one-time lump sum payments; proceeds from reverse mortgages; war reparations.
- The client consents to pay the maximum home care cost-share if she/he refuses to provide the required financial information for determining her/his cost-share. Clients who refuse to provide financial information and who refuse to agree to pay the maximum cost-share may not receive home care services.
- Clients who will be authorized for home care but who disagree with their designated cost-share are informed in writing that they have the right to a redetermination, and to formally contest the re-determination if they do not agree with it.

Compliance 4.8. Assessment/Reassessment Summary. The case manager completes an Assessment Summary (and Reassessment Summaries) of his/her findings and analysis of the client's situation. The Summary is sufficiently detailed to address the client's safety at home and to indicate issues that still need attention. It includes:

- Client's strengths, current support and resources;
- Factors that negatively affect the client's everyday functioning and long-term well-being;
- Client's status with regard to engagement in personal and community interests;
- Goals that have yet to be realized and how the case manager will help the client attain them.

Examples of Assessment Summary Content:

- *An explanation that the client will be able to manage with less than five weekday meals because he has family or other informal supports.*
- *An explanation that the client's strong religious faith helps her face the loss of her spouse and motivates her in other parts of her life.*
- *An explanation that the client has accepted some of the plan offered by the case manager but refused others and a statement that the case manager will continue to review goals with the client.*
- *Statement of steps the case manager will take to obtain missing information when the assessment is incomplete – e.g. obtaining additional medical, nutritional, mental health or housing assessments if need is indicated.*

Compliance 4.9. Assessment/Reassessment Sign-off. The case manager signs off on the initial assessment and subsequent reassessments. For example, "The Case manager completed the Assessment on this date" is written at the end of the assessment summary in the case notes section.

Standard 5: Event-based Reassessments

The program conducts event-based reassessments when needed.

Compliance 5.1. An event-based reassessment is conducted before the next scheduled reassessment if there is a major change in the client's health, functional capacity, social or physical environment, formal or informal support system, or if other circumstances require re-evaluation of the care plan.

Standard 6: Assessment Timeframes

The program follows required timeframes for the initial assessment, subsequent reassessments, and event-based reassessments.

Compliance 6.1. Initial assessment . The assessment occurs no later than ten business days after initial Intake. If the assessment cannot be performed within ten business days, the client is placed on a waiting list for assessment.

Exception: An assessment may be temporarily delayed if requested by the client or his/her authorized representative. The client's file documents the reason for the delay.

- The assessment occurs prior to authorization for DFTA-funded homecare. Note: DFTA-funded home-delivered meals may be authorized or arranged prior to the assessment when the client is presumed eligible.

Compliance 6.2. Reassessments . Reassessments are conducted at least every twelve months (365 days), or more often as appropriate to the client's changing needs (event-based reassessment).

- A reassessment may be temporarily postponed if requested by the client or his/her authorized representative, or if there is a sudden change in her/his condition (e.g. hospital or nursing home stay) which affects the information collected. Circumstances of postponement are noted in the client's file.

Compliance 6.3. Event-based Reassessments . An event-based reassessment is conducted within five days of the precipitating event.

Standard 7: Care Plan

The program develops comprehensive care plan(s) for each client based on assessment/reassessment findings.

Each client has a current plan that is the product of an active and ongoing process that begins during the initial assessment and that changes over time as client needs change. The case manager involves the client in care plan development to the extent possible by discussing goals and presenting choices and options. The care plan is comprehensive and includes not only services (where needed), but other appropriate interventions and linkages, including those to health care and to opportunities for the client to engage or re-engage with personal interests and the life of the community.

Compliance 7.1. The initial care plan is developed within six business days of the date of the completion of the initial assessment.

Compliance 7.2. The client or the client's authorized representative participates in care planning, along with (when appropriate) informal caregivers who provide assistance with activities of daily living or instrumental activities of daily living. The case manager explains the client's choices and elicits the client's preferences.

Compliance 7.3. Care plan(s) include:

- Services and/or needed linkages to address assessed unmet needs, health and mental health care issues, and quality of life issues.
 - Where the client has a need for home care, the type(s) of home care service appropriate to and consistent with, the client's assessed unmet ADL and/or IADL needs (e.g., housekeeping service when client has only IADL impairments).
 - Supplemental services (offered at the program's discretion) where necessary to achieve a care plan goal and the service cannot be obtained through other means. Examples of supplemental services include friendly visiting, support groups, home remediation/services, legal services, medical, dental, and mental health expenses not covered by insurance, and transportation for non-emergency appointments.
- Social work interventions where needed, such as client advocacy and support.
- Supports provided by existing caregivers and interventions to strengthen and support caregivers when possible.
- Entitlements/benefits counseling and application when pertinent to the client's needs.
- Assist clients to connect with providers that provide counseling and assistance with long-term care planning.

