West Virginia

Bureau of Senior Services

Aging Well in
West Virginia

Lighthouse Program
Policy Manual

Effective July 1, 2015

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Attachments

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6	Denial/Reduction of Services Action Letter	Yes
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13	Lighthouse Cost Share Accountability Form	Yes
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15	Lighthouse Plan of Care	Yes
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18	Lighthouse Direct Care Worker Service Log	Yes

NOTE: For a copy of forms and instructions, go to www.wvseniorservices.gov, click on *Documents Center* then *Program Specific Documents* to either complete a form in a fillable PDF file, or print and complete form in ink. To alter any of the above state and Lighthouse specific forms, you must have written approval from the Director of Lighthouse Program at the Bureau of Senior Services.

I. Introduction

The Lighthouse Program began in 2007. Realizing the vast need for in-home assistance for seniors who did not qualify for other programs, Governor Joe Manchin III introduced legislation that was passed by the 78th Legislature of West Virginia to expand senior services throughout the state.

Lighthouse is funded entirely by the State of West Virginia. The Lighthouse Program is provided in all 55 counties. It is administered by the West Virginia Bureau of Senior Services (the Bureau), while direct services are delivered through the local Title III-B county aging provider.

This program is designed to assist seniors with functional needs in their homes. Services are provided by a direct care worker employed by a county aging provider after an applicant for the program has been determined medically eligible by the provider's registered nurse (RN). Direct care workers provide personal assistance, stand-by assistance, supervision, or cues for people having difficulties with activities of daily living in the following areas: bathing, dressing, grooming, eating, walking, transferring, and toileting. Care is provided in the service recipient's residence.

Lighthouse is considered a program of last resort and cannot be provided in conjunction with or in place of Medicaid funded in-home care service programs. If applicants for the Lighthouse program appear to qualify for the Aged and Disabled Waiver, Traumatic Brain Injury Waiver or Medicaid Personal Care, they should be referred to any of these programs. Lighthouse services can be provided to applicants while they are actively pursuing application for one of the Medicaid programs but cannot be used to provide care to individuals who appear likely eligible for Medicaid services but refuse to apply. Once a waiver slot opens for the service recipient, Lighthouse can no longer be used.

Title III-B Personal Care services cannot be blended/supplemented with Lighthouse services within the same month. They must be provided separately due to different cost sharing/contribution requirements. Providers using both services for the same service recipient in different months must take care to report each correctly in SAMS.

Lighthouse services may be provided in conjunction with the Family Alzheimer's In-Home Respite program (FAIR), hospice care and veteran in-home care, as long as there is no duplication of services. Services may not overlap, and special caution must be used to ensure that hours of service are properly and accurately billed to the appropriate funding source. Additional caution is necessary to ensure that state cost share income for Lighthouse and federal cost share income for Title III programs are placed into separate accounts and handled according to each program's policies.

If the Lighthouse service recipient is receiving services through another program, the

Lighthouse RN must work with the other program when developing the Plan of Care to avoid duplication of activities. **If a service recipient is receiving other services, that person cannot receive maximum hours on the Lighthouse Program. Lighthouse is a program of last resort. To avoid duplication of services, Lighthouse can provide services only on days the other program is not in the home.**

Preference will be given to older individuals with greatest economic and/or social needs, with particular attention to low-income individuals, individuals at risk for institutional placement and individuals residing in rural areas. (Refer to Section II, Definitions: Target Population for Lighthouse and Policy Section XX, Prioritization of Services and Waitlists.)

This manual sets forth the WV Bureau of Senior Services' requirements for Lighthouse services provided to eligible West Virginians. The goals and objectives of this program are focused on providing services that are person-centered and that promote choice, independence, respect, dignity, and community integration. The Bureau has a grant agreement with each Title III-B provider agency to manage and implement the Lighthouse Program. Each provider agency, board of directors, with local input via public meetings, determines service priorities for the Lighthouse program. To offer Lighthouse, the provider agency must also be a Title III-B provider, and services must be provided by a trained worker employed by the county aging provider.

II. Definitions

A. Definitions Specific to Lighthouse

Direct Care Worker – An in-home worker who is employed by the county aging provider agency. For Lighthouse, the direct care worker provides assistance as outlined on the Plan of Care to service recipients having two or more deficits in the following: bathing, grooming, dressing, toileting, transferring, repositioning, walking, feeding, preparing meals, grocery/pharmacy shopping. The worker may be any qualified and properly trained individual with the exception of the spouse of the Lighthouse service recipient.

Direct Care Worker Service Log - Form used to document tasks performed by the direct care worker under the Lighthouse program.

Environmental Tasks - Includes light housekeeping, dishwashing, making/changing a service recipient's bed and service recipient's laundry.

Family Alzheimer's In-Home Respite (FAIR) - A State funded program designed to provide support and respite for caregivers of individuals with a written diagnosis of Alzheimer's or a related dementia.

Hardship Waiver - Document that removes part or all of the state cost share that a service recipient is required to pay for services. A hardship waiver must be kept in the service recipient's chart if granted by the Lighthouse nurse. Hardship waivers do not exempt the provider agency from the obligation of averaging a minimum of $1.00 per hour of service provided.

LED - Lighthouse Eligibility Determination form which establishes if an applicant is medically eligible for Lighthouse services.

Service Recipient - Person requiring much assistance or greater in two or more of the following areas: bathing, grooming, dressing, toileting, transferring, repositioning, walking, eating, preparing meals, grocery/pharmacy shopping.

B. Other Definitions

Abuse - (WV Code §61-2-29) Infliction of or threat to inflict physical pain or injury on an incapacitated adult or elder person.

Activities of Daily Living (ADL) - Activities that a person ordinarily performs during the course of a day such as mobility (walking/transferring), personal hygiene, bathing, dressing, grooming, and eating.

Aging and Disability Resource Center (ADRC) – The ADRC provides a coordinated and integrated system for older individuals, individuals with disabilities and caregivers to access comprehensive information and assistance on the full range of public and private long-term care programs, options, service providers and resources within a community.

Area Agency on Aging (AAA) – Agency designated under the Older Americans Act by the State Unit on Aging (SUA), based on planning and services area, to develop, implement and monitor programs and services for older persons at the local level.

At-Risk Individuals – Persons susceptible to experiencing adverse outcomes from mistreatment, injury, disease or the effects of dysfunctional behavior. Characteristics which can increase and/or identify risk level include functional dependence, disability, poor physical health, vision issues, nutritional risks, frequent hospitalizations, high number of prescription medications (6+), cognitive and/or memory impairment, poor mental health, low income, isolation and minimal family/community supports.

By-laws - Rules established by an organization to regulate itself.

Competency Based Curriculum - A training program which is designed to give participants the skills they need to perform certain tasks and/or activities. The curriculum must have goals, objectives, and an evaluation system to demonstrate competency in training areas.

Conflicts of Interest - 1) One or more inconsistencies (conflicts) between the private interests and official responsibilities of a person in a position of trust, 2) One or more inconsistencies (conflicts) between competing duties, services, or programs of an organization, and/or portion of an organization, and 3) Other conflicts of interest identified in guidance issued by the Assistant Secretary for Aging and/or by State agency policies (OAA§1321.3).

Documented Specialist – A person who concentrates primarily on a particular subject or activity, a person highly skilled in a specific and restricted field. Someone who possesses supporting documentation, i.e., a degree in the designated area, training verifications, certifications, and/or vita (a brief biographical sketch) with listed experience that would designate that individual as a specialist in a designated area.

Domestic Partner- Adults in a committed relationship with another adult, including both same sex and opposite sex relationships, including civil union.

Elder Abuse - Any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult.

Emergency Contingency Service Operation Plan (ECSOP) - A written plan which details who is responsible for what activities in the event of an emergency, whether it is a natural or man-made incident.

Ethnicity - Consistent with Office of Management and Budget (OMB) requirements ethnicity categories are Hispanic or Latino or Not Hispanic or Latino.

Ex-Officio - A member of a body (a board, committee, etc.) who is part of it by virtue of holding another office but has no voting rights on board actions.

Family Alzheimer's In-Home Respite (FAIR) – a state-funded program designed to provide support and respite for unpaid caregivers of individuals with a written diagnosis of Alzheimer's or a related dementia.

Financial Exploitation - A type of neglect of an incapacitated adult involving the illegal or unethical use or willful dissipation of his/her funds, property or other assets by a formal or informal caregiver, family member, or legal representative - either directly as the perpetrator or indirectly by allowing or enabling the condition which permitted the financial exploitation. Examples of financial exploitation include cashing a person's checks without authorization, forging a person's signature, misusing, or stealing a person's money or possessions or deceiving a person into signing any contract, will, or other document.

Frail - 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 or, due to cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to herself/himself or to another individual. (OAA102(a)(22)(A)(i) and (B).)

Greatest Economic Need - A need resulting from an income level at or below the federal established poverty line. (OAA102(a)(23).)

Greatest Social Need – Need caused by noneconomic factors, which include:

(1) Physical and mental disabilities
(2) Language barriers
(3) Social or geographical isolation, including due to:
    (i) Chronic conditions
    (ii) Housing instability, food insecurity, lack of access to reliable and clean water supply, lack of transportation, or utility assistance needs
    (iii) Interpersonal safety concerns
    (iv) Rural location
    (v) Any other status that restricts the ability of an individual to perform normal or routine daily tasks or threatens the capacity of the individual to live independently.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule - The HIPAA Privacy rule regulates the use and disclosure of Protected Health Information (PHI) held by covered entities.

