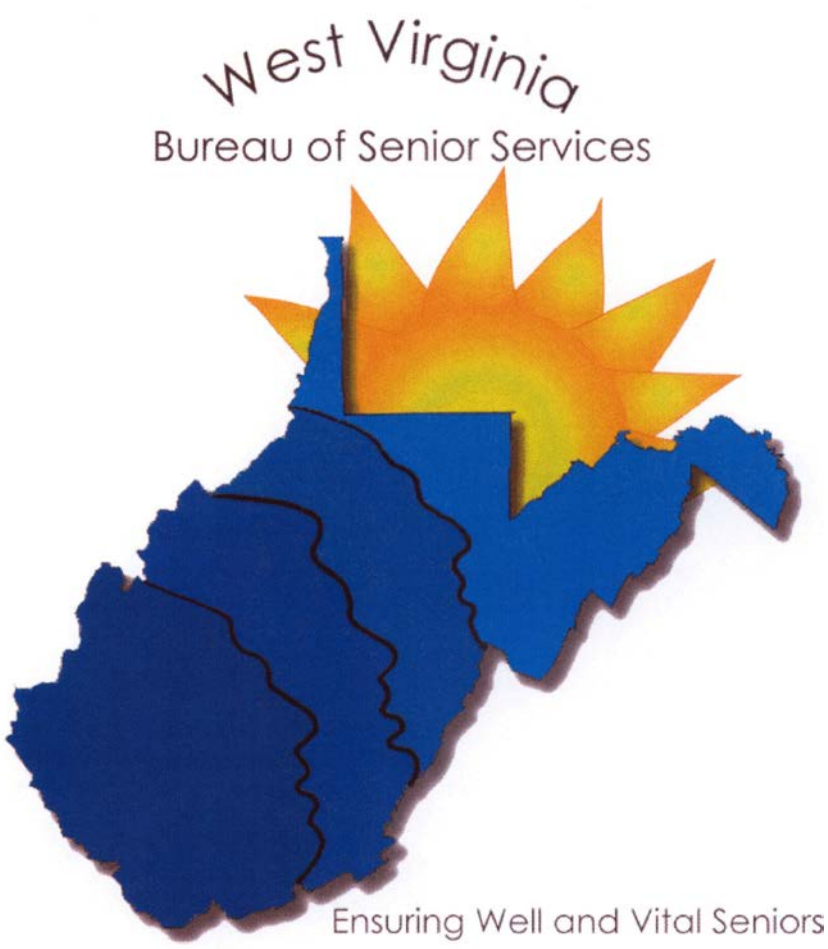

West Virginia Bureau of Senior Services
Family Alzheimer's In-Home Respite (FAIR)
Policy Manual

Effective July 1, 2015

Revised May 1, 2017

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FAIR Attachment List

Number	Form Name	Instructions
1	Confidentiality Agreement – Board Member	Yes
2	Confidentiality Agreement – Employees and Volunteers	Yes
3	SAEF	Yes
4	Rights and Responsibilities (For FAIR, use Attachments 20 & 21)	Yes
5	Rights and Responsibilities Posting	Yes
6	Denial/Adverse Action Letter	Yes
7	Grievance Procedures Form	Yes
8	Grievance Procedures Posting	Yes
9	Personal Conduct Policy Form and Posting	Yes
10	Board Certification	Yes
11	State Cost Share Chart	No
12	FAIR State Cost Share Invoice	Yes
13	FAIR Cost Share Accountability Form	Yes
14	FAIR Activity Plan	Yes
15	FAIR Congregate Respite Guidelines	No
16	FAIR Sample Letter to Physician	Yes
17	FAIR Job Description Congregate	No
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19	FAIR Personal History	Yes
20	FAIR Service Recipient Responsibility Agreement – Congregate	Yes
21	FAIR Service Recipient Responsibility Agreement – In-Home	Yes
22	FAIR Worker Notes	Yes
23	FAIR Supplemental Services Worker 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 in ink. To alter any of the above state and FAIR specific forms (except the letter to physicians), you must have written approval from the Director of Alzheimer's Programs at the Bureau of Senior Services.

I. Introduction

Caring for someone with Alzheimer's disease or a related dementia can be extremely **stressful, and family caregivers need a regular break from the demands of the job.** To address this need, the FAIR Program was created, building on a similar respite program implemented in sixteen counties from 2002–2008 through an Administration on Aging Alzheimer's Disease Demonstration Grant. Funding for FAIR was proposed by Governor Joe Manchin III and passed by the Legislature in 2006. The program began July 1 of that year. FAIR is state-funded, administered by the West Virginia Bureau of Senior Services, and available in all fifty-five counties. To offer FAIR, the provider agency must also be a Title III-B provider.

FAIR is designed to provide a regular break for caregivers of individuals with a written diagnosis of Alzheimer's disease or a related dementia. **The client (service recipient) in the FAIR program is the family (unpaid) caregiver.** FAIR supplements but does not replace the care provided by the unpaid caregiver. The in-home respite service is provided by a trained worker employed by a county aging provider agency after the care receiver has been determined to be medically eligible (has a written diagnosis of Alzheimer's disease or a related dementia). FAIR also provides socialization and stimulation for the individual with dementia, through an activities plan developed for that individual, based on his/her interests and abilities determined by the Personal History. In approved instances, congregate respite services may also be provided through FAIR.

FAIR services are available to individuals of any age who care for a loved one with Alzheimer's disease or a related dementia. Payment is determined on a state cost share schedule, based on the income of the care receiver or care receiver and spouse when the individual with dementia is married. (Refer to Policy Section XXI on State Cost Share.)

Preference will be given to older individuals with greatest economic and/or social needs (with particular attention to low-income individuals, including low-income minority individuals, individuals at risk for institutional placement and individuals residing in rural areas). (Refer to Policy Section XX regarding prioritization of services.)

This manual sets forth the WV Bureau of Senor Services' requirements for FAIR services provided to eligible West Virginians. The goals and objectives of this program are focused on providing services that are person-centered and promote choice, independence, respect, dignity and community integration. The WV Bureau of Senior Services has a grant agreement with each provider agency to manage and implement FAIR. Provider agency boards of directors, with local input via public meetings, determine service priorities for county programs.