Compliance 7.4. New care plans are developed every 365 days, following client reassessments.

Note: Interventions specified in the care plan may be for a shorter period of time than 365 days. However, if the client's needs or situation appear to have changed to the point where the care plan needs to be amended, an event-based reassessment is conducted (see Standard 5) and an updated care plan is developed. The care plan may include a plan to reassess the client at an earlier date than 365 days, based on the client's particular needs and level of risk.

Compliance 7.5. The case manager uses reassessments as opportunities to review/update the care plan with the client.

- Goals are reconsidered. Some may have been achieved, some may still be relevant, some may need to be revisited if they no longer match the client's needs and new goals may need to be formulated, with appropriate referrals/interventions planned.
- Service needs are reviewed. Current services, whether or not they are DFTA-funded, may need to be terminated. New services, whether or not they are DFTA-funded, may need to be arranged or authorized.
- Goals or services previously rejected or refused by the client are revisited if still relevant to the client's situation. The case manager uses the new care plan as an opportunity to re-introduce them for the client's consideration.

Compliance 7.6. If at reassessment there are no changes to the Care Plan, the case manager indicates in case notes that the Care Plan continues to be in effect and updates the date field.

Standard 8: Consent Form

The program receives a signed Consent Form from each client.

Compliance 8.1. A signed DFTA Consent Form (or program-preferred form with same content) is obtained during the initial in-home assessment. The Consent Form authorizes the agency to act on behalf of the client in obtaining or giving out financial, health and social information when necessary to apply for services, benefits and entitlements. The signed Form is in effect until the case has been closed.

- See also General Program Standards, Standard 7.

Standard 9: Client and Service Provider Rights and Responsibilities.

The program reviews a statement of Client and Service Provider Rights and Responsibilities with each client. *Case managers ensure that client rights are protected in all aspects of the program.*

Compliance 9.1. During the initial assessment and each subsequent reassessment, the DFTA-issued Client and Service Provider Rights and Responsibilities is reviewed with the client or authorized representative and the client is given a copy.

- The case manager documents in case notes that the client received a copy.

Standard 10: Service Agreements

The program obtains signed Service Agreements from clients in receipt of home care and home-delivered meals.

The Service Agreement specifies type(s), frequency, and duration of the home care and/or home-delivered meals that will be provided. It is not required if the client will not receive these services.

Compliance 10.1. As part of the initial assessment and each reassessment process, the case manager and the client (or authorized representative if the client is mentally frail) sign and date a current Service Agreement. If the client or her/his authorized representative refuses to sign the Service Agreement, DFTA-funded home care or home-delivered meals may not be authorized.

- A copy of the Service Plan is given to the client or her/his authorized representative and, if requested by the client, to informal caregiver(s).
- A new signed Service Agreement is obtained at each reassessment even if service type, amount, duration and frequency have not changed.

Standard 11: Supervisory Review

Program supervisors ensure comprehensive casework by case managers.

Compliance 11.1. Initial supervisory review timeframe. The case manager's supervisor reviews and signs off on each client's case record, including intake, assessment, assessment summary, care plan, service plan (where applicable) and case notes no later than ten (10) business days after the completion date of the initial in-home care plan.

Examples of Supervisory Sign-Off:

I reviewed the case record through DATE and approve.

I reviewed the case record through DATE and advised the case manager to follow up with the client's daughter about a potential referral and linkage to the local caregiver program.

Compliance 11.2. Compliance 11.2 Subsequent supervisory review timeframe. The case manager's supervisor reviews and signs off on each client's case record, including case notes since the last assessment, reassessment, reassessment summary, updated care plan, and updated service plan (where applicable) no later than ten (10) business days after the completion date of each reassessment care plan.

Standard 12: Implementation of Interventions

The program implements interventions specified in the client's care plan(s).

Compliance 12.1. The case manager:

- Makes all planned authorizations, linkages and arrangements;
- Carries out planned social work interventions; and
- Encourages and supports the client in carrying out any actions for which the client has responsibility.