Incapacitated Adult – In the context of abuse/neglect, any person who by reason of physical, mental or other infirmity is unable to independently carry on the daily activities of life necessary to sustaining life and reasonable health. (WV Code 9-6-1(4)).

Informal Supports - Family, friends, neighbors, or anyone who provides a service to an individual but is not reimbursed.

Instrumental Activities of Daily Living (IADL's) - Activities that are not necessary for fundamental functioning, but they assist an individual with living independently in a community. Examples: light housework, ability to use a telephone, access to transportation, managing money and grocery shopping.

Legal Representative - A personal representative with legal standing (power of attorney, medical power of attorney, guardian, etc.).

Multipurpose Senior Center – A community facility for the organization and provision of a broad spectrum of services, which shall include provision of health (including mental and behavioral health), social, nutritional, and educational services and the provision of facilities for recreational activities for older individuals, as practicable, including as provided via virtual facilities.

Neglect - (WV Code §9-6-1) Failure to provide the necessities of life to an incapacitated adult or facility resident with the intent to coerce or physically harm the incapacitated adult or resident and/or the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or resident.

Notification of Grant Award (NGA) - Grant from the Bureau awarding state and federal funds to provider agencies for the delivery of aging services.

Nutrition Screening - Completion of a nutrition screening checklist (Nutritional Health Assessment) on the Services Assessment and Evaluation Form (SAEF) by eligible service recipients to determine if they are at nutritional risk. A score of six (6) or higher is considered high nutritional risk. Nutritional screening data is a federal collection requirement of the Administration for Community Living (ACL) for the annual State Performance Report (SPR) and the Older Americans Act Performance System (OAAPS).

Person-Centered Care - A process-oriented approach which focuses on the person and his/her needs by putting him/her in charge of defining the direction for his/her life. Person-centered care training includes training on collaborative and respectful partnerships between staff and service recipients that promote equal partnerships in planning, developing, and monitoring care.

Personally Identifiable Information - Information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, biometric records, etc. alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother's maiden name, etc.

Prioritization of Services - To assess and rate an individual for services (Lighthouse) and prioritize and provide services based on those with the highest need. Requires the use of the Bureau's Service Assessment and Evaluation Form (SAEF), along with agency established prioritization policies.

Program Income – Gross income earned by the non-federal entity that is directly generated by a supported activity or earned as a result of the state award during the period of performance. Program income includes, but is not limited to, voluntary contributions, cost share income, income from fees for services performed, the use or rental of real or personal property acquired under federal awards, the sale of commodities or items fabricated under a federal award, license fees and royalties on patents and copyrights, and principal and

interest on loans made with federal award funds. Interest earned on advances of federal funds is not program income. Except as otherwise provided in federal statutes, regulations, or the terms and conditions of the federal award, program income does not include rebates, credits, discounts and interest earned on any of them.

Protected Health Information (PHI) - Any information held by a covered entity which concerns health status, provision of health care, or payment of health care that can be linked to an individual.

Race - Consistent with federal OMB requirements, race categories are American Indian/ Native Alaskan, Asian, Black/African American, Native Hawaiian/Other Pacific Islander, non-minority (White, non-Hispanic), White-Hispanic, Other. Respondents should be given the opportunity to designate all categories that apply to them.

Senior Community Service Employment Program (SCSEP) – A program authorized under Title V of the Older Americans Act that provides part-time community service training positions to low-income persons aged fifty-five (55) and older.

Services Assessment and Evaluation Form (SAEF) - The Bureau assessment form which contains service recipient information such as demographics, income, nutritional assessments, ADL and IADL needs, etc. This form must be fully completed per SAEF instructions for each individual who receives Lighthouse services. Refer to SAEF Instructions regarding sections that need to be completed for each service.

Social Assistance Management System (SAMS) - The Bureau's official web-based data collection application utilized for service recipient tracking and reporting of services and federal reporting compliance.

State Cost Share - Process that requires service recipients in state funded programs to share in the cost-of-service provision through the use of a state cost share schedule and self-declaration of income. State cost share for the Lighthouse program is based on the income of the service recipient, or, in the case of a married couple, the combined income of the service recipient and spouse, minus medical expenses, according to the current state cost share schedule. The schedule utilizes 200% of the federal poverty guidelines as a starting point. (Refer to Policy Section XXIV on State Cost Share.)

State Health Insurance Assistance Program (SHIP) - A federal program funded by the Administration for Community Living that provides free, objective, and confidential help to West Virginia Medicare beneficiaries and their families through one-on-one counseling and assistance via telephone or in person with SHIP counselors statewide, under the direction of the State SHIP Director and the Bureau.

State Unit on Aging (SUA) - Agency of each state and territorial government designated by governor and state legislatures to administer, manage, design and advocate for benefits, programs and services for the elderly and their families.

Target Population - Persons aged 60 or older, with particular attention to low-income individuals, individuals at risk for institutional placement and individuals residing in rural areas.

Trauma-Informed Care - A framework for relating to and helping individuals who have experienced negative consequences after exposure to dangerous experiences. Principles emphasize the need to understand trauma impacts on health, thoughts, feelings, behaviors, communication and relationships. (Trauma-informed approaches ask not "what is wrong with you?" but rather "what happened to you?".) Resources for both information and training can be found on the internet.

Unduplicated Service Recipient Count - Counting a service recipient only once during the reporting period. (State Fiscal Year is July 1 through June 30).

Unit Count - The number of units of service received by an unduplicated service recipient during the reporting period.

Universal Precautions- The Occupational Safety and Health Administration (OSHA) defines universal precautions as an approach to infection control to treat all human blood and body fluids as if they contain bloodborne pathogens.

Volunteer - An uncompensated individual who provides services or support to service providers agencies.

WV Aging & Disability Resource Center (ADRC) – A coordinated and integrated system for older individuals, individuals with disabilities and caregivers to provide comprehensive information and assistance on the full range of public and private long-term care programs, options, service providers and resources within a community.

WV Bureau of Senior Services (Bureau) - State Unit on Aging designated by the Governor and State Legislature to administer, manage, design and advocate for benefits, programs and services for the elderly and their families.

WV Senior Legal Aid - Legal services available to needy senior West Virginians aged sixty (60) and over to assist with protecting their homes, income security, access to healthcare, other benefits and their autonomy.

III. Provider Agency Requirements and Office Criteria

To provide Lighthouse services, a county aging provider agency must be a Title III-B provider and meet the following requirements and office criteria:

1. Be located in West Virginia.
2. Have a business license issued by the State of West Virginia.
3. Have a federal tax identification number (FEIN).
4. Have an organizational chart.
5. Complete and maintain a Board Certification Form (Attachment 10 of the Older Americans Act manual). The Board Certification Form must be submitted to the AAA annually and at any time changes occur.
6. Notify the Bureau of any change in the Lighthouse Coordinator position within two days of ending employment of a Lighthouse Coordinator.
7. Maintain appropriate personnel information on all Lighthouse agency staff, which includes their qualifications.
8. Have written policies and procedures for processing service recipient grievances, including the service recipient's right to appeal denial or reduction of services.
9. Have written policies and procedures for processing staff complaints.
10. Have written policies and procedures for the discontinuation of a service recipient's services.
11. Have office space that allows for service recipient confidentiality.
12. Have an Emergency Contingency Service Operation Plan (ECSOP) for service recipients and office operation. (Refer to Policy Section XVI).
13. Meet the Americans with Disabilities Act of 1990 (ADA) requirements for physical accessibility. (Refer to 28CFR36, as amended.)
14. Be readily identifiable to the public.
15. Maintain a primary telephone that is listed under the name and local address of the business. (Note: Exclusive use of a pager, answering service, a telephone line shared with another business/individual, facsimile machine, cell phone, or answering machine does not constitute a primary business telephone).
16. Maintain an agency secure (HIPAA compliant) e-mail address for communication with the Bureau and the AAA.
17. Be open to the public at a location within the county at least forty (40) hours per week. Observation of state and federal holidays is at the provider's discretion. The main focal point center for the delivery of comprehensive services must be open at least forty (40) hours per week.
18. Contain space for securely maintaining service recipient and personnel records and have written policies regarding a service recipient's right to request their records.
19. Maintain a contact method during any hours-of-service provision.

20. Provide the Bureau with a contact phone number for the Director and a designee for emergencies.
21. Maintain on file a completed Confidentiality Agreement for each board member (Attachment 1), and a completed Confidentiality Agreement for each employee/volunteer (Attachment 2). Review annually with board members, employees and volunteers.
22. Employ qualified and appropriately trained personnel who meet minimum standards for each program. (Refer to Policy Section VIII on staff training).
23. Furnish information to the Bureau, as requested, as per the Notification of Grant Award (NGA).
24. Maintain records that fully document and support the services provided.
25. Maintain a list of current service recipients.
26. Maintain a fully completed Service Assessment and Evaluation Form (SAEF) for all service recipients that receive a Bureau funded service. All required fields of the SAEF must be fully completed per instructions for each service to be reimbursed for services as per program requirements. (Refer to Attachment 3 for SAEF completion instructions for Lighthouse).
27. Enter all service recipient services that are funded by the Bureau into the SAMS operating system.
28. Follow the Bureau's policy regarding prioritization of services. (Refer to Policy Section XXIII).
29. Ensure that services are delivered, and documentation meets regulatory and professional standards before an invoice is submitted.
30. Follow the Bureau's state cost share policy (Refer to Policy Section XXIV).
31. Develop and submit to the Bureau an annual budget for Lighthouse and FAIR, based on in-home services award and program service projection requirements.
32. Develop a provider plan in coordination with the AAA and the development of required area plans that meet federal requirements.
33. Hold public meetings to receive input from seniors and other interested parties regarding services they want the county aging provider to provide. Public comments should be considered and incorporated within the four (4) year provider plan/area plan.
34. Annual audit must be presented by the auditor to the agency board of directors. (Refer to NGA for details on required audits.)
35. Must have written policies and procedures in effect regarding whistle-blowers, document retention and intentional destruction of internal documents per Sarbanes-Oxley Act and policy manual section IV.
36. Must have a written conflict of interest policy ensuring that board members, officers, directors, trustees and/or employees do not have interests that could give rise to conflict or financial gain and that demonstrate no conflict between competing duties, services, or programs of an organization.