II. Definitions

A. Definitions Specific to FAIR

Activity – In the FAIR Program, anything legal and allowed by the provider agency can be considered an activity, as long as the focus is on the care receiver and that care receiver, to the extent possible, is included in everything the worker does.

Activity Plan – The plan that guides the direct care worker during the time she/he is with the care receiver. The plan should be developed from information in the Personal History, with input from the service recipient and, whenever possible, the care receiver.

Caregiver - Family member or other unpaid person who gets a break from caregiving responsibilities through FAIR. The caregiver does not have to live with the care receiver to be eligible for FAIR but must show that there is physical and/or emotional stress resulting from caregiving responsibilities that could be eased through these services.

Service Recipient - the person who receives FAIR services**. For FAIR, this is the caregiver** (not the individual with a diagnosis of Alzheimer's or a related dementia).

Care Receiver - Person for whom care is provided. (This is the individual with a diagnosis of Alzheimer's or a related dementia.)

Direct Care Worker - In-home worker employed by the county aging provider agency. For FAIR, the worker provides services detailed in the care receiver's Activity Plan. Neither the primary unpaid caregiver nor the spouse of the individual with Alzheimer's disease or a related dementia may be the FAIR worker.

Hardship Waiver - Document that removes part or all of 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 provider agency. Hardship waivers do not exempt the provider agency obligation of a minimum of $1.00 per hour of service provided.

Personal History – Particular information about the care receiver that helps the direct care worker get to know the person for whom she/he will be providing care. It also guides development of the activity plan. The service recipient, other family members, *and the care receiver* should all provide input into completing the person history.

Target Population for FAIR – Unpaid caregivers of individuals with Alzheimer's disease or a related dementia, with particular attention to low income individuals, including low-income minority individuals, individuals with limited English proficiency, individuals at risk for institutional placement and individuals residing in rural areas.

B. Other Definitions

Abuse - (WV Code §61-2-29) Infliction 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.

By-laws – Please refer to the Bureau dictionary of key terms.

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 should have goals, objectives and an evaluation system to demonstrate competency in training areas.

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.* (www.aoa.gov)

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.

Felony - A serious criminal offense designated as a felony under state or federal law.

Financial Exploitation - A type of neglect of any 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 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 the individual or to another individual. (OAA102(a)(22)(A)(i) & (B).)

Greatest Economic Need - A need resulting from an income level at or below the federal established poverty line. (OAA 102(a)(23).)

Greatest Social Need - Need caused by non-economic factors, which include physical and mental disabilities; language barriers; and cultural, social, or geographical isolation, including isolation caused by racial or ethnic status that restricts the ability of an individual to perform normal daily tasks; or threatens the capacity of the individual to live independently. (OAA 102(a)(24)(A-C).)

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. W.Va. Code 9-6-1(4).

Informal Supports - Family, friends, neighbors or anyone who provides a service to a member 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, managing money and grocery shopping.

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

Misdemeanor - A serious criminal offense designated as a misdemeanor by state or federal law.

NAPIS (National Aging Program Information System) - Annual performance reporting requirements established by the Administration on Aging for Older Americans Act programs. The system includes the State Program Report (SPR).

Neglect - (WV Code §9-6-1) The a) 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 b) 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 county aging provider agencies for the delivery of aging services, in lieu of bidding out the provision of 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 or higher is considered high nutritional risk. Nutritional screening data is a federal collection requirement of the National Aging Program Information System (NAPIS), found in the Federal Register, Volume 59, No. 188, September 29, 1994.

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.

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 and service delivery (Congregate Respite, In-Home Respite) and prioritize and provide services based on those with the highest need, based on the SAEF.

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 ideally be given the opportunity for self-identification and are allowed to designate all categories that apply to them. (AoA Title III/VII Reporting Requirements Appendix – http://www.aoa.gov.)

Services Assessment and Evaluation Form (SAEF) - A Bureau assessment form which contains service recipient's information, such as demographics, income, nutritional assessment, ADL and IADL needs, etc. This form must be fully completed for each individual who receives FAIR in-home or congregate services.

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.

Social Assistance Management System (SAMS) - WV Bureau of Senior Services official web-based data collection application utilized for service recipient tracking and reporting service delivery.

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 fee schedule and self-declaration of income. For FAIR, the state cost share is based on the income of the care receiver, or, in the case of a married couple, the combined income of the care receiver and spouse, according to the current State Cost Share Schedule. (Refer to Policy Section XXI on State Cost Share.)

State Units on Aging (SUA) - Please refer to the Bureau dictionary of key terms.

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.

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

WV Aging & Disability Resource Network (ADRN) (and partner agencies) – A network of professionally trained counselors who assist seniors, persons with a disability, their families and professionals with questions about long-term care services and supports and find resources and coordinate services that may allow individuals to remain at home and active in the community for as long as possible.

WV Bureau of Senior Services (The 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 age sixty (60) and over to assist with protecting their homes, income security, access to healthcare and other benefits and their autonomy

III. Provider Agency Requirements and Office Criteria

To provide FAIR 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. Maintain a list of the board of directors and annually submit to the AAA a Board Certification Form. (Refer to Policy Section XV.)
6. Maintain a list of all agency staff, which includes their qualifications.
7. Have written policies and procedures for processing service recipient grievances, including the service recipient's right to appeal adverse actions.