Compliance 12.2. Where linkages are proposed, the case manager works closely with the proposed service provider so that the linkages support the client's goals.

Compliance 12.3. Temporary increase in DFTA-funded home care. Once the client is receiving home care, s/he may have weekly hours temporarily increased to include escort to a medical appointment for that week. The case manager first consults with the home care provider to determine if there are available hours.

Compliance 12.4. The case manager explains any deviations from the current care plan in case notes.

Standard 13: Ongoing Case Management

The program provides each client with ongoing case management, including services coordination, follow-up and monitoring of care plan appropriateness.

The case manager is active in the client's ongoing care by following-up on referrals, ensuring that services are coordinated, calling the client to monitor service appropriateness, responding with appropriate interventions to emerging needs, and maintaining ongoing communications with service providers to resolve potential problems or health and safety issues.

Compliance 13.1. Next day follow-up on receipt of home care or home-delivered meals. The case manager either makes a home visit or a phone call to the client the business day following the day the service was scheduled to begin to ascertain service start.

Compliance 13.2. Fifteen (15)-day follow-up on receipt of home care or home-delivered meals. The case manager contacts the client no later than 15 business days after a DFTA-funded service has begun to ascertain adequacy, appropriateness and satisfaction with the service.

- The 15-day contact is a home visit if the client is receiving homecare.

Compliance 13.3. Follow-up on Entitlement/Benefit application. The case manager follows up with the appropriate government office to ensure receipt and status of client's benefits application until a decision is reached. The case manager also keeps the client informed.

Compliance 13.4. Client care plan monitoring. The case manager or a staff person under the case manager's direction, monitors the client's care plan via phone or home visit as often as needed but at least once every two (2) months (60 days). When clients have complex needs, the case manager makes as many contacts (either by phone or home visit) as needed to adequately address them, beyond the minimum requirement

- Monitoring involves active inquiry, coordination and follow-up to ensure that:
 - Services are being implemented as authorized;
 - Client's needs are being addressed;
 - Progress is being made to reach the client's goals;
 - New issues/needs are brought to the case manager's attention so that they can be dealt with;
 - Problems with the care plan are identified and followed-up with the service provider; and
 - Client remains safe at home.

Note: Case managers are not expected to review all the above items in a single monitoring contact, but rather the item(s) most relevant at the time of the contact.

- Case management needs that come to the case manager's attention between assessments are followed up appropriately and documented in the case record.

Examples:

The case manager is helping the client to apply for SNAP benefits. She has already linked the client with DFTA-funded home-delivered meals. During her monitoring call, the case manager informs the client that she has just mailed the completed SNAP application. As the conversation continues, the client informs the case manager that she missed her doctor's appointment because she is experiencing worsening problems with her gait. The case manager and client agree that the case manager should help the client apply for Access-A-Ride.

The case manager contacted the client for a monitoring call. The client has DFTA-funded home care. She informs the case manager that while she likes the aide who has been helping her over the past two months, she does not like her cooking and wants to change the aide. As the discussion continues, it becomes clearer that there may be some personality conflict between the client and the aide. The case manager and client agree that a follow up discussion and review with the home care agency is the next step to determine how to resolve this situation.

Compliance 13.5. Severe or imminent threats.

- The case manager reports to his/her supervisor as soon as possible any situations posing possible severe or imminent threats to the health or safety of the client or any indications of elder abuse, mistreatment, or neglect. The case manager's actions are documented in the client case record.
- The supervisor investigates reported serious client health and safety issues and reports these instances to DFTA and other appropriate government agencies such as APS, police, DoHMH, as needed. The supervisor's actions are documented in the client's record.

Compliance 13.6. "No answer" when a client does not answer door to home-delivered meals deliverer, the case management program may respond in any of the following ways:

- The case manager may follow up beyond reaching out to the emergency contacts until client safety has been verified;
- The case manager may maintain a list of clients deemed high risk. If a client on that list is a No answer case manager must conduct follow up beyond the emergency contacts until client safety has been verified;
- For clients assessed to be low risk, the case manager may call or email the emergency contact and await a response. If however, a client who is deemed low risk is a No Answer on two consecutive days, the case manager must follow up beyond the emergency contacts until client safety has been verified.

Compliance 13.7. Documentation in the case record. Service coordination, follow up, monitoring contacts and collateral phone calls are documented in the case record.

- The case manager provides sufficient detail when documenting monitoring or follow-up contacts to demonstrate that steps taken and information obtained were relevant to the client's situation and that the client's needs and/or safety were addressed.