37. Must have computer(s) for staff with HIPAA secure email account, UMC web portal software, internet access, and current (within the last five years) software for spreadsheets.
38. Utilize any database system, software, etc., compatible with/approved and/or mandated by the Bureau.
39. Must have written policies and procedures for the use of personally and agency owned electronic devices which includes, but are not limited to
    - Prohibiting use of personally identifiable information (PII) in texts and subject lines of emails.
    - Prohibiting the use of PII in the body of emails, unless the email is sent securely and is HIPAA compliant.
    - Prohibiting PII to be posted on social media sites.
    - Prohibiting use of public Wi-Fi connections without use of secure VPN (Virtual Private Network) connection.
    - Informing agency employees that during an investigation, information on their personal cell phones is discoverable.
    - Requiring all electronic devices to be encrypted.
40. Must participate in all mandatory meeting/training sessions.
41. Ensure that employees are not required to sign any type of agreement that limits employment opportunities that would affect service recipient's choice of provider agency or worker.
42. Have an Emergency Succession Plan in place for unplanned or temporary Executive Director leadership changes. Emergency Succession Plans are to be signed by the Board President and updated and maintained annually by the Board.

IV. Service Recipient Record/Documentation Requirements

County Aging Providers must abide by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Service recipients have the right to have all records and information obtained and/or created by a provider maintained in a confidential manner, in accordance with applicable state and federal laws, rules, regulations, policy and ethical standards. Providers must safeguard against personal information being disclosed to or seen by inappropriate persons or entities that could use the information in a manner that is not in a service recipient's best interests. Lists of persons in need of services or lists of persons receiving services are to be used only for the purpose of providing services and may not be disclosed without the informed consent of each individual on the list and then only to those with a verified need to know the information. The provider must also provide access to personal records to service recipients and legal representatives as required by law.

Service recipient signatures are required for the documentation of services received. An electronic signature or a faxed signature is acceptable to initiate Lighthouse services. A fully completed Services Assessment and Evaluation Form (SAEF) is also required for reimbursement (Refer to Attachment 11 for SAEF completion instructions for each service).

Providers may utilize electronic signatures in accordance with this policy and state and federal regulations regarding such. For documentation that requires a service recipient's signature, if the service recipient is unable to sign, a representative may sign for them (the representative must sign the service recipient's name and then their name. It must be documented in the service recipient's chart that they are unable to sign their name.) Documents electronically signed are part of the service recipient's legal service record. Providers must have written policies in place to ensure that they have proper security measures to protect use of an electronic signature by anyone other than the individual to which the electronic signature belongs.

Only employees designated by the provider agency may make entries in the service recipient's record. All entries in the service recipient's record must be dated, signed or initialed, and logged per the policy for each service. Adequate safeguards must be maintained to protect against improper or unauthorized use, and sanctions (i.e. reprimands, suspension, termination, etc.) must be in place for improper or unauthorized use. Rubber stamps are prohibited as a means of signature and/or for authenticating a record.

The section of the electronic record documenting the service provided must be authenticated by the employee who provided the described services. Any authentication method for electronic signatures must meet the following basic requirements: 1) unique to the person using it, 2) capable of verification, 3) under the sole control of the person using it, and 4) linked to the data in such a manner that if the data is changed, the signature is invalidated.

Providers must ensure that access to a hard copy and/or electronic copy of service records can be made available to the AAA and Bureau staff and others who are authorized to access to service records by law.

For documentation that requires service recipient signatures, if the service recipient is unable to sign, a representative may sign for them. The representative must sign the service recipient's name and then their name.

Providers must keep documentation for services provided to service recipients, such as rosters, Lighthouse Eligibility Determination forms (LED's), SAEFs, Plans of Care, RN Assessments, Direct Care Worker Service Logs, sign-in sheets for training, Nurse's Notes, six-month call sheets, and any other required service documentation for a period of **five (5)**

years after the discontinuation/closure of Lighthouse services. If a monitoring is initiated before the expiration of the **five (5) year period**, the records shall be retained until the monitoring has been completed and final reports issued. Keep all service recipient records if not discontinued or closed.

V. Personnel Record Requirements

Personnel documentation including training records, licensure, confidentiality agreements, driver's license, criminal investigation background checks (CIB), and Form I-9 must be maintained on file by providers.

Minimum credentials for professional staff (RN's, social workers, counselors, etc.) must be verified upon hire and thereafter based upon their individual professional license requirements and must be kept current. Social workers and RN's must have a current license at the time-of-service provision, and their license must be in good standing (cannot be on probation). The provider agency must employ a registered nurse to oversee and administer the Lighthouse program.

Providers must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the Lighthouse program, Bureau policy and procedures and state law. Providers must also agree to make themselves, board members, employees/volunteers, and all records pertaining to recipient services available to any audit or desk review. Providers must develop and maintain an agency personnel manual containing agency employment policies and procedures.

VI. Service Recipient Rights and Responsibilities

Honoring individual rights and treating service recipients with respect and dignity is one of the most important components of providing quality services. All staff employed by a provider agency to directly provide or oversee services, including volunteers, have a role in contributing to the overall quality of services and in assuring that people are treated fairly and respectfully. Service recipients also have a responsibility to the provider agency for assisting the agency in providing quality services to them.

A. Service Recipients Rights:

Lighthouse service recipients are entitled to the following rights:

1. To be treated with respect and dignity.
2. To be free from discrimination as required by Title VI of the Civil Rights Act of 1964.

3. To be free from abuse, neglect, and exploitation.
4. To have personal records maintained confidentially.
5. To have access to all of their files maintained by the provider agency.
6. To have access to rules, policies and procedures pertaining to services.
7. To take part in planning and decisions about their services.
8. To be fully informed in advance about each service provided and about any change in such service that may affect the well-being of the service recipient.
9. The right to voice a grievance with respect to services without discrimination or reprisal.
10. The right to have their property treated with respect.
11. To have services responsive to their interests, physical and mental health, and social; to be made aware of available supports; and to respect their desire to live where and with whom they choose.

B. Service Recipient Responsibilities:

Lighthouse service recipients have the following responsibilities:

1. To notify the provider agency at least twenty-four (24) hours prior to the day services are to be provided if services are not needed.
2. To notify the provider agency promptly of changes in medical status or service needs.
3. To comply with the Lighthouse program Plan of Care.
4. To cooperate with scheduled home visits.
5. To notify the provider agency immediately if there is a change in status that requires any change in service or disruption of service (Ex.: hospital or nursing home admission, change of residence, will not be home due to an appointment, trip, etc.).
6. To maintain a safe home environment for the provider agency to provide any in-home services.
7. To maintain safe access to their home for provider agency staff who are providing in-home care.
8. To verify services were provided by signing/initialing required provider agency forms.
9. To communicate any problems with services to the provider agency.
10. To report any suspected fraud to the provider agency and/or the Bureau.
11. To report any incidents of abuse, neglect, or exploitation to the Adult Protective Services Hotline 1-800-352-6513 or to the provider agency.
12. To report any suspected illegal activity to their local police department or appropriate authority.
13. To comply with the Personal Conduct Policy. (Refer to Policy Section XI);
14. To adhere to all policies specific to the Lighthouse program.

The Service Recipients Rights and Responsibilities Form (Attachment 4) must be provided to and signed by service recipients prior to receiving Lighthouse services. The Service Recipients Rights and Responsibilities Posting (Attachment 5) must be posted in a visible area at the provider agency. The service recipient must be given a copy of the signed Rights and Responsibilities Form. Additionally, the service recipient must read, agree to and sign the Personal Conduct Policy**.**

VII. Service Recipient Grievance Rights and Procedures

Applicants who are denied eligibility and service recipients who have had a denial or reduction of Lighthouse services have a right to file a grievance within fifteen (15) calendar days of written notification.

All other types of complaints or issues are to be handled internally according to the county aging providers' approved agency policy. This includes personality conflicts between service recipients, issues regarding what activities are offered and at what time, etc.

All service recipients and applicants who are denied Lighthouse services or have a reduction of services, must be provided in writing a Denial/Reduction of Services Letter (Attachment 6), and a Grievance Form (Attachment 7).

All Lighthouse provider agencies will post the Grievance Procedure Policy (Attachment 8) in an area that is visible to all applicants and service recipients at their agency location(s). Providers must explain the grievance procedure at initial application for services and annually thereafter. Grievance Forms are to be made readily available.

All filed Grievance Forms and other documentation related to the grievance are to be maintained in an administrative file for monitoring purposes.

You must contact the Bureau any time a grievance is filed with your agency.

If a service recipient files a grievance, services are to continue until the grievance is finalized. (Providers may make exceptions to this requirement if they deem it to be an unsafe situation due to threatening/violent behavior or health and safety concerns. You must contact the Bureau for written approval and maintain that documentation per record retention policy requirements

If a provider is dealing with an individual that is threatening or violent, they may choose to bypass the grievance procedure and instead contact their local law enforcement agency and the Bureau and maintain a copy of all documentation. If the situation subsides, the service recipient should be provided with his/her grievance rights.