8. Have written policies and procedures for processing staff complaints.
9. Have written policies and procedures for the discontinuation of a service recipient's services.
10. Have office space that allows for service recipient confidentiality.
11. Have an Emergency Contingency Services Operation Plan (ECSOP) for service recipients and office operation. (Refer to Policy Section XVI.)
12. Meet Americans with Disability Act of 1990 (ADA) requirements for physical accessibility. (Refer to 28CFR36, as amended.)
13. Be readily identifiable to the public.
14. 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.)
15. Maintain an agency secure (HIPAA compliant) e-mail address for communication with the Bureau and AAA.
16. Be open to the public at a location within the county at least forty hours per week. Observation of state and federal holidays is at the provider agency's discretion.
17. Contain space for securely maintaining service recipient and personnel records.
18. Maintain a contact method during any hours of service provision.
19. Provide the Bureau with a contact phone number for the Director (or designee) for emergencies.
20. Maintain on file a completed Confidentiality Agreement for each board member (Attachment 1), employee and volunteer (Attachment 2). Review annually with employees, volunteers and board members.
21. Employ qualified and appropriately trained personnel who meet minimum standards for each program. (Refer to Policy Section VIII on staff training.)
22. Furnish information to the WV Bureau of Senior Services, as requested, as per the Notification of Grant Award (NGA).
23. Maintain records that fully document and support the services provided.
24. Maintain a list of current service recipients.
25. Maintain a fully completed Services Assessment and Evaluation Form (SAEF) for all service recipients that receive a Bureau funded service. All fields of the Services Assessment and Evaluation Form (SAEF) must be fully completed in order to be reimbursed for services as per program requirements. (Please refer to Attachment 3 for SAEF completion instructions for FAIR.)
26. Enter all service recipient services that are funded by the Bureau into the SAMS/Harmony system.
27. Follow the Bureau policy regarding prioritization of services. (Refer to Policy Section XX.)
28. Follow the WV Bureau of Senior Services' state cost share policy (Refer to Policy Section XXI)
29. Have an annual consolidated agency budget.

30. Develop a two-year plan of service operations.
31. Have public meetings to receive input from seniors and other interested parties regarding services they want the senior service program to provide. Public comments should be considered and incorporated within the two-year plan.
32. Annual audit must be presented by the auditor to the agency board of directors. (Refer to NGA for details on required audits.)
33. Must have written policies and procedures in effect regarding whistle-blowers and the intentional destruction of internal documents per Sarbanes-Oxley Act.
34. Must have written policies and procedures in effect regarding document retention and destruction (Refer to Sarbanes-Oxley Act http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf and Policy Section IV.)
35. 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.

IV. Service Recipient Records/Documentation Requirements

Bureau contract provider agencies 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 agency maintained in a confidential manner, in accordance with applicable state and federal laws, rules, regulations, policy and ethical standards. Provider agencies 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 agency 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. A fully completed Services Assessment and Evaluation Form (SAEF) is also required for reimbursement. (Refer to Attachment 3 for SAEF completion instructions.)

Provider agencies are allowed to utilize electronic signatures in accordance with this policy and state and federal regulations regarding such. An original signature must be obtained from the service recipient before the first initial service can be provided and maintained on file. If a service recipient's signature varies after time, the provider must obtain a new signature on file. Documents electronically signed are part of the service recipient's legal service record. Provider agencies 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 and signed or initialed per the policy for each particular service. Adequate safeguards must be maintained to protect against improper or unauthorized use and sanctions (i.e., reprimands, suspension, termination, etc.).

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.

The policy must also ensure that access to a hard copy of service records can be made available to the AAA and Bureau staff and others who are authorized access to service records by law.

Provider agencies must keep documentation for services provided to service recipients such as rosters, SAEFs, In-Home Respite Plan, Activity Schedules, signature sheets, log sheets, Personal History documents, and any other required service documentation for a period of five years after the discontinuation/closure of FAIR services. (If a monitoring is initiated before the expiration of the five year period, records shall be retained until the monitoring has been completed and final reports issued).

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 provider agencies.

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).

Provider agencies must agree to abide by all applicable federal and state laws, policy manuals, and other documents that govern the FAIR program, WV Bureau of Senior Services policy and procedures and state law. Provider agencies must also agree to make themselves, board members, employees, volunteers, and any and all records pertaining to recipients' services available to any audit or desk review. Provider agencies 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 to assist the agency in providing quality services to them, as well as other agency service recipients.

A. Service Recipient Rights:

FAIR service recipients are entitled to the following rights:

1. To be treated with respect and dignity;
2. To be free from discrimination based on gender, race, marital status, religious affiliation, sexual orientation, national origin, disability or age;
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 their services;
7. To take part in decisions about their services;
8. To address dissatisfaction with services through the grievance procedure (Refer to Policy Section VII, Service Recipient Grievance Rights and Procedures.)

B. Service Recipient (Caregiver) Responsibilities:

FAIR service recipients have the following responsibilities:

1. To notify the provider agency twenty-four hours prior to the day respite 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 respite plan;
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 the 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 or the Bureau;

11. To report any incidents of abuse, neglect or exploitation to the Adult Protective Services hotline at 1-800-352-6513 or to the provider agency
12. To report any suspected illegal activity to the local police department or appropriate authority.
13. To be in compliance with the Personal Conduct Policy. (Refer to Policy Section XI.); and
14. To adhere to all policies specific to FAIR In-Home and FAIR Congregate Programs.

This information, Service Recipient Responsibilities Agreement for FAIR In-Home (Attachment 21) and Service Recipient Responsibilities Agreement for FAIR Congregate (Attachment 20), must be provided to and signed by service recipients prior to receiving FAIR services. The service recipient (unpaid caregiver) must be given a copy of the signed Service Recipient Responsibilities Agreement. The documents must be posted in a visible area that can be seen by all service recipients at the provider agency location(s).

VII. Service Recipient Grievance Rights and Procedures

Service recipients who are dissatisfied with the services they receive from a provider agency or who have an adverse action taken (ex. reduction of services, denial of services, suspension, etc.) have a right to file a grievance within fifteen (15) calendar days of written notification of the adverse action.

Applicants who are denied eligibility for FAIR also have a right to file a grievance within fifteen (15) calendar days of written notification of the denial.

All service recipients and applicants for FAIR who are denied services or have an adverse action taken must be provided in writing a Denial/Adverse Action letter (Attachment 6) and a Grievance Form (Attachment 7).

All FAIR provider agencies will post the Grievance Procedure Policy (Attachment 8) in an area that can be seen by all applicants and service recipients at their agency location(s). Provider agencies 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 are to be maintained in an administrative file for monitoring purposes.

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 AAA and maintain a copy of the report on file.

The grievance procedure policy consists of the following levels:

A. Level One: FAIR Provider Agency

The provider agency has seven (7) business days from the date they receive a Grievance Form to hold a meeting, in person or by telephone, with the applicant or service recipient filing the grievance. 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.

B. 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 hold a meeting, in person or by telephone, 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 grievance [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. 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.

C. 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 FAIR Program Manager 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 hold a meeting, in person or by telephone, 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 directors and AAA). The decision by the Bureau is final and not appealable.