Examples of Adequate Documentation:

A client is receiving meals and has no other need. The client has remained stable during the past few months without any crisis. The case manager wrote the following about the monitoring contact: "We reviewed her current living situation and meal service from Totally Awesome HDML. I determined that there were no major changes needed in her care plan and she continues to remain safely at home with the meals."

The client has meals but the case manager introduced the topic of SNAP because the client had refused to apply for this benefit when they last spoke. He wrote: "The client continues to appreciate the hot kosher meals but I encouraged her to reconsider her refusal of SNAP because it will help stretch her current budget. Client remains unsure if she wants to do it, said she doesn't need government help even though she complains that she doesn't have enough money to buy new shoes."

The client has a daughter who lives in another state. The client begins to exhibit unusual behavior during a monitoring call. The case manager wrote: "The client was very confused during the call. She mentioned that she was expecting her husband to return home today even though her husband has been deceased for the past two years. She was also confused about which day it was. This is unlike this client who generally has a good memory and had never displayed any signs of disorientation. After talking with her, I contacted the client's daughter. The daughter mentioned that she had taken her mother to the doctor last week and that her medication had been changed. The daughter stated that she will follow up with mother's physician."

Example of Inadequate Documentation:

The case manager wrote: "The client was contacted today and everything was fine. No further assistance was needed."

Procedures and Methods

Standard 14: Service Authorizations and Referrals

The program follows required procedures for service authorizations and referrals.

Compliance 14.1. Referrals for home care and home-delivered meals. The case manager authorizes and sends referrals for home care services (homemaker/personal care and housekeeping services) and home-delivered meals through DFTA's client tracking system.

- Referrals for home care and home-delivered meals are consistent with the Service Agreement signed by the client regarding the types, amounts, frequency and duration of services and the assessed home care cost-share amount, where appropriate.
- Referrals that include 6th and 7th home-delivered meals specify Citymeals as the funder.
- Referrals specify special instructions for the provider when needed, including indication of high-risk clients to home-delivered meals providers.
- Referrals specify when there are other clients attached/linked to this case who will be receiving home-delivered meals (see Compliance 2.3) or a secondary client in the home who will indirectly benefit from having housekeeping tasks performed.

Example:

Mr. John Doe is authorized for 12 hours of home care and related housekeeping tasks. Mrs. Jane Doe, the client's spouse, is a secondary client because she will benefit from having the couple's apartment being cleaned.

Compliance 14.2. Timing of reauthorization referrals.

- The case manager sends a reauthorization referral through DFTA's client tracking system for homemaker/personal care or housekeeping/chore service if the client will continue to need the service.
 - This reauthorization is sent within ten business days of the reassessment.
- The case manager sends a referral for ongoing home-delivered meals service only if there will be a change in the client's meal delivery – for example, if the client requested a change from hot kosher to frozen kosher meals.

Compliance 14.3. Referrals for other services. The case manager documents other referrals in the client's case notes.

Standard 15: Wait Lists

The program maintains required wait lists.

Compliance 15.1. The program maintains these wait lists regardless of number of clients on the list or length of wait:

- Case management wait list for clients for whom the in-home assessment* cannot be conducted within ten business days of completion of Intake. Clients are only placed on a wait list under these conditions: (1) the Intake has been completed; (2) they can be safely maintained on the wait list; (3) they are deemed eligible for case management; and (4) they are informed about other possible community resources/options but would still benefit from case management. **Note: The client on a wait list for assessment can be authorized for needed home delivered meals in the interim.*
- Wait list for DFTA-funded services (personal care, housekeeping and home-delivered meals)* if the service provider is at capacity and cannot accept additional clients. **Note: Clients cannot be placed on a wait list for personal care or housekeeping service until an in-home assessment has been completed.*

- Compliance 15.2. Counseling on options.** The case manager documents that discussion with the client of all possible community resources and other options occurred before the client was placed on the wait list.
- The program does not place clients who cannot be safely maintained while waiting for the service on a wait list. The case manager works with the client who cannot be safely maintained without service to ensure alternatives are found and put in place.
- Compliance 15.3. Prioritization.** Clients on the wait list for assessment and for home care or home-delivered meals services are prioritized on the Wait List Prioritization Form in the DFTA client tracking system.
- The client is advised of the approximate wait for the service s/he needs and that her/his priority may change because other clients with higher needs may rank higher.
 - The client with the highest priority on the wait list is referred first when service becomes available.
- Compliance 15.4. Interim services.** Clients for whom interim or gap-filling services have been arranged (e.g. private pay home care) may continue on the wait list until service becomes available.
- Compliance 15.5. Monitoring of clients on the Wait List.** Clients on the wait list for a service receive a monitoring call every two months to review their status, including any changes in their need for the service.