The Grievance Procedure Policy consists of the following levels:

Level One: Lighthouse Provider Agency

The Lighthouse provider agency has seven (7) business days from the date they receive a Grievance Form to make an initial contact to schedule a meeting by telephone (or in person if all parties agree), with the applicant or service recipient filing the grievance.

Once scheduled, the meeting will be conducted by the agency director (or designee) with the applicant or service recipient (and/or legal representative).

The provider agency has seven (7) business days from the date of the meeting to respond in writing to the grievant [with a carbon copy (cc) to the board of directors and the Bureau].

If the applicant or service recipient is dissatisfied with the Level One decision, he/she may request that the grievance be submitted to the provider agency board of directors for a Level Two review and decision within seven (7) business days of the Level One (1) decision.

If unable to contact the grievant after a minimum of three (3) documented attempts (at least one of those via certified mail), the provider agency may uphold their grievance decision based on grievant unavailability and lack of response/participation. If a grievant is a no show to a scheduled grievance hearing, the provider may also uphold the grievance decision. In both situations, a notification of decision must be sent to the grievant. The provider agency must maintain all documentation.

Level Two: Provider Agency Board of Directors

If the applicant or service recipient is dissatisfied with the Level One decision, he/she may request the grievance proceed to Level Two.

The applicant or service recipient shall file a Grievance Form requesting a Level Two decision with the provider agency's board of directors within seven (7) business days of the Level One decision.

The provider agency board of directors, within seven (7) business days of the receipt of the Grievance Form requesting a Level Two decision, must make an initial contact to schedule a meeting by telephone (or in person if all parties agree) with the applicant or the service recipient (and/or legal representative), and the agency director (or designee).

The provider agency board of directors has seven (7) business days from the date of the meeting to respond in writing to the grievant [with a carbon copy (cc) to the Executive Director and the Bureau].

If the applicant or service recipient is dissatisfied with the Level Two decision, he/she may request that the Grievance be submitted to the Bureau for a Level Three review and decision within seven (7) business days of the Level Two (2) decision.

The provider agency board of directors must submit the Grievance Form as well as any additional documentation regarding the grievance, to the Bureau for the Level Three review.

If unable to contact the grievant after a minimum of three (3) documented attempts (at least one of those via certified mail), the provider agency may uphold their grievance decision based on grievant unavailability and lack of response/participation. If a grievant is a no show to a scheduled grievance hearing, the provider may also uphold the grievance decision. In both situations, a notification of decision must be sent to the grievant. The provider agency must maintain all documentation.

Level Three: State Review Team

If the applicant or service recipient is dissatisfied with the Level Two decision, he/she may request the grievance proceed to Level Three.

The applicant or service recipient shall file the Grievance Form requesting a Level Three decision with the Bureau within seven (7) business days of the Level Two decision.

Level Three will consist of a review team comprised of the AAA Director (from the grievant' s region), the Lighthouse Program Director, and the Commissioner (or designee) from the Bureau.

The review team, within seven (7) business days of the receipt of the Grievance Form requesting a Level Three, must make an initial contact to schedule a meeting by telephone (or in person if all parties agree), with the applicant or service recipient (and/or legal representative) to review the Level One and Two decisions.
The review team has seven (7) business days from the date of the meeting to respond in writing to the grievant (cc the Executive Director, Board of Director and AAA).

If unable to contact the grievant after a minimum of three (3) documented attempts (at least one of those via certified mail), the provider agency may uphold their grievance decision based on grievant unavailability and lack of response/participation. If a grievant is a no show to a scheduled grievance hearing, the provider may also uphold the grievance decision. In both situations, a notification of decision must be sent to the grievant. The provider agency must maintain all documentation.

The Level Three decision by the Bureau is final and not appealable.

VIII. Staff Training Requirements

All new provider staff who administer the Lighthouse program must contact the State Lighthouse Director within fourteen (14) days of hire to schedule a phone training on the Lighthouse policy and procedures manual, budget processes, etc. within the first thirty (30) calendar days of employment.

A. Initial Training

Direct care staff who provide Lighthouse Program services must be at least eighteen (18) years of age and must have the following competency-based training before providing services:

1. **Cardiopulmonary Resuscitation (CPR) -** Must be provided by a certified CPR trainer and must include a skills-based demonstration. An on-line CPR course is allowed, if it contains a post test that includes a skills-based physical examination. Documentation for CPR must indicate that trainees successfully completed the course and must be maintained in their personnel files. Employees must have a current CPR card or certificate, issued by the certifying entity, maintained in their personnel file.

2. **First Aid -** Must be provided by a certified trainer, the agency RN or a qualified internet provider. Employees must have proof of the current First Aid training maintained in their personnel file.

3. **Service Recipient Health and Welfare** – Must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider. Training must include emergency plan response (signs of heart attack, stroke, infection, confusion), fall prevention, reporting service recipient issues or environmental concerns to the appropriate agency staff, home safety and risk management and training specific to any service recipient's special needs (i.e. mental health, specific equipment, special diets, etc.).

4. **Universal Precautions training** – Must be provided by the agency RN, a documented specialist in this content area or a qualified internet training provider.

5. **Personal Care Skills -** Training in assisting service recipients with ADLs such as bathing, grooming, feeding, toileting, transferring, positioning and ambulation. Training must be provided by the agency RN or documented specialist in this content area.

6. **Health Insurance Portability and Accountability Act (HIPAA) -** Training must include agency staff responsibilities regarding securing Protected Health Information (PHI). Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider. All employees must have HIPAA training annually.

7. **Abuse, Neglect and Exploitation and Reporting Requirements -** training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider. All employees must have annual trainings on abuse, neglect and exploitation.

8. ***Person-Centered Care and Trauma-Informed Care** – Person-centered care training on collaborative and respectful partnerships between staff and service recipients that promote equal partnerships in planning, developing and monitoring care. Trauma-informed care training that acknowledges the need to understand an individual's life experiences to deliver effective care. Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

   *OAA provider agencies that are also Medicaid ADW and/or Personal Care providers may use training modules provided by the Medicaid Operating Agency for these mandatory trainings.

These training requirements apply to all employees providing direct care services, as well as volunteers doing the same type of work. It is the provider's responsibility to determine if any additional agency employees/volunteers beyond the ones required in this policy manual should have these training (or additional training) to ensure the health and safety of their service recipients.

B. Annual Direct-Care Worker Training

CPR, First Aid, Universal Precautions, Recognizing and Reporting Abuse, Neglect, Exploitation, and HIPAA training must be kept current as follows:

1. CPR is current as defined by the terms of the certifying agency. Documentation for CPR must indicate the trainee successfully completed the course and must be maintained by the agency and made available upon request. If training is conducted by agency staff, documentation that each trainer has successfully completed and been certified by the certifying entity must be maintained by the agency and made available upon request. Employees must have a current CPR card or certificate issued by the certifying entity and maintained in their personnel

2. file. Lighthouse requires that the employee sign the card before placing it in the employee's file.

1. First Aid, if provided by the American Heart Association, American Red Cross, or other qualified provider, is current as defined by the terms of that entity. If first aid is provided by the agency RN or a qualified internet provider, it must be renewed within twelve (12) months or less. Training will be determined current in the month it initially occurred. (i.e., If First Aid training was conducted July 3, 2024, and considered current for one year, it would be valid through July 2025.)

3. HIPAA, Universal Precautions, and Recognizing and Reporting Abuse, Neglect and Exploitation must be renewed within twelve (12) months or less. Training will be determined current in the month it initially occurred.

In addition to the above training, Lighthouse direct care workers must receive four (4) more hours of continuing training each year on topics related to caring for individuals. A service recipient specific on-the-job training or qualified internet training can be counted toward this requirement.

C. Training Documentation

Documentation for training conducted by the agency RN, social worker/counselor, or a documented specialist in the content area must include the training topic, date of the training, beginning time of the training, ending time of the training, location of the training and the signature of the instructor and the trainee. Training documentation for internet-based training must include the person's name, the name of the internet provider and a certificate or other documentation proving successful completion of the training. Training documentation for CPR must be a card or certificate issued from the certifying entity and must be signed by both the trainer and the trainee.

Certification cards for CPR and First Aid belong to the individuals who took the course, not the agency. These cards should be made available to the employees.

IX. Financial Staff

Provider agency employees who perform the agency financial responsibilities such as accounts payable, accounts receivable, payroll, audits, budgets, general ledger, financial reports, etc. should preferably, at a minimum, have an associate's degree in accounting or business administration or an associate's degree in any subject area and at least two years of responsible accounting or bookkeeping experience. Provider agencies must have financial staff who can perform computerized accounting, develop and monitor annual program budgets, perform cost allocation, determine meal costs and have knowledge of

local, state, and federal regulatory and reporting requirements. Provider agencies are required to utilize computerized accounting software such as FreshBooks, QuickBooks, Intuit, etc. It is recommended that provider agency employees who perform financial responsibilities be bonded

X. Criminal Investigation Background Checks

The WV Clearance for Access: Registry & Employment Screening is administered by the Department of Health & Human Resources (DHHR) and the WV State Police Criminal Investigation Bureau in consultation with the Centers for Medicare & Medicaid Services, the Department of Justice and the Federal Bureau of Investigation. Title VI, Subtitle B, Part III, Subtitle C, Section 6201 of the Patient Protection and Affordable Care Act of 2010 (PL 111-148 established the framework for a nationwide program for states to conduct background checks. The West Virginia State Police contracts with a private agency to securely capture and transmit fingerprints to be processed through the State Police and the FBI.