VIII. Staff Training Requirements

All new provider staff who administer the FAIR Program must notify the State Director of Alzheimer's Programs within fourteen days of hiring date and receive training on the FAIR policy manual and procedures from the Director of Alzheimer's Programs within the first thirty calendar days of employment. New staff who administer the FAIR Program must also take the dementia care training, *The Person Comes First: A Practical Approach to Alzheimer's Care,* before providing the training to direct care workers. All provider agencies will have at least two qualified individuals who have taken the dementia care training, *The Person Comes* First, and who can present the training to their direct care staff. Qualified individuals include provider agency nurse, FAIR Coordinator, provider agency director, social worker, documented specialist in the content area and volunteers who are approved by the Bureau to provide the training.

Direct care staff who will provide FAIR In-Home Respite and FAIR Congregate Respite must be at least 18 years of age. Before providing FAIR In-Home or FAIR Congregate services, each FAIR worker is required to have the dementia care training, *The Person Comes First: A Practical Approach to Alzheimer's Care* from a trained provider agency staff person, documented specialist in the content area or a qualified trainer approved by the Bureau. Additionally, every worker 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 physical demonstration exam to show the ability to perform CPR. Employees must have a current CPR card or certificate issued by the certifying entity and 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 First Aid training maintained in their personnel files.

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

4. Personal Care Skills – training on assisting service recipients with ADL's 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.

5. 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.

6. Service Recipient Health and Welfare – training must include emergency plan response, 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 recipients' special needs (e.g. mental health, specific equipment, special diets, etc.). Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

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 training annually.

8. Person-Centered Care – training on collaborative and respectful partnerships between staff and service recipients. Training must be provided by the agency RN, social worker/counselor, a documented specialist in this content area, or a qualified internet training provider.

FAIR workers must have the following additional training within twelve months of their beginning date of employment:

1. Communication skills
2. Psycho-social needs of service recipients (geriatric, social and psychological needs);
3. Service recipient rights
4. Role of the respite worker

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 trainings (or additional trainings) to ensure the health and safety of their service recipients.

A. Annual Direct Care Worker Training

CPR; First Aid; Universal Precautions; 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. Employees must have a current CPR card or certificate issued by the certifying entity and maintained in their personnel file.

2. 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 months or less. Training will be determined current in the month it initially occurred. (Example: If First Aid training was conducted May 10, 2017, it will be valid through May 31, 2018.)

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

In addition to the above training, direct care workers must receive four more hours of continuing training each year, which include topics related to caring for individuals, including issues related to providing care for individuals with Alzheimer's disease or a related dementia. Service recipient-specific on-the-job training or qualified internet training can be counted toward this requirement.

B. 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. The initial dementia care training, *The Person Comes First: A Practical Approach to Alzheimer's* Care, must be provided in person and documented as stated above. 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 and First Aid must be a card or certificate issued from the certifying entity and must be signed by both the trainer and trainee.

IX. Financial Staff

Provider agency employees who perform agency financial responsibilities such as accounts payable, accounts receivable, payroll, audits, budgets, general ledger, financial reports, etc. should preferably have an Associate's degree in accounting or business administration but at a minimum should have an Associate's degree in any subject area and at least two years of responsible accounting or bookkeeping experience. They should have the ability to perform computerized accounting and knowledge of local, state, and federal regulatory and reporting requirements. 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 Sate 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.

A. Pre-Screening

All direct access personnel (including volunteers) will be prescreened for negative findings by way of an internet search of registries and licensure databases through the DHHR's designated website, WV Clearance for Access: Registry & Employment Screening (WV CARES).

"Direct access personnel" is defined as an individual who has direct access by virtue of ownership, employment, engagement, or agreement with a covered provider or covered contractor. Direct access personnel does not include volunteers or students performing irregular or supervised functions, or contractors performing repairs, deliveries, installations or similar services for the covered provider.

If the applicant has a negative finding on any required registry or licensure database, the applicant will be notified, in writing, of such finding. Any applicant with a negative finding on any required registry or licensure database is not eligible to be employed.

Negative findings that would disqualify an applicant in the WV CARES Rule:

1. State or federal health and social services program-related crimes;
2. Patient abuse or neglect;
3. Health care fraud;
4. Felony drug crimes;
5. Crimes against care-dependent or vulnerable individuals;
6. Felony crimes against the person;
7. Felony crimes against property;
8. Sexual Offenses;
9. Crimes against chastity, morality and decency; and

10. Crimes against public justice.

B. Fingerprinting

If the applicant does not have a negative finding in the prescreening process, and the entity or independent health contractor, if applicable, is considering the applicant for employment, the applicant must submit to fingerprinting for a state and federal criminal history record information check and may be employed as a provisional employee not to exceed sixty (60) days subject to the provisions of this policy.

Applicants considered for hire must be notified by the hiring entity that their fingerprints will be retained by the State Police Criminal Identification Bureau and the Federal Bureau of Investigation to allow for updates of criminal history record information according to applicable standards, rules, regulations, or laws.

C. Employment Fitness Determination

After an applicant's fingerprints have been compared with the state and federal criminal history record information, the State Police shall notify WV CARES of the results for the purpose of making an employment fitness determination.

If the review of the criminal history record information reveals the applicant does not have a disqualifying offense, the applicant will receive a fitness determination of "eligible" and may be employed.

If the review of the criminal history record information reveals a conviction of a disqualifying offense, the applicant will receive a fitness determination of "not eligible" and may not be employed, unless a variance has been requested or granted.

The hiring entity will receive written notice of the employment fitness determination. Although fitness determination is provided, no criminal history record information will be disseminated to the applicant or hiring entity.

A copy of the applicant's fitness determination must be maintained in the applicant's personnel file.

D. Provisional Employees

Provisional basis employment for no more than sixty (60) days may occur when:

1. An applicant does not have a negative finding on a required registry or licensure database and the employment fitness determination is pending the criminal history record information; or

2. An applicant has requested a variance of the employment fitness determination and a decision is pending.

All provisional employees shall receive direct on-site supervision by the hiring entity until an eligible fitness determination is received.

The provisional employee, pending the employment fitness determination, must affirm, in a signed statement, that he or she has not committed a disqualifying offense, and acknowledge that a disqualifying offense shall constitute good cause for termination. Provisional employees who have requested a variance shall not be required to sign such a statement.

