West Virginia

Bureau of Senior Services

Aging Well in
West Virginia

Family Alzheimer's In-Home Respite (FAIR) Policy Manual



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FAIR Attachments

Number	Form Name	Instructions
1	Confidentiality Agreement – Board Member	Yes
2	Confidentiality Agreement – Employees and Volunteers	Yes
3	SAEF	Yes
4	FAIR Service Recipient Responsibility Agreement – Congregate	Yes
4A	FAIR Service Recipient Responsibility Agreement – In-Home	Yes
5	Rights and Responsibilities Posting	Yes
6	Denial/Reduction of Services Action Letter	Yes
7	Grievance Procedures Form	Yes
8	Grievance Procedures Posting	Yes
9	Personal Conduct Policy Posting and Signature Form	Yes
10	Board Certification	Yes
11	State Cost Share Chart	No
12	FAIR State Cost Share Invoice	Yes
13	Approved Program Expenses	No
14	FAIR Activity Plan	Yes
15	FAIR Congregate