Examples:

The case manager calls the client on the wait list for personal care and learns that her daughter still has a chaotic work schedule and cannot come regularly to help her bathe. The case manager and client agree that she will continue on the wait list for personal care.

The case manager contacts the client to monitor status. The case manager informs the client that she will need to continue waiting. The client informs the case manager that she will pay for private housekeeping with some financial help from her son who lives in another state. Because of this change in the client's situation, the case manager removes the client from the wait list for housekeeping service.

- Compliance 15.6. Six-month review of clients on the Wait List.** After the client has been on a wait list for six months, the case manager calls the client (3rd monitoring call) to evaluate the situation and again explore the possibility/feasibility of other service arrangements. The case manager documents discussion of alternatives with the client.

- If other arrangements cannot be made, the case manager determines whether to visit the client for a reassessment of her/his priority on the waiting list or whether to continue the client at the same priority.

Standard 16: Collection of Past Due Cost-share Amounts

The program follows required procedures for collection of past due cost-share amounts.

Compliance 16.1. Timing of cost share collection procedures. The program begins past-due collection procedures when it receives a copy of the Late Payment Notice sent to the client by the home care provider. The case manager has 30 calendar days from the day of receipt of the Late Payment Notice to resolve the late payment issue with the client.

Note: The DFTA-funded home care provider is required to send the client a Late Payment Notice when no payment or a lesser amount than invoiced has been received from the cost-share client by the due date. The provider is also required to send a copy of the Late Payment Notice to the case management agency.

- The Late Payment Notice is kept in the client's file.

Compliance 16.2. Case manager actions.

- The case manager tries to reach the client by phone to discuss the payment problem. If the client or the client's representative cannot be reached by phone, the case manager documents efforts and sends a follow-up letter to both. Note: Clients or their representatives may not be harassed for payment. Reminder phone calls can only be made during normal business hours. Caregivers or authorized representatives may be called after normal business hours only if necessary to establish contact.
- Within the 30-day timeframe, the case manager obtains the client's agreement to one of the following:
 - The client agrees to pay the assessed cost-share in the future and to make specified pro-rated payments on the past-due amount until the entire amount past-due is paid off (Option One). Note: The case manager may conduct a new Financial Assessment and recalculate a new cost-share going forward if it appears that the client's income and allowable expenses have changed.
 - The case manager obtains an agreement from the client to pay the assessed cost share in the future and to pay off the past-due amount before or upon receipt of the next bill (Option Two).

A client may be permitted to continue to make lesser payments and still receive services where the case manager determines that the client is acting in good faith and has sudden or temporary personal or family expenses not included in the cost-share formula.

- If within the 30-day timeframe a payment plan (Option One or Option Two) cannot be agreed upon, the case manager sends a Termination Notice to the client with information about the client's right to contest termination. (See Standard 18 and DFTA's Termination Procedures).
- The case manager continues to work with the client and the client's informal supports to make long term care plans. The case manager documents discussion and planning with the client in case notes.

Compliance 16.3. Coordination with home care provider. Within 30 calendar days of the date of the Late Payment Notice, the case manager informs the home care provider about the specific details of the negotiated payment plan with the client, or sends the home care provider a copy of the Termination Notice sent to the client.

- The case manager informs the home care provider if the client requests a Fair Hearing and suspends the Termination Notice pending the Hearing outcome.

Standard 17: Service Discharge/termination Procedures
The program follows required service discharge/termination procedures.

Compliance 17.1. Voluntary termination of services.

- Reasons for voluntary termination of case management service are as follows:
 - Client requests termination of all services including case management.
 - Client no longer needs case management because service goals have been achieved and client agrees with this determination.
 - Client has died/moved/is expected not to return home within 90 days from hospital/nursing home/skilled nursing facility and client or family representative agrees to service termination.
 - Medicaid funded home care or the client's caregivers will assist with all the client's needs. No additional DFTA service are needed.
 - Client is referred to APS and APS will take over the case (client or client's designated representative agrees to discharge from the case management program).
- Reasons for voluntary termination of home care services or home-delivered meals service are the same as those for voluntary case management termination, with this exception: The client may request termination of home care or home-delivered meals services but continue to receive case management if s/he still has case management needs.
- If the home care client will not be relocating, the case manager conducts a reassessment to determine if the service can be safely discontinued.
 - If the client will not allow the reassessment, the agency sends a letter to the client stating its recommendation for a reassessment and documenting its attempts to schedule the reassessment.