E. Variance

The applicant, or the hiring entity on the applicant's behalf, may file a written request for a variance of the fitness determination with WV CARES within thirty (30) days of notification of an ineligible fitness determination.

A variance may be granted if mitigating circumstances surrounding the negative finding or disqualifying offense is provided, and it is determined that the individual will not pose a danger or threat to residents or their property.

Mitigating circumstances may include:

1. The passage of time;

2. Extenuating circumstances such as the applicant's age at the time of conviction, substance abuse, or mental health issues;

3. A demonstration of rehabilitation such as character references, employment history, education, and training; and

4. The relevancy of the particular disqualifying information with respect to the type of employment sought.

The applicant and the hiring entity will receive written notification of the variance decision within sixty (60) days of receipt of the request.

F. Appeals

If the applicant believes that his or her criminal history record information within the State of West Virginia is incorrect or incomplete, he or she may challenge the accuracy of such information by writing to the State Police for a personal review.

If the applicant believes that his or her criminal history record information from outside the State of West Virginia is incorrect or incomplete, he or she may appeal the accuracy of such information by contacting the Federal Bureau of Investigation for instructions.

If the purported discrepancies are at the charge or final disposition level, the applicant must address this with the court or arresting agency that submitted the record to the State Police.

The applicant shall not be employed during the appeal process.

G. Responsibility of the Hiring Entity

Monthly registry rechecks – The WV CARES system will provide monthly rechecks of all current employees against the required registries. The hiring entity will receive notification of any potential negative findings. The hiring entity is required to research each finding to determine whether or not the potential match is a negative finding for the employee. The hiring entity must maintain documentation establishing no negative findings for current employees. NOTE: This includes the Office of Inspector General List of Excluded Individuals and Entities (OIG LEIE) check.

H. Record Retention

Documents related to the background checks for all direct access personnel must be maintained by the hiring entity for the duration of their employment. These documents include:

1. Documents establishing that an applicant has no negative findings on registries and licensure databases.

2. The employee's eligible employment fitness determination;

3. Any variance granted by the Secretary, if applicable; and

4. For provisional employees, the hiring entity shall maintain documentation that establishes that the individual meets the qualifications for provisional employment.

Failure of the hiring entity to maintain state and federal background check documentation that all direct access personnel are eligible to work, or employing an applicant or engaging an independent contractor who is ineligible to work may subject the hiring entity to civil money penalties.

I. Change in Employment

If an individual applies for employment at another long term care provider, the applicant is not required to submit to fingerprinting and a criminal background check if:

1. The individual previously submitted to fingerprinting and a full state and federal criminal background check as required by this policy;

2. The prior criminal background check confirmed that the individual did not have a disqualifying offense;

3. The individual received prior approval from the Secretary to work for or with the health care facility or independent health contractor, if applicable; and

4. No new criminal activity that constitutes a disqualifying offense has been reported.

The WV CARES system retains all fitness determinations made for individuals.

XI. Personal Conduct Policy

Individuals who display inappropriate, disruptive and/or threatening behaviors on a regular basis, despite staff's attempt to mediate and counsel, may be suspended from visiting 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, if doing so does not present a health and safety risk for staff.

Any suspensions require documentation of any and all attempts to mediate the behavior and a formal letter of action to the service recipient with a Grievance Form (Attachment 7). Provider agencies are required to immediately notify the Bureau and the board of directors of any suspensions.

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

XII. Voluntary Program Termination or Agency Closure (Notification of Grant Award Amendment or Termination)

A provider agency may terminate participation in the FAIR Program with sixty calendar days' written notification of voluntary termination. The written termination notification must be submitted to the Bureau, to both the Commissioner and the Director of Alzheimer's Programs. The provider agency must also provide a complete list of all current FAIR service recipients and indicate which FAIR service(s) they receive. The provider agency must work with the Bureau on assets, 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.

XIII. Involuntary Program Termination or Agency Closure for Cause (Notification of Grant Award Amendment or Termination - NGA)

The Bureau may administratively terminate a county provider agency from participation in the FAIR Program, at any time, for violation of the rules and regulations, for non-performance or for the conviction of any crime related to service delivery. If the provider agency is a corporation, its owners, officers, or employees who have violated the rules and/or regulations or have been convicted of a crime related to health care delivery, may likewise be excluded from further participation in FAIR. 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 FAIR 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 agency. This contract does not renew 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 FAIR funds and/or services.

XV. Board of Director Requirements

The board of directors for any provider agency that wishes to receive 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 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 agency organized as a nonprofit corporation must also meet, at a minimum, the following Bureau requirements:

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

    a. Two individuals sixty 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 representatives of agencies located within the provider agency's service area and/or professionals (e.g., attorney, CPA, physician, 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 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. Term Limits - Board members can serve no more than ten consecutive years. Elected officials at the discretion of the agency may be exempt from board term limits as long as they are holding office.

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 year after serving as a board member. Provider agency employees cannot serve as a board member for at least one year from their agency employment end date.

5. Immediate family members (parents, children, siblings, spouse, parents-in-law, children-in-law, grandparents, grandchildren, step-parents, 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.

6. Each board member will be required to complete at least one board training in a two-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 are to be sent to the AAA within one week of approval.

9. Annually complete a Board Certification Form (Attachment 10) and submit to the AAA by July 1. (See Board Certification Form Instructions, Attachment 10.)

The AAA and/or Bureau will review the bylaws of the provider agency when it monitors the agency and will have the authority, if necessary, to request modification of the bylaws 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 at www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=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 and the Bureau. The ECSOP describes how contingency services are provided to eligible service recipients during times of inclement weather and/or natural disasters.

The ECSOP is to be submitted to the AAA annually. Regarding FAIR, the ECSOP 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 general 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). (Cooperate with county health departments on county emergency plans.)

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 days or ten percent (10%) of the regularly scheduled days of service operations in any month shall be reviewed by the Bureau for possible repayment of corresponding budget amounts, as outlined in the NGA, or for adjustment in financial awards in the fee-for-service programs.

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 FAIR service allowed per week is sixteen. If a care recipient is receiving sixteen hours of service per week, there must be a note in that service recipient's file documenting the reasons for providing maximum service hours.