It is the provider's responsibility to determine which of their agency employees are required by law to have criminal investigation background checks. It is also the provider's responsibility to determine any additional employees, beyond the requirements of the law, they deem should have a background check to ensure the health and safety of their service recipients, the confidentiality and safety from misuse of Protected Health Information (PHI) and Personally Identifiable Information (PII) and the financial integrity and security of their agency.

For additional information reference West Virginia Code Chapter 16, Article 49 and/or www.wvdhhr.org/oig/wvcares.

XI. Personal Conduct Policy

Individuals who display inappropriate, disruptive and/or threatening behaviors, despite staff's attempts to mediate and counsel, may be suspended from the Senior Center and/or from receiving services for a period of time. During a suspension from the Senior Center, a service recipient may continue to receive services, if that service can be delivered at the person's residence and if doing so does not present a health and safety risk for staff.

If that is not an option due to health and safety risks, alternative services, resources and referrals are to be offered. Examples include providing home-delivered meals during the suspension period, referring the individual to another meal or in-home care program in the community or arranging alternative transportation for an individual.

All suspensions require documentation of all attempts to mediate the behavior. A formal letter of action must be sent to the service recipient with a Grievance Form (Attachment 7), and a copy of the letter placed in the service recipient's file. Provider agencies are required to immediately notify the Bureau and their own board of directors of any suspensions.

The Personal Conduct Policy Posting/Form (Attachment 9) must be posted at provider agency locations. The In-Home Personal Conduct Policy must be reviewed, signed, and dated by in-home service recipients. It must be maintained in the service recipient's file and a copy given to the service recipient (client).

Service recipients who present ongoing or egregious, inappropriate or threatening behavior may be permanently suspended from the center or from receiving in-home services. A permanent suspension would be warranted only in extreme situations that would generally also include involvement with law enforcement, mental health professionals and/or Adult Protective Services. Documentation must be maintained, and the Bureau must approve any permanent suspension.

XII. Voluntary Program Termination or Agency Closure

A provider may terminate participation in the entire OAA Title III program with one hundred twenty (120) calendar days' written notification of voluntary termination. If a provider requests to terminate participation in one or more OAA services, the AAA, with approval from the Bureau, may terminate their entire OAA grant agreement. If this occurs, the Bureau will also terminate their state funded programs (Lighthouse and FAIR, plus LIFE funding) to ensure comprehensive service delivery and the maximum co-location and coordination of services for older individuals as required per federal regulations. (OAA 102(a)(21) and 306(a)(3)(A).) The written termination must be submitted to the AAA and the Bureau simultaneously. The provider must also provide a complete list of all current Lighthouse and FAIR service recipients, as well as all Title III service recipients, and indicate which Title III service(s) they receive. The provider must work with the AAA and the Bureau on assets and service transfers and location of all service sites.

Upon termination, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, original copies of all service recipient records and service delivery/utilization reports and records, and any other requested information related to Lighthouse funds and/or services. Access numbers for the Bureau's web-based data collection system will be inactivated.

XIII. Involuntary Program Termination or Agency Closure for Cause

The Bureau may administratively terminate a county provider agency from participation in the Lighthouse program, at any time, for violation of the rules and regulations, for non-performance, for falsifying and/or altering documentation, for providing false and/or fraudulent information or for the conviction of any crime related to service delivery. Providers who have violated the rules and/or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in the Lighthouse program. After suspension or termination, the provider agency may request a review by the Bureau.

Upon termination for non-performance, or any other breach, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, all service recipient records, service delivery/utilization reports or other requested information related to Lighthouse funds and/or services.

XIV. Notification of Grant Award (NGA)

The NGA shall terminate by its terms at the end of the current applicable state fiscal year. The Bureau shall have the authority to determine if any subsequent agreement is offered to the service provider. This contract is not renewed automatically. Upon expiration of the term of the NGA, if requested by the state, the contract entity shall deliver to the Bureau, or any other person designated by the Bureau, all service recipient records, service delivery/utilization reports, or other requested information related to Lighthouse funds and/or services.

XV. Board of Directors Requirements

The board of directors for any provider agency that receives grant funding from the Bureau and is organized as a nonprofit corporation must act in accordance with the provision of the West Virginia Nonprofit Corporation Act. The county contracted provider Board President or an authorized county provider Board Member must sign all NGA's, budget revisions and all legal documents related to the agency. The provider agency must maintain by-laws as required by West Virginia Code and must have in-place a comprehensive, board-approved policies and procedures manual, including a fiscal manual.

Any board of directors of a service provider organized as a nonprofit corporation must also meet, at a minimum, the following Bureau requirements:

1. The board must consist of at least seven (7) members with the following minimum composition requirements:

   A. Two (2) individuals sixty (60) years of age or older who are service recipients in programs offered by the provider agency or are eligible to participate in such programs.

   B. Two (2) representatives of agencies (with senior interests) are located within the provider agency's service area and/or professionals (e.g., attorney, CPA, physician, pharmacist, psychologist, United Way, Family Resource Network, etc).

   If the provider agency is administered by a governmental entity, this requirement will not apply. However, every effort will be made to include individuals sixty (60) years of age or older, if only in an ex-officio capacity. Other exceptions or modifications to these requirements may be requested in writing, and consideration will be given to demonstrations of good cause.

2. County Provider Agencies are to establish their own policies regarding board member term limits to ensure a qualified and functioning board that serves the interests of the seniors of their county. This should include members who are active in their communities, willing to devote time and effort, individuals whose education and experience may provide support for the agency (i.e. administration/management, legal, human resources, promotion/marketing, financial, etc.) and individuals with an understanding of senior issues.

3. Current staff members cannot serve on the board unless in an ex-officio capacity.

4. Board members cannot be employed by the provider agency for at least one (1) year after serving as a board member. Provider agency employees cannot serve as a board member for at least one (1) year from their agency employment end date.

5. Immediate family members (parents, children, siblings, spouse, domestic partner, parents-in-law, children-in-law, grandparents, grandchildren, stepparents, step siblings, stepchildren, and individuals in a legal guardianship) of agency staff cannot serve on the board. Immediate family members (same list as above) of board members cannot be employed by the provider agency. The provider agency must have a nepotism policy in place regarding these restrictions. The nepotism policy must restrict family members from supervising other family members employed by the agency.

6. Each board member will be required to complete at least one (1) board training in a two (2) -year period. This training will be provided or approved by the AAA.

7. Maintain on file a signed Confidentiality Agreement (Attachment 1) for each board member.

8. Copies of all approved board minutes and financial reports are to be sent to the AAA within one (1) week, seven calendar days, of approval.

9. Annually complete a Board Certification Form (Attachment 10) and submit it to the AAA by October 1.

The AAA and/or Bureau will review the by-laws of the provider agency when it monitors the agency and will have the authority, if necessary, to request modification of the by-laws that will bring the provider agency into compliance with grant conditions. For more information, refer to West Virginia Code, West Virginia Non-Profit Corporation Act, Chapter 31E.

XVI. Emergency Contingency Service Operation Plan (ECSOP)

All provider agencies funded by the Bureau must have in place an ECSOP approved by the AAA. ECSOP describes how contingency services are provided to eligible service recipients and how agency operations continue to function during times of inclement weather, natural disasters, pandemics and other health-related situations that affect the county and the senior population.

The plan must be a continuity of operations plan (COOP) and an all-hazards emergency response plan based on the completed Risk Assessment Worksheet (Attachment 24 of the Older Americans Act Manual) for all hazards (45 CFR Subpart E 1321.97 – Emergency and Disaster Requirements).

The ECSOP is to be submitted to the AAA annually. The ECSOP regarding Lighthouse services must address, at a minimum:

1. Emergency Closure of Services Operations

a. Guidelines for the authority within the provider agency for the closure of regular service(s) and authorization for implementation of contingency services.
b. Guidelines for notifying staff, service recipients and the public.
c. Guidelines for notifying the AAA and the Bureau.
d. Guidelines for identifying and having emergency plans in place for high need/risk service recipients (i.e. service recipients who use oxygen; service recipients who have dementia). Providers should work with and cooperate with county health departments and emergency services on emergency planning and implementation.

2. Contingency Services

a. Guidelines for contingency services when utilized as a precautionary measure for impending emergencies.

b. Guidelines for contingency services, when appropriate, during emergency closure of standard service operations. (Cooperate with county health departments on county emergency plans.)
c. Guidelines for contingency services during emergencies beyond normal service operation hours.

Emergency closure of service operations that exceed two (2) days or ten percent (10%) of the regularly scheduled days of service operations in any month shall be reviewed by the AAA for possible repayment of corresponding budget amounts, as outlined in the NGA, or for adjustment in financial awards.

XVII. Grant Restrictions and Use with other Programs

Federal and state grant funds cannot be used to pay West Virginia Directors of Senior and Community Services, Inc. dues.

The maximum hours of Lighthouse service per month is sixty (60). If a service recipient receives sixty (60) hours of service per month, there must be documentation of at least five (5) tasks on the LED documenting the need for providing maximum hours.

Lighthouse services may be provided with other programs, including, but not limited to, FAIR, hospice care, respite, and VA in-home services. Services may not overlap. Special caution must be used to ensure that hours of service are properly and accurately billed to the appropriate funding source. If another program is being used, the Lighthouse program is the "fill-in" program. Due to this, if a service recipient is receiving another program, Lighthouse cannot offer maximum hours. Lighthouse services will only be available on days the other program is not at the home to avoid duplication of services.