Compliance 17.2. Assistance with service needs. If it appears that the client being discharged has further need of services, the case manager assists the client in accessing appropriate care.

- If the client appears mentally incompetent or at-risk, the agency makes a referral to an appropriate agency such as HRA's Adult Protective Services in order to ensure the client's safety.

Compliance 17.3. Involuntary Termination of Services.

- Case management service is terminated (client is discharged from the service) without requiring the client's consent when:
 - Client is no longer eligible for the service.
 - Client has been in a hospital/nursing home/skilled nursing facility for more than 90 days and is not expected to return home.
 - Client has failed to cooperate with program requirements or has refused to comply with his/her care plan.

- Home care services and home-delivered meals service are terminated without the client's consent for any of the reasons that apply to case management involuntary termination. In addition, home-delivered meals are terminated when the case manager determines that the client's need for meals is being met or can be met by the home care provider.

Compliance 17.4. The program follows DFTA's protocol for involuntary termination of services and notification to the client of her/his right to contest the involuntary termination and seek a resolution through a Settlement Conference and/or a Hearing.

- The client has a right to contest involuntary terminations in the following situations:
 - The client has been denied a DFTA-funded service (home care, home-delivered meals) based on a determination that he/she is not functionally or programmatically eligible.
 - The client contests the amount of assessed cost share.
 - The client has failed to make cost-share payments or to make negotiated payments on a past-due amount.
 - The client has failed to cooperate with program requirements such as permitting a case manager to visit or refusing to agree to a care plan.
 - The client remains unavailable to receive services after 90 days of service suspension.

Compliance 17.5. **Notification to providers.** When case management and other DFTA-funded services (home care, home-delivered meals) are terminated, the case manager sends a termination referral to providers through DFTA's client tracking system.

Service Levels

Standard 18: Budgeted Units

The program provides its budgeted annual units.

Compliance 18.1. The case management agency meets its service level requirement.

Compliance 18.2. The program uses the correct unit definition in documenting case management service units. A unit of case management represents one hour spent on direct client service as follows:

- Intake interview
- Inputting client data
- Assessment
- Care Plan Development
- Collateral contacts on behalf of the client
- Contact with the client by telephone (client monitoring)
- Follow-up/coordination/discussion of the client's services with client's service providers
- Entering case notes on the client
- Maintaining the client's case record in DFTA's client tracking system and the client's paper file (if applicable)
- Travel time to the client's home

- Discussing the client's case during a case conference or during supervision (only that portion of the case or supervisory conference devoted to the client may be counted toward a case management unit). Note: Either the client's case manager or the case manager's supervisor counts the time, not both.
- Supervisory review of the case record

Example of case conference/supervisory conference unit calculation.

The case manager meets her/his supervisor for 1 hour. They spend 30 minutes discussing Client A's alcohol problem and the supervisor provides the case manager with guidance on the case. The supervisor spends 15 minutes with the case manager reviewing the case notes and other documentation on Client A and another 15 minutes with the case manager reviewing case notes on Client B. Units attributable to Client A: .75 hour. Units attributable to Client B: .25 hour. Either the case manager or the supervisor enter the time spent on the case. The program has a policy about whether the case manager or the supervisor claims the unit.

Client A's alcohol problem has worsened. The case manager meets with her supervisor and a co-worker who is a certified alcohol counselor to discuss Client A. For an hour, they discuss Client A and how to proceed with the case. One (1) unit (one hour of service) is attributed to the client. Although three staff participated in the conference, only one staff person enters the time spent on Client A's case. While a case manager typically works a seven or eight hour day, this does not mean that each day he/she will generate seven or eight hours of case management units.

Time spent in administrative, educational or general activities cannot be counted as units of service. Units may not be counted for time spent traveling to and participating in professional development activities such as trainings, time spent developing a new form, or time spent informing the public/other providers about the service.