FAIR services may be provided with other in-home programs, including, but not limited to, Lighthouse, Medicaid Aged and Disabled Waiver, Medicaid Personal Care, Title III-B Personal Care, hospice care, and VA in-home 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.

Title III-E respite and FAIR may be provided to the same service recipient, but not in the same month. Any exception to this rule must be approved by the Director of Alzheimer's Programs at the Bureau. Provider agency must ensure that state cost share income for FAIR and federal cost share income for Title III programs are recorded separately and handled according to each program's policies.

XVIII. Documentation

All FAIR 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.

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

All services must be entered into SAMS by the 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.

XIX. Provider Agency Billing

FAIR services are to be billed monthly. Invoices will be sent to the Bureau. All invoices are due to the Bureau on the tenth (10th) calendar day of each month. Additionally, a SAMS Roster 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 ninety calendar days.

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

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

¼ hour = .25 Unit

½ hour = .50 Unit

¾ hour = .75 unit

1 hour = 1 unit

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

XX. Prioritization of Services

The following services must be prioritized based on SAEF scores for each service, and service recipients must be served by prioritization processes established by the provider agency board of directors, using the SAEF.

- FAIR In-Home Respite
- FAIR Congregate Respite

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

XXI. State Cost Share

FAIR is a state-funded program, and there is a requirement that families receiving FAIR must share in the cost of the service, using the current state cost share fee schedule based on the individual income of the care receiver or, in the case of a married couple, the combined income of the care receiver 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 income of the care receiver or care receiver and spouse. Other household members' incomes are not to be considered. Spouse's income is not counted, if there is a legal separation. An individual or married couple's 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 (Attachment 11). Medical expenses may include insurance premiums, copays, prescriptions, dental, etc. Medical expenses can vary, and provider agencies should use their professional judgment in determining 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 are to be pooled with Lighthouse state cost share funds and utilized to provide additional hours of service in either FAIR or Lighthouse at the appropriate hourly rate in the county where the 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 sixteen hours per week. FAIR state cost share income may be carried over to the following fiscal year. It must be utilized by June 30 of the fiscal year following the fiscal year in which it was collected. The Bureau may change the state cost share schedule at its discretion.

If it is determined that paying the appropriate state cost share would cause a hardship for the care receiver, the reasons for the hardship should be clearly documented in the service recipient's file and an hourly fee worked out that is acceptable to both the provider agency and the service recipient. A Hardship Waiver may be granted and needs to be reevaluated annually. Hardship waivers should be limited.

The provider agency is responsible for averaging a minimum of $1.00 collected for each hour of FAIR services provided. At the end of the fiscal year, total state cost share fees 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.

Service recipients must be prioritized (Refer to Policy Section XX) and must be made aware of the share of costs that the care receiver will be charged for the services provided. At the end of each month, all FAIR service recipients will receive the State Cost Share Invoice (Attachment 12), detailing services provided and the share of the cost of those services, which they are expected to pay. If a service recipient chooses not to participate in cost sharing, the provider agency, following 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 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 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). 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.) 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 FAIR service recipients. For every initial assessment and annual reassessment conducted for FAIR, the provider agency may deduct the current approved amount from current year state cost share income to help offset non-billable costs associated with FAIR.

In order to deduct for the initial assessment, the service recipient must actually 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 FAIR. Deductions are limited to one assessment per year, unless the service recipient is getting services through both Lighthouse and FAIR. In those instances, provider agency may deduct the current approved amount annually for the

Lighthouse assessment/reassessment and the current approved amount for the FAIR assessment/reassessment. 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's office for fiscal monitoring purposes. It does not have to be submitted with the annual State Cost Share Accountability Form (Attachment 13).

The amount of state cost share income deducted for assessments and reassessments will be reported annually to the Bureau on the State Cost Share Accountability Form (Attachment 13).

XXII. FAIR Program

In the FAIR Program, each Title III-B provider agency has the flexibility to design and implement a respite schedule for the service recipient and an activity plan for the care receiver that best meet the needs of those individuals. The only restrictions are those described in the eligibility requirements for FAIR In-Home and FAIR Congregate services and the training standards listed in Policy Section VIII for respite workers.

Administrative costs are included in the cost reimbursement. Provider agency match is to be $1,000 annually and can be cash or in-kind non-federal sources not used to match other programs. Local cash (not state cost share income), state funds (including LIFE), and in-kind are all legitimate match. Costs must be in support of FAIR services.

A. FAIR In-Home

FAIR In-Home is a respite service provided in the home setting for unpaid caregivers of individuals with a written diagnosis of Alzheimer's disease or a related dementia. It gives the caregiver a temporary break from the responsibilities of caregiving. It also provides socialization, stimulation and companionship for the individual with dementia through an Activity Plan (Attachment 14) developed for that individual, based on his/her interests and abilities as defined in the Personal History (Attachment 19).

Services must be provided by a trained worker employed by the county provider agency. The worker may be any qualified and properly trained individual, with the exception of the spouse or primary caregiver of the care receiver (the individual with Alzheimer's or a related dementia). Each provider agency will determine whether or not, as part of the activity plan, the care receiver may be transported by the FAIR worker. If it is allowed, then the provider agency will also determine by what means the care receiver may be transported (provider agency van, care receiver's vehicle, worker's vehicle or other means of transportation) and any restrictions on where the

worker and care receiver may go. Also, if transporting the care receiver is allowed, provider agency assumes all responsibility for the safety of the care receiver.

FAIR In-Home Respite Fund Identifier: FAIR, State Cost Share, LIFE, Local

Service Unit: 1 hour

Service Limit: FAIR respite is limited to a maximum of sixteen hours of respite service per week, which would include any congregate respite hours of service.

Eligibility Requirements: There must be an unpaid caregiver over the age of eighteen (the service recipient) of an individual of any age with a written diagnosis of Alzheimer's disease or a related dementia. The care must be provided in West Virginia.

Documentation Requirements: A worker note that includes the date of service, beginning and ending time, care receiver name, service recipient (unpaid caregiver) signature, staff signature and a brief description of the activities provided must be documented and maintained by the provider agency in the service recipient's file. A Personal History (Attachment 19) for the care receiver must be completed and an Activity Plan (Attachment 14) for the care receiver developed based on the Personal History. Service recipient must read, agree to and sign the In-Home Service Recipient Responsibility Agreement (Attachment 21), which must also be signed by the agency representative. Service recipient will receive a copy of the signed Service Recipient Responsibility Agreement. Service recipient must also read, agree to and sign the Personal Conduct Policy. A fully completed SAEF is required to enter the service recipient into the SAMS system.