XVIII. Legislative Initiatives for the Elderly (LIFE)

LIFE funds are appropriated by the Legislature through lottery funds and are allocated based on legislative instruction. LIFE funds are distributed equally to Title IIIB program providers. Funds are available on the State fiscal year (July 1 to June 30) and do not have match requirements. LIFE funds can be utilized for operational costs (i.e., rent, utilities, facility insurance, repairs, kitchen equipment). Providers may also use LIFE monies for any Title III service, as well as Lighthouse and FAIR authorized supplemental funds. Funds used for services must adhere to the program/service policies for which they were used. Any program income received as a result of the provision of LIFE services is to be used to provide additional services in that program, is to be accounted for separately and must be expended in the current fiscal year it is received or the following fiscal year.

LIFE monies cannot be used for gifts, raffles and fundraising events. For information on LIFE budget and invoicing processes, contact your AAA.

XIX. Private Pay Programs

County aging providers may provide private pay programs and may enter into contracts and commercial relationships but must develop policies and procedures for doing so that meet Older Americans Act manual requirements.

Individuals who receive information about private pay programs who are eligible for Lighthouse services must be made aware of those Lighthouse services, and any similar contributions-based service options, even if there is a waitlist for those services. They must be provided with this information initially and on a periodic basis to allow individuals to determine whether they will select contributions-based services or private-pay programs.

XX. Documentation

All Lighthouse services must be documented per policy (including service recipient signatures) and entered into SAMS (refer to each service area for specific requirements for each service). Services that are not documented per policy will result in no reimbursement or a payback of funds for services unless permission is granted by the Lighthouse Director.

The SAEF must be fully completed per instructions for each Lighthouse service in order to be reimbursed for services as per program requirements. Only one (1) SAEF is required for a service recipient who receives more than one (1) service.

All services must be entered into SAMS by the tenth (10th) calendar day of each month.

Providers must use the forms developed and implemented by the Bureau. If your agency wants to modify or use a different form, you must submit a written request with the proposed form to the Bureau and receive written approval. **All forms must have the Service Recipient's given name.**

XXI. Provider Agency Billing

Lighthouse services are to be billed monthly. Invoices for all Lighthouse services will be sent to the Bureau by the tenth (10th) calendar day of each month. Additionally, a SAMS roster that includes daily entries is required that lists the names of service recipients and the units of service during the period covered. Invoices not received by the deadline may be processed with the next month's invoice. Invoices for services and/or expenses will not be accepted after

thirty (30) calendar days. **A Service Recipient cannot be invoiced for more than 60 hours of Lighthouse services per month. Any hours above 60 hours will be invoiced as "Private Pay", or the agency will cover the cost of those hours.**

Final year end fund requests and/or invoices must be received by the Bureau within thirty (30) calendar days of the grant's end. All state funds expire on June 30 of each fiscal year.

For services whose services unit is one (1) hour, you must round to the nearest ¼ of an hour (.25 unit).

¼ hour = .25 unit

½ hour = .50 unit

¾ hour = .75 unit

1 hour = 1.00 unit

[Example: If a service recipient received a service for eight (8) minutes, the Roster would reflect .25 unit (or ¼ hour). If a service recipient received a service for thirty-three (33) minutes, the Roster would reflect .50 units (or ½ hour).]

XXII. Person-Centered and Trauma-Informed Services

Services must be provided to older adults and family caregivers in a manner that is person-centered and trauma informed. Services should be responsive to their interests, physical and mental health, social needs, available supports, and desire to live where and with whom they choose.

Services should, as appropriate, provide older adults and family caregivers with the opportunity to develop a person-centered plan led by the individual or, if applicable, by the individual and the individual's authorized representative (OAA Section § 1321.77).

XXIII. Prioritization of Services and Waitlist

Lighthouse services must be prioritized based on a combination of SAEF scores and the prioritization processes established by the provider agency's board of directors.

If there is a waitlist for Lighthouse services, individuals must be prioritized and be served based on SAEF scores and prioritization policy established by the provider agency board of directors. Instructions on the prioritization scoring system are included in Attachment 3 with the SAEF.

There is a system within SAMS that will allow each county aging provider, Area Agency on Aging and the Bureau to monitor and track eligible individuals for services that county aging providers are unable to serve at any given time (the waitlist). Waitlisted service options in SAMS include home-delivered meals, IIIB Personal Care, IIIB Homemaker, IIIE In-Home Respite, as well as state-funded programs, Lighthouse, FAIR In-Home and FAIR Congregate. For the Lighthouse program, there must be a completed SAEF entered into SAMS for all persons on the Lighthouse waitlist. For an individual to be counted as part of a county's Lighthouse waitlist, this is required. All individuals on a waitlist must also be referred to the Aging and Disability Resource Center (ADRC).

XXIV. State Cost Share

Lighthouse is a state-funded program, and there is a requirement that service recipients share in the cost of their service, using the current State Cost Share Chart (Attachment 11), based on the individual income of the service recipient or, in the case of a married couple, the combined income of the service recipient and spouse. When assessing an individual's eligibility for state cost sharing, it must be based solely on a confidential self-declaration of income (not considering assets, savings, or other property owned by the individual). All income is to be considered. The state cost share amount is based on the service recipient or the service recipient and spouse's incomes only. Other household members' incomes are not to be considered. Spouse's income is not counted if there is a legal separation. Income does not include any allowance and/or stipend that the individual or married couple receive for other services provided to them. Monthly medical expenses must also be deducted from declared income before applying the State Cost Share Chart. Medical expenses may include insurance premiums, copays, prescriptions, dental, medical supplies and equipment, etc. Medical expenses can vary, and provider agencies should use their professional judgment to determine if an expense is an actual medical expense. If an applicant does not want to share income and medical expense information, then a 100% fee may be charged.

All monies collected through Lighthouse state cost share are to be pooled with FAIR state cost share funds and utilized to provide additional hours of service in either Lighthouse or FAIR at the appropriate hourly rate in the county where the state cost share fees were collected. State cost share fees collected may not be used to reimburse the provider agency for hours of service that exceed the program maximum of sixty (60) hours per month. Lighthouse state cost share income should be carried over to the following fiscal year and expensed for additional services by December 31 of the state fiscal year following the fiscal year in which it was collected. The Bureau may change the state cost share schedule at its discretion. The State Cost Share Chart is updated each year, based on 200% of the federal poverty guidelines as a starting point.

Funds received for state cost share must be logged in by service and deposited and tracked in the accounting system as state cost share revenue for FAIR/Lighthouse. All revenues must be counted and balanced by two people. A receipt must be provided to service recipients for state cost share with the monthly State Cost Share Invoice (Attachment 12).

If it is determined that paying the appropriate state cost share would cause a hardship for the service recipient, the reasons for the hardship should be clearly documented in the service recipient's file and an hourly amount worked out that is acceptable to both the provider agency and the service recipient. A Hardship Waiver must be reevaluated annually. Hardship Waivers should be limited. At the end of the fiscal year, total state cost shares collected must be equal to or greater than the hours of service provided, or the provider agency must make up the difference from other sources, unless granted a waiver by the Bureau. The provider agency is responsible for averaging a minimum of $1.00 (one dollar) collected for each hour of Lighthouse and FAIR services provided.

Service recipients must be prioritized (Refer to Policy Section XXIII) and must be made aware of the share of costs that they will be charged for the Lighthouse services they receive. At the end of each month, all Lighthouse service recipients will receive the State Cost Share Invoice (Attachment 12), detailing services provided and their share of the cost of those services, which they are expected to pay. If a service recipient chooses not to pay the agreed upon cost share, the provider agency, following their Board approved policy, will determine whether to continue services for that service recipient, discontinue services or to offer a hardship waiver. If the decision is made to discontinue services for non-payment, the service recipient will be notified in writing and given ample time to respond, according to the provider agency's approved policy. A Grievance Form (Attachment 7) must accompany the written notice.

Funds received for state cost share must be logged in by service, deposited and tracked in the accounting system as state cost share revenue for Lighthouse/FAIR. All revenues must be counted and balanced by two (2) people. A receipt must be provided to service recipients for state cost share with the monthly State Cost Share Invoice (Attachment 12). State Cost Share funds collected and **deposited** in any given fiscal year are considered state-cost share income for that fiscal year and should be reported as such. Use the date the state cost share funds were deposited to determine when to account for them. (Example: If state cost share funds are due to the provider agency for hours of service provided in June but are collected and deposited in July, then those funds would be considered part of the fiscal year that began in July.) The state cost share income collected annually is reported to the Bureau on the State Cost Share Accountability Form (Attachment 13).

Assessments and Reassessments: An initial assessment and annual reassessment are required for all Lighthouse service recipients. For every initial assessment and annual reassessment conducted for Lighthouse, the provider agency may deduct the current approved amount from current-year state cost share income to help offset non-billable costs associated with Lighthouse program administration.

To deduct for the initial assessment, the applicant must receive services through the program for which the assessment was conducted. It may not be deducted if an assessment is done for someone who does not ultimately receive services through the Lighthouse program. Deductions are limited to one assessment per year, although if the service recipient is getting services from both Lighthouse and FAIR, the provider agency may deduct the current approved amount annually for the Lighthouse initial assessment or reassessment and the same amount for the FAIR initial assessment or reassessment. The provider agency cannot deduct more than the total amount of state cost share income collected in the current year. If an assessment is conducted in one fiscal year and services begin in the next fiscal year, then the provider agency would deduct the approved amount in the fiscal year that the service begins.

Documentation of assessments to be deducted, at a minimum, must include service recipient's name, assessment date, and start date of service or date of reassessment and must be maintained in provider agency office for fiscal monitoring purposes. It must be submitted with the annual State Cost Share Accountability Form (Attachment 13).