Compliance 18.3. The program uses the correct unit definition in documenting supplemental services units. A unit of supplemental services represents:

- One friendly visit to a client;
- One hour of a support group;
- One client assisted in obtaining one of the following services:
 - Home remediation/services
 - Legal services
 - Medical, dental, mental health expenses not covered by insurance
 - Transportation for non-emergency appointments
 - Other as approved by DFTA

Compliance 18.4. Case management units in DFTA's client data system match 100% with invoiced units.

Staff Appropriateness and Continuity

Standard 19: Staff and Supervisor(s) Qualifications
Staff and supervisor(s) meet required qualifications.

Compliance 19.1. Cultural Competency. All direct service staff:

- Speak one or more of the three predominant languages in the program's catchment area and know how to access interpreter services when needed.
- Are knowledgeable about and sensitive to the diverse needs, preferences and characteristics (including religious and cultural expectations and communication styles) of older persons in the program's catchment area.
- Are knowledgeable about and sensitive to socioeconomic, health care and other issues of minority and immigrant populations.
- Are sensitive to issues of gender identity and sexual orientation.
- Are knowledgeable about linguistically and culturally competent service providers in the community.
- Are knowledgeable about the communication needs of persons with visual and/or hearing impairments.

- Compliance 19.2. Case manager.** Case managers meet or exceed the following qualifications:
- MSW or related Master's degree (e.g. social services, public administration, nursing, or public health) preferred when practicable and budget allows); or
 - Bachelor's level degree; or
 - High school diploma or Associate degree with four years or more of casework experience in a community social service or social action program; or
 - Registered nurse with one year of satisfactory full-time paid experience as a nurse.

- Compliance 19.3. Case management supervisor qualifications.** Supervisors meet or exceed the following qualification:
- MSW degree or related Master's level degree (e.g. social services, public administration, nursing or public health).

- Compliance 19.4. Case management program director qualifications.** The case management program director (Director) meets or exceeds the following qualification:
- MSW degree or related Masters level degree (e.g. social services, public administration, nursing or public health).
- In addition, Directors meet the following qualifications:
- At least three years of full-time experience in social services or related field;
 - At least two years of supervisory experience;
 - Experience working in the field of aging;
 - Proven leadership experience;
 - Crisis-management skills; and
 - Excellent communication skills.

- Compliance 19.5. Intake staff qualifications.**
- Staff who perform the screening and/or intake function have at least the same qualifications as case managers, and, preferably (though not required), the same qualifications as supervisors.
 - Staff who perform the screening and/or intake function have received training on interviewing skills and on the range of available resources to meet client needs.

- Staff who perform the screening and/or intake function are able to:
 - Elicit and evaluate the client's presenting problem;
 - Determine preliminary eligibility;
 - Make necessary referrals to resources/services;
 - Provide program information;
 - Provide callers with a positive impression of the program and types of assistance available.

Standard 20: Use of Case Aides, Undergraduate and MSW students
The program uses case aides, undergraduates and MSW students appropriately.

Compliance 20.1. Case Aides and undergraduates. The program ensures that Case Aides and undergraduates are only permitted to perform administrative tasks. They assist case managers to whom they are assigned only with these duties: pre-screening calls; arranging services; two-month monitoring calls and follow-up calls to "no answers; assisting with data entry and other administrative tasks. They may not conduct assessments or reassessment; may not do care planning; may not authorize services; may not terminate clients from the program.

- Case Aides and undergraduates receive appropriate training for their duties.
- The program ensures a regular flow of communication from the case aides/students and the case managers with whom they work.

Compliance 20.2. MSW students. MSW interns do assessments and care planning, under the supervision of an MSW supervisor. The supervisor is responsible for the case(s) managed by the MSW intern.

Standard 21: Background Checks
The program conducts background checks on all employees.

Compliance 21.1. The program conducts background checks on all employees and complies with requirements of the case management contract with regard to the screening of staff, obtaining of references and compliance with applicable Federal, State and city laws.

- Copies of background checks are kept on file.

Standard 22: Staff Orientation
The program orients all staff.

Compliance 22.1. All staff members are provided with an orientation that includes:

- Name of person who will supervise the staff member.
- Provision of a kit containing program policies and procedures, personnel policies; a written job description; DFTA's standards; the narrative section of the RFP response; and Client and Service Provider Rights and Responsibilities.
- A review of:
 - Specific program components;
 - Staff roles and responsibilities;
 - Client Rights;
 - Emergency procedures;

- Elder Abuse protocols;
- Worker Safety Practices and Protocols including agency safety systems (e.g., dedicated emergency phone line, “buddy systems” for joint visits on potentially dangerous home visits); safety information to be obtained prior to the home visit from the client; safety preparations prior to the home visit; getting to the home visit safely; and safety measures to follow at the home visit;
- Demographics of the community served, including but not limited to socioeconomic data, languages spoken, number of live-alones, major health issues (data available from DFTA).