Reassessment Requirements: Each service recipient will be reassessed at least annually, more frequently if needs or income of the service recipient or the care receiver change. Reassessment includes a home visit, completion of a new SAEF and determination of appropriate state cost share. The Personal History must be updated annually or more frequently if the care receiver's personal information changes. The Activity Plan will be updated at least annually or more frequently if care receiver's needs and/or preferences change. The Activity Plan is a fluid document that can be updated any time it is appropriate to do so, based on new information from the direct care worker or the service recipient (unpaid caregiver). Updates to the Personal History or Activity Plan must be dated and initialed by the agency representative. **The only new document required at each reassessment is a SAEF.**

B. FAIR Congregate

FAIR Congregate is a respite service, delivered by the provider agency in a community setting, for unpaid caregivers of individuals with a written diagnosis of Alzheimer's disease or a related dementia. It gives the service recipient (unpaid caregiver) a temporary break from the responsibilities of caregiving. It also provides socialization, stimulation and companionship for the individual with dementia through an activity schedule, developed for all congregate respite participants. The activity schedule will

be modified to reflect each FAIR care receiver's abilities and preferences, as defined in the Personal History.

Services must be provided by a trained worker employed by the county aging provider agency. The worker may be any qualified and properly trained individual, with the exception of the spouse or primary caregiver of the care receiver (the individual with Alzheimer's or a related dementia).

To be approved to provide congregate respite through FAIR, the provider agency must meet criteria established by the Bureau of Senior Services that include:

1. Identification of need
2. Description of site
3. Maximum number of individuals projected to be served at the congregate respite site at any one time
4. Projected hours of operation
5. Plan for dementia-specific programs and activities
6. Staffing plan, including required training

Any provider agency interested in establishing a congregate respite program that would utilize FAIR funding should follow detailed proposal guidelines and submission instructions (Attachment 15). The Bureau reserves the right to accept or reject any proposals, in part or whole, at its discretion. The FAIR award cannot be used for capital improvements.

Provider agencies previously approved and providing FAIR Congregate Respite may continue that service, unless otherwise notified by the Bureau.

FAIR Congregate Respite Fund Identifier: FAIR, State Cost Share, LIFE, Local

Service Unit: 1 hour

Service Limit: FAIR respite is limited to a maximum of sixteen hours of respite service per week, which would include any in-home respite hours of service.

Eligibility Requirements: There must be an unpaid caregiver over the age of eighteen (the service recipient) of an individual of any age with a written diagnosis of Alzheimer's disease or a related dementia. The care must be provided in West Virginia.

Documentation Requirements: A sign-in sheet that includes the date of service, beginning and ending time, care receiver name, service recipient signature (unpaid caregiver), and staff signature must be documented and maintained by the provider agency in the service recipient's file. A Personal History (Attachment 19) for the care receiver must be completed and maintained in the service recipient's file. All fields of the Personal History that apply to the congregate setting are to be completed. The service recipient must read, agree to and sign the Congregate Service Recipient Responsibility Agreement (Attachment 20), which must also be signed by the agency representative. The service recipient will receive a copy of the signed Service Recipient Responsibility Agreement. Service recipient must also read, agree to and sign the

Personal Conduct Policy. An Activity Schedule that has activities scheduled on a daily basis and takes into account each care receiver's interests and abilities must be maintained by the provider agency and posted in the congregate respite center. A fully completed SAEF is required to enter the service recipient (unpaid caregiver) into the SAMS system.

Reassessment Requirements: Each service recipient will be reassessed at least annually, more frequently if needs or income of the service recipient or the care receiver change. Reassessment can be conducted in the congregate setting. It must include completion of a new SAEF. The Personal History must be updated annually or more frequently if the care receiver's personal information changes. Updates to the Personal History must be dated and initialed by the appropriate agency representative. The Activity Plan will be reviewed at the annual reassessment, and changes made if the care receiver's needs and/or preferences have changed. Changes to the Activity Plan must be dated and initialed by the person conducting the reassessment. **The only new document required at each reassessment is a SAEF.**

C. Job Description

Each provider agency will have a job description specifically for FAIR In-Home Respite that reflects the duties and responsibilities of workers providing respite through this program (Sample: Attachment 18). Agencies providing FAIR Congregate Respite must have a FAIR Congregate Respite job description (Sample: Attachment 17).

D. Diagnosis Requirement

Prior to providing FAIR services, the provider agency must have in hand a written diagnosis of Alzheimer's disease or a related dementia for the care receiver, signed by a physician, physician's assistant or nurse practitioner. An electronic signature that adheres to requirements in Policy Section IV is acceptable. A faxed copy of the written diagnosis is also sufficient to initiate and provide FAIR. A sample letter to the physician requesting confirmation of the diagnosis is included (Attachment 16).

E. Personal History

The Personal History, Facts and Insights Form (Attachment 19) must be completed, to the extent possible, at the time of the initial assessment, when the SAEF is completed. The family caregiver, other family members and, **whenever possible**, the person with dementia, should all provide input into completing this form. As new information about a care receiver is learned, it should be added to his/her personal history.

Direct care workers should have access to completed personal histories of the individuals for whom they are providing care. The provider agency will determine whether a copy of the history will be kept in the care receiver's home and/or in an accessible file in the office. In all cases, a copy of the form should be maintained in the service recipient's file.

F. Activity Plan

With input from the service recipient and the care receiver (person with dementia) and using the completed Personal History, the provider agency will determine activities for the care receiver that would encourage socialization and stimulation and provide companionship. The Activity Plan must be shared with the service recipient for signature, and a copy of the plan maintained in the service recipient's file.

The Activity Plan is a fluid document that can be updated any time it's appropriate to do so. Updates do not require a whole new plan. Inform the service recipient of all proposed changes. Document that the service recipient approved them; then simply initial and date the changes.