The amount deducted for assessments and reassessments will be reported annually to the Bureau on the State Cost Share Accountability Form (Attachment 13). (Number of initial Lighthouse and FAIR assessments X current approved amount (Line 2), plus number of Lighthouse and FAIR annual reassessments X current approved amount (Line 3) = Amount provider may keep to use toward non-billable costs in both programs.)

XXV. Lighthouse Program

A. Lighthouse Services

In the Lighthouse Program, each Title III-B provider agency offers support in four (4) areas:

1. **Personal Care:** Bathing, dressing, grooming, and toileting.
2. **Mobility:** Transferring, walking and repositioning.
3. **Nutrition:** Meal preparation, eating, special dietary needs, and grocery and/or pharmacy shopping.
4. **Environment:** Light housecleaning, making and changing the service recipient's bed, dishwashing, and service recipient's laundry. This cannot exceed 1/3 of the monthly hours a service recipient receives. This is based on the registered nurse assessment**. The Lighthouse Program does not provide housekeeping services only. Personal care *must* be provided to receive light housekeeping services.**

Environmental services are direct and practical assistance with household tasks and related

activities. Environmental services assist individuals who have lost the ability to perform instrumental activities of daily living to allow them to live in a clean, safe, and healthy home environment. Environmental services must be provided in the home and cannot exceed more than one-third (1/3) of the monthly hours that a service recipient receives. Light housekeeping cannot exceed sixty (60) minutes per week. The 2/3 (two-third), 1/3 (one-third) rule still must apply.

Lighthouse Fund Identifiers: Lighthouse, State Cost Share, LIFE, Local

Service Unit: 1 hour

Service Limit: Lighthouse services are limited to a maximum of sixty (60) hours of service per month, based on the RN's Assessment (Attachment 14), resources available, and subsequent Plan of Care (Attachment 15). Since medical eligibility is based on only two (2) identified needs, it is anticipated that many of the service recipients in the program will not require the maximum hours of service per month.

It is possible to qualify for the Lighthouse program and not need any assistance with bathing. Service hours and the Plan of Care (Attachment 15) should be based on the unique needs of the individual service recipient and must provide assistance in two (2) of these areas: personal care, mobility or nutrition. Maximum hours should be reserved for those service recipients who require much assistance or greater in most or all areas on the LED (Attachment 16), and the RN Assessment must clearly document the need for maximum hours.

Eligibility Requirements: There are three (3) eligibility criteria for the Lighthouse program:

1. Sixty (60) years of age or older.
2. Medically eligible based on a functional evaluation by the provider agency's RN. Two (2) needs must be identified under "Activities of Daily Living" on the Lighthouse Eligibility Determination form (LED). A need is an ADL that requires "Much Assistance" or "Total Assistance."
3. A resident of West Virginia at the time service is provided. **Services must be provided in West Virginia.**

Documentation Requirements: The RN Assessment (Attachment 14) must be completed at the time of the initial home visit and annually thereafter. The assessment should be detailed enough to determine Plan of Care needs. In addition to the annual reassessment, a six (6) month follow-up phone call with the service recipient and/or family member must be made, with documentation of findings and follow-up as indicated. Six (6) month calls must be completed by the provider agency RN or a designated professional agency staff member. In addition to six (6) month calls and annual reassessments, follow-up by the RN is required any time there has been an incident or change in the service recipient's condition. Additional contacts may be indicated based on the service recipient's condition and the RN's

professional judgment. All contacts should be documented in the Nurse's Notes section of the service recipient's file.

Admission requirements for Lighthouse service recipients must include the following.

1. A completed SAEF with all required areas completed
2. A completed Plan of Care (POC)
3. A completed Lighthouse Eligibility Determination (LED) form
4. A completed Nursing Assessment
5. Service Recipient service logs that match the Plan of Care
6. An In-Home Service Recipient Responsibility Agreement with the Service Recipient's signature and date
7. In-Home Personal Conduct Policy, which must also be read, agreed to and signed by the service recipient, who will receive a copy of the signed policy. A Family member can sign if the Service Recipient is unable to do so, based on medical or physical disability

Please do not leave blanks on any Lighthouse form.

Six (6) month call documentation must include the following:

1. Service recipient's name and date of call
2. The name of the person you spoke to and how that person is related to the service recipient
3. Any cognitive issues
4. Any issues with care
5. Any changes in medication and/or mobility
6. Any needed changes to the Plan of Care
7. Satisfaction with current services
8. Any additional comments
9. The RN's signature.

If the six (6) month call (Attachment 17) is completed by someone other than the RN, the RN must sign to confirm that he/she has read and understood the call note. The six (6) month call must be completed with the service recipient or the service recipient's informal support. The call cannot be with the direct care worker. If the direct care worker is a family member, the six (6) month call must be with someone else. You do not have to complete the six (6) months call by the exact date the Plan of Care was completed. It can be completed in the month for which it is due. (Example: Plan of Care was completed on July 10. The six (6) month call can be completed any time in July).

Nurse's Notes: All Lighthouse service recipients shall have a Nurse's Notes section in their agency files. This section should be used to document all contact with the service recipient,

including home visits, six (6) month calls, Plan of Care changes and follow up by the RN. The RN must document when the initial/annual assessment is completed or if the Plan of Care is changed for any reason. The RN should also document if the service recipient is in the hospital or rehab or suspends services for any reason. If the direct care worker reports any problems with the service recipient, the RN needs to follow-up with the service recipient either by telephone or in person and document the findings in the Nurse's Notes.

Reassessment Requirements: Each service recipient will be reassessed for the Lighthouse Program at least annually, every 12 months, and more frequently if needs or income of the service recipient or spouse change or if deemed necessary by the Bureau. Reassessment begins with the completion of a new Lighthouse Eligibility Determination (Attachment 16) by the Agency RN. Determination will be made at this time if a service recipient is still eligible, if there is a change in the state cost share schedule, and if there needs to be a referral made to another program for services. Annual reassessment includes a home visit, plus completion of a SAEF, RN Assessment, Plan of Care and appropriate determination of State Cost Share.

B. Job Description

Each provider agency will have a job description specifically for the Lighthouse program that reflects the duties and responsibilities of direct care workers providing Lighthouse services through this program.

C. Referral

After a referral is received, the provider agency RN shall determine appropriateness of the Lighthouse program either by telephone conversation with the applicant or by home visit. At this time, the SAEF will be completed to determine the priority level of the applicant. All avenues of in-home services should be explored—e.g., Veterans Administration, Medicaid Personal Care, Medicaid Aged and Disabled Waiver, Medicaid TBI Waiver, private insurance, and other in-home care programs.

D. Initial Home Visit: Completion of Service Assessment and Evaluation Form (SAEF) and Lighthouse Eligibility Determination (LED) Form

Once the applicant is determined to be appropriate for Lighthouse and the provider agency has an opening in the Lighthouse program, the RN shall make a home visit. Medical eligibility will be determined with the LED at the time of the visit and the information in the SAEF will be reviewed for accuracy.

The required sections of the SAEF that must be completed for the Lighthouse Program are Levels one through three, plus Level 4, question 1; scores; signature of the person competing the SAEF; and if the SAEF was reviewed with the Service Recipient. Every Lighthouse service recipient must have a completed SAEF in the SAMS database.

The LED must be completed in its entirety. Medical eligibility for the Lighthouse program is determined by the "Activities of Daily Living" (ADL) Section of the LED. When determining the level of need for each ADL, do not use ranges. Consider how the applicant/service recipient is on **most** days and use that level of need. If at least two (2) of the Activities of Daily Living indicate "Much Assistance" or "Total Assistance," then the applicant is medically eligible to participate in the Lighthouse program. All applicants **must have** a minimum of two "2's, two "3's", or one "2" and one "3" to qualify. The LED must be signed by the RN. The LED must be completed annually to determine continuing eligibility for the Program. The state cost share schedule and the provider agency's policy for payment will be discussed with the applicant at the time of the eligibility determination.

If medically eligible, the applicant will be advised at this time. If medically ineligible, the applicant will be advised at this time, and the interview concluded. Referral to the Aging and Disability Resource Center (ADRC) would then be appropriate.

E. RN Assessment

The RN Assessment (Attachment 14) must be completed in full by the provider agency RN at the initial visit, and must have a narrative, which includes the service recipient's living conditions, medical history, medications, diagnoses, and ability to perform personal care, mobility, nutritional, and environmental tasks. This assessment is used to develop the service recipient's Plan of Care (POC); therefore, as much detail as possible must be included. The assessment should paint a picture of the service recipient and validate the tasks and time frames on the POC. After completion, the RN Assessment should be signed and dated by the agency RN, and the assessment should be maintained in the service recipient's file.

The RN Assessment must be completed initially and annually thereafter and whenever there are changes to the service recipient's needs and condition that the RN believes warrant a completely new assessment. Nursing notes may be more appropriate for some types of updates and changes.

F. Plan of Care (POC)

The Plan of Care (Attachment 15) will be developed based on the RN Assessment and the expressed needs of the service recipient. The RN should use his/her professional judgment to determine the tasks needed and time required for each task to be completed. No tasks can be provided outside the service definitions. Time in minutes should be entered for all tasks on the POC. Times indicated will be averages and are used to determine a block of time for completion of the task. Excessive time for tasks must have thorough documentation. The RN should indicate the number of hours approved for each day under "hours approved daily" for every day of service. The hours approved daily must correlate with the total minutes indicated for each of the tasks to be performed that day. Plan of Care hours cannot exceed four (4) hours per day. Environmental tasks are incidental to the other tasks and cannot exceed one-third (1/3) of the total monthly hours that the service recipient receives. When

developing the POC, the RN should include in the "Comments" section any instructions to the direct care worker related to the task. Always include the number of meals to be prepared under the comment section for "meal preparation."