Compliance 22.2. Staff member orientation is documented and new staff sign a statement that they have reviewed the orientation kit.

Standard 23: DFTA Training Requirements

Staff meet DFTA training requirements.

Case management staff, including directors, supervisors, case managers, and sub-contracted staff who function as the primary case manager for clients, must attend annual trainings as required by DFTA.

Compliance 23.1. All newly hired case management staff attend DFTA’s multi-day “Introduction to DFTA-Funded Case Management: Theory and Practice” training before the first anniversary of their date of employment.

Compliance 23.2. All newly hired or promoted supervisors and directors attend DFTA-conducted training specifically for case management supervisors and directors before the first anniversary of their date of employment or promotion.

Compliance 23.3. All newly hired or promoted case management staff attend DFTA’s “Elder Abuse Detection and Response Protocols” training as required by City law before the second anniversary of their date of hire or promotion

Compliance 23.4. After the first anniversary of the start date, and after completing DFTA’s 8-day introductory case management training or the 7-day supervisory training, all case management staff annually attend sixteen hours of training relevant to case management practice or program administration. Attendance at non-DFTA trainings may be used to satisfy this requirement provided prior approval is obtained from DFTA. Staff may also be required to attend mandated trainings as per DFTA policy.

- The case management agency maintains documentation of training in each worker’s personnel file. This includes topic, date, trainer’s name and organization, and number of hours in attendance.

Standard 24: Supervision of Case Managers

Case managers are adequately supervised.

Compliance 24.1. Case managers receive biweekly scheduled individual and/or group supervision which include a discussion of their cases and the application of guidelines to practice.

- Compliance 24.2.** When practicable and the budget allows, no more than five case managers report to a supervisor to ensure effective supervision. Where appropriate, the Director of the program may also supervise case managers.
- Compliance 24.3.** The Program Director provides monthly scheduled individual and/or group supervision to supervisors. Such supervision includes a discussion of the oversight and support of case managers. If a supervisor also carries a caseload, the Program Director supervises their cases.
- Compliance 24.4.** The case management agency sponsor provides regularly scheduled supervision with the Program Director. Such supervision includes discussion of staff oversight, program performance, related budgetary issues, and other items that have a direct impact on client service and safety.
- Compliance 24.5.** All case management staff who provide direct service to clients have an annual performance review.

Documentation and Recordkeeping

Standard 25: Documentation

Interactions with clients are documented in case notes.

Case Notes are a record of substantive contact with the client or on behalf of the client (e.g., with family/ significant others, formal and informal service providers). Case notes also document attempts to contact clients or other informal/formal providers that are not successful.

- Compliance 25.1.** Case Notes are written within three days of the event date.
- Compliance 25.2.** Case note entries include the date, identity of person with whom there was contact, type of contact, (e.g., home visit, phone call), a brief summary of the contact, a summary of actions to be taken and the identity of persons responsible for taking those actions.

Standard 26: Recordkeeping

Accurate client and service information is maintained in the client tracking system.

- Compliance 26.1.** Programs with sub-contractors monitor entry into the client tracking system of all required information as well as maintenance of other required records.
- Compliance 26.2.** Each client has a case record that is maintained in DFTA's client tracking system (may be supplemented in paper files). Any client data, paperwork, or documents should be kept by the organization for seven (7) years from the end of the City fiscal year in which the client was discharged from the program.
- The following are maintained in the client tracking system:
 - Intake
 - Assessment and Reassessments (including completed sections, PHQ2/9, Strengths and Accomplishments, Assessment Summary)
 - Care Plans and Service Plans

- Cost Share Worksheet (where applicable)
 - Service Authorizations/Referrals (DFTA-funded)
 - Documentation of provision of emergency services
 - Case notes
 - Documentation of supervisory review
- The following may be maintained in paper files (unless scanned in):
 - Form signed by the client indicating she/he has been informed of, understands and has received a copy(ies) of the DFTA Client and Service Provider Rights and Responsibilities;
 - Signed Consent Form;
 - Correspondence and other paper records pertinent to the client record.