G. Service Recipient Responsibility Agreement

Prior to receiving services through FAIR, the service recipient must read, agree to, and sign the appropriate Service Recipient Responsibility Agreement. There is an agreement for in-home respite (Attachment 21) and one for congregate respite (Attachment 20). The agreement will then be signed by the agency representative. The service recipient will be given a copy of the agreement, and the original will be placed in the service recipient's file.

H. Supplemental Log

Each month, a supplemental service recording log (Attachment 23) with the following information must accompany the invoice for that month's services:

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

You must use either the supplemental log (Attachment 23) or, preferably, the SAMS Monthly Services Roster. On whichever form you use, please record ***service recipient (unpaid caregiver) names only***.

I. 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. Alzheimer's or related dementia diagnosis for the care receiver
4. Care receiver's estimated income
5. Signed Service Recipient Responsibility Agreement
6. Signed Personal Conduct Policy
7. Personal history of the care receiver
8. Activity plan for the care receiver/Activity schedule for congregate respite
9. A copy of the in-home worker's notes for at least the last three months
10. Documentation of hardship if service recipient has been exempted from state cost share
11. Documentation of need if service recipient is receiving maximum hours of service per week
12. Evidence that the service recipient has read and approved worker's notes

J. Worker Notes

Respite is different from most other services. The service recipient is the client, and the primary objective is to give the service recipient a regular break, knowing that the care receiver is safe and being cared for by a trained worker. A second objective, however, is just as important – to ensure that the time spent with the care receiver is focused on that individual to the fullest extent possible, making the hours spent with the care receiver the best they can be, regardless of the stage of the illness or capabilities of the care receiver. Therefore, FAIR workers will keep a daily log of activities engaged in with each care receiver. Worker notes (service log) should be brief but should reflect activities defined in the care receiver's Activity Plan. It should be a record of what the two of them actually did together. Activities do not need to be tied to any specific time increments. For congregate respite, there should also be a brief note each day, documenting the participation of the FAIR care receiver in activities for that day.

Provider agencies must use the worker notes form for in-home respite (Attachment 22). The worker notes form should include the following:

1. Days and hours of service
2. Space for notes
3. A record of what the worker and care receiver actually did together
4. Evidence of care receiver's participation to the extent possible
5. Space for signatures – Service recipient and agency representative

To ensure that all service recipients have read the worker notes, all provider agencies will use one of the following options or a combination of the following options to document that. The worker notes will become a part of each service recipient's file.

Option 1: Service recipient is there when worker arrives or leaves: Service recipient initials log at least weekly and signs at least twice monthly.

Option 2: Service recipient is not there when worker arrives or leaves. What you can do:

1. The service log stays in the home, and the service recipient initials it at least weekly and signs at least twice monthly. Worker returns the signed log to her/his supervisor. (The initials and signature may always be a few days behind, but there will be documentation that the service recipient has read the notes.)
2. The service log remains in the home only until the worker's next visit. The service recipient signs the log from the previous service day, and the worker returns the log, one service day behind, to her/his supervisor.
3. Worker turns in the service logs as determined by the provider agency. Originals are kept in the service recipient's file. A copy of the log is mailed with the monthly invoice for signature and returned with payment. Signed copies are kept with the originals.
4. The service recipient may go by the office to read and sign the worker's notes. This would necessitate the service recipient stopping by the office at least monthly.
5. If getting the service recipient's signature is causing an undue hardship for the provider agency and/or the service recipient, provider agency staff will call the service recipient at least monthly to discuss the worker notes. Documentation of that call – date of call, name of caller and who the caller talked to – is entered into the service recipient's file, including any comments made by the service recipient concerning the FAIR program and the care his/her loved one is receiving.

K. Reporting

FAIR services must be reported using the Harmony/SAMS Client Tracking Software. A fully completed SAEF is required to enter the FAIR service recipient into the SAMS system. 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 FAIR service must be documented in SAMS using the service code **FAIR Respite – In-Home or FAIR Respite - Congregate** and the fund identifier of **FAIR, State Cost Share, LIFE** or **Local** depending on the funding used to provide the service. Service units documented must be rounded to the nearest quarter of an hour (.25, .50, .75).

XXIII. Monitoring of FAIR Services

Providers of FAIR services will be monitored at least every twelve months by the Bureau to document continuing compliance with policy requirements in this manual and in any grant agreements. Monitoring may include onsite visits, desktop monitoring, home visits or telephone interviews with service recipients and/or interviews with staff. FAIR service recipient records, personnel records and all other documents related to the FAIR program will be provided upon request. Review findings should show what the provider agency is doing well and where the FAIR Program could be improved.

Negative review findings will lead to a Plan of Correction, payback of grant funds, no reimbursement, or, in severe cases, loss of privileges to provide FAIR services.

A Plan of Correction will be requested when review findings, as evidenced by failure to follow program policies and procedures, indicate that changes need to be made to bring the FAIR program in line with policies. Agencies will be given forty-five days to respond when a Plan of Correction is requested. Technical assistance will be provided as need and requested. In order to correct deficiencies, conditions can be added to an NGA.

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 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 15% and 33% of annual award during the prior grant year.
2. Services provided that do not meet policy requirements
3. Performance deficiencies showing that eligible service recipients in your service area are underserved.
4. Evidence that state cost share is not being spent appropriately.
5. Employees who do not meet the requirements for the provision of services.
6. Services provided that do not meet the documentation requirements.
7. Services provided to individuals who do not meet the eligibility requirements.
8. Failure to average $1.00 per hour of FAIR/Lighthouse 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 your grant award and corrective action:

1. Expiring more than 33% of your award during the prior grant year.
2. Severe performance and review deficiencies, indicating a health and safety concern for service recipients or care receivers that are not corrected immediately.
3. Failure to report and adhere to a specified plan of correction.
4. Other severe review deficiencies.
5. Falsification of documents.
6. Accumulation of any two or more conditions that may result in a downward adjustment as defined above.

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.

If justification for a reduction or termination of award is found, you will be notified, with explanation, in writing. You would then have five 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 Director of Alzheimer's Programs.

If you lose the privilege to provide FAIR services within your county, the privilege will be offered to another Title IIIB provider agency within the aging network, based on that agency's review history and location.

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

Monitoring Tools can be found on the WV Bureau of Senior Services website at www.wvseniorservices.gov.

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