Plan of Care specifics must be discussed in detail with the service recipient prior to implementation. (Since a service recipient must pay according to the state cost share schedule, it is possible that he or she may wish to limit the number of hours of service received.) A copy of the **current** Plan of Care must be left in the home for the direct care worker to utilize and must be kept in the service recipient's record.

The POC must be completed initially, annually and as indicated with any documented change in service recipient condition. Any changes to the POC must have adequate documentation to support the tasks needed and times needed for each task to be completed. The RN documentation, either in the RN Assessment or in a nursing note, must validate the tasks and times on the POC. All changes to the Plan of Care must be documented in the Nurse's Notes section of the service recipient's record, along with documentation that the changes were discussed with the service recipient prior to being made.

G. Rights and Responsibilities Agreement

Prior to receiving services through Lighthouse, the service recipient must read, agree to, and sign the Service Recipient Rights and Responsibilities Form (Attachment 4). The service recipient will be given a copy of the agreement, and the original will be placed in the service recipient's file.

H. Direct Care Worker Service Log

The Lighthouse direct care worker must indicate the time of arrival and departure, and initial on the Direct Care Worker Service Log (Attachment 18) only the tasks completed each day. The Service Log must directly reflect the Plan of Care, a copy of which is kept in the service recipient's home for the direct care worker to utilize.

The direct care worker should initial beside every task performed each day. If a task that is on the Plan of Care is not completed, the direct care worker should not initial. Instead, they should document in the comment section, the reason that task was not completed (e.g., service recipient does not feel well enough for a bath, washing machine broken so unable to do laundry, etc.). If a task is not performed, the direct care worker should not document the time that should have been spent on that service. For example, if the Plan of Care allowed thirty (30) minutes for a bath and the service recipient refused the bath, the direct care worker should deduct thirty (30) minutes from the total time allowed for the day. Any changes or concerns regarding the service recipient should be documented by the direct care worker in the comment section of the Service Log.

At the end of the week, the service recipient must sign and date the Service Log verifying the times the direct care worker was present and that he/she received services as initialed. If the service recipient is unable to sign, a representative may sign for her (the representative must sign the service recipient's name and then her own name. It must be documented in the service recipient's chart that she is unable to sign her name). After the service recipient signs, the direct care worker should also sign the Service Log to verify service delivery. The Service Log must be turned in weekly, bi-weekly or semi- monthly, depending on the provider's employee pay schedule, to the RN after the service recipient and caregiver have signed. The RN then carefully reviews the service log for compliance with the POC and addresses any discrepancies prior to signing off, which then begins the billing process. If any discrepancy is found, follow-up is expected with documentation in the service recipient record. The RN signature indicates that he/she has reviewed the Service Log and agrees that the POC has been followed, and follow-up has been completed related to any discrepancy or change noted. The RN needs to date the signature on the Service Log for the date that he/she actually signs it. All signatures should be original. Signature stamps are not allowed. Original Service Logs must be maintained at the provider agency in the service recipient's file. Service logs must be completed in ink and white out should not be used. Service recipients must be given a copy of the Service Log, if requested.

I. Service Provision

Services will be provided by a trained direct care worker employed by the provider agency. **The direct care worker may be any qualified individual, except for the service recipient's spouse.** Provider agency will determine whether to employ and properly train family members other than the primary caregiver to be direct care workers.

No transportation to doctor's appointments is permitted under the Lighthouse Program.

It is required that the agency RN have Lighthouse manual training upon hire by the Lighthouse Director at the Bureau to ensure the quality of the program. A certificate of training will be provided to the Agency/RN to be placed in the employee's file. The State Director of the Lighthouse Program is to be notified of any change in RN staff within fourteen (14) days of hire, and required training is to be completed within thirty (30) days of hire. Registered nurses professional level of care is expected at all times.

The RN must be licensed in WV. A temporary license will not be accepted. All agency and direct care staff who work with the Lighthouse program are required to have a signed confidentiality form in their personnel record.

J. Reporting

Lighthouse services must be reported using the WellSky/SAMS Client Tracking System. A fully completed SAEF (Levels 1, 2, 3, and question 1 on Level 4) is required to enter the Lighthouse service recipient into the SAMS system. Scores must be documented on the back page of the SAEF. A roster is the appropriate method for entering the service recipient's service units. Active service recipients will automatically appear on the next month's roster.

All units of Lighthouse service provided must be documented in SAMS using the service code **Lighthouse Personal Care** and the fund identifier **Lighthouse, State Cost Share, LIFE,** or **Local** depending upon the funding used to provide the service. Special caution must be used to ensure that the hours of service are properly and accurately billed to the appropriate funding source. Service units documented must be rounded to the nearest quarter of a unit (i.e. .25, .50, and .75). A SAMS Monthly Services Roster that includes daily entries must be used.

Each month, a supplemental service recording log with the following information or, preferably, the SAMS Monthly Service Roster with daily entries must accompany the invoice for that month's services:

1. Provider agency name.
2. Funding source.
3. Month the services were provided.
4. Name of person completing form.
5. Names of service recipients.
6. Hours of service and the days the services were provided.
7. Total hours of service for that month.

K. Service Recipient Files

For monitoring purposes, each service recipient's file must include the following:

1. A SAEF for the service recipient
2. An updated SAEF for the service recipient for each annual reassessment
3. A completed LED with at least two (2) "2's", two (2) "3's" or one (1) "2" and one (1) "3"
4. Service Recipients/Spouses estimated income
5. Signed Service Recipient Responsibility Agreement
6. Signed Personal Conduct Policy
7. A Plan of Care (POC) for the Service Recipient
8. Nursing Assessment that matches LED and POC
9. Documentation of hardship if service recipient has been exempted from state cost share or if state cost share was reduced.
10. Documentation of need if service recipient is receiving maximum hours of

service per week; this would be mostly 2's and 3's on the LED (at least 5)
11. Evidence that the service recipient, direct care worker and nurse have read/completed direct care worker service logs
12. Completed direct care worker service logs for months of review
13. A copy of the Service Recipient's Invoice for months of review that states how much state cost share is being used.
14. Nurse's notes and 6-month call sheet for review period.

XXVI. Monitoring and Grant Adjustments

Lighthouse service providers will be monitored by the Bureau on a 24-month cycle, alternating between a Bureau-generated self-evaluation one year and a desktop or onsite review by the state Lighthouse Director the other year, to document continuing compliance with policy requirements in this manual and in any grant agreements. Providers may be monitored more often, if needed. Monitoring by the Lighthouse Director may include home visits, phone interviews with service recipients, and/or interviews with direct care workers and other agency staff. Records regarding service recipients, billing records, and records of any personnel who work with the Lighthouse program will be provided upon request. The number of service recipient records reviewed will be determined by the Lighthouse Director.

Review findings should show what the provider agency is doing well and where the Lighthouse program could be improved. Negative review findings may lead to a plan of correction, payback of funds, no reimbursement, or, in severe cases, loss of privileges to provide Lighthouse services.

A plan of correction will be requested when review findings, as evidenced by failure to follow program policy and procedures, indicate changes need to be made to bring the Lighthouse program in line with policies. Provider agencies will be given forty-five (45) days to respond when a plan of correction is requested. Technical assistance will be provided as needed and requested. To correct deficiencies, conditions can be added to an NGA. The Bureau may request a desktop self-audit of all case files.

A percentage of provider agencies may be randomly selected annually for an onsite review to validate any desktop review documentation. Targeted onsite reviews may also be conducted based on complaints and/or in situations where service recipients' health and safety are in question. Targeted reviews may include a review of all records.

Conditions that may result in the recoupment of funds, downward adjustment of grant award and/or corrective action:

1. Expiring between twenty percent (20%) and thirty-three percent (33%) of annual award at least two of the last three prior grant years.
2. Providing services that do not meet policy, documentation and/or eligibility

requirements.
3. Performance deficiencies showing that eligible service recipients in your service area are underserved.
4. Evidence that state cost share funds are not being spent appropriately.
5. Having employees who do not meet the requirements for provision of services.
6. Failure to average $1.00 per hour of Lighthouse/FAIR services provided.

This is not an all-inclusive list of conditions that may result in the recoupment of funds or the downward adjustment of a grant award.

Conditions that may result in termination of all or part of grant award and corrective action:

1. Expiring more than thirty-three percent (33%) of your grant award during two of the last three grant years.
2. Severe performance and review deficiencies, indicating health and safety concerns for service recipients, that are not corrected immediately.
3. Failing to report and/or adhere to a specified plan of correction.
4. Having other severe review deficiencies.
5. Falsifying documents.
6. Accumulating multiple conditions that may result in a downward adjustment as defined above.

This is not an all-inclusive list of conditions that may result in termination of all or part of a grant award.

If justification for a reduction or termination of award is found, you will be notified, with explanation, in writing. You would then have five (5) business days to set up a repayment schedule with the WV Bureau of Senior Services or submit a written appeal to the Commissioner and the State Lighthouse Director.

If you lose the privilege to provide Lighthouse services within your county, that privilege will be offered to another Title III-B provider agency within the ageing network, based on that agency's review history and location. You may also lose the privilege to operate as a Title IIIB provider agency.

The Bureau has the discretion to make changes to the Lighthouse program, with ample notice to service provider agencies, as the need arises. The Bureau retains the authority to make final decisions regarding Lighthouse grant distribution.

Monitoring Tools can be found on the Bureau's webpage at www.wvseniorservices.gov.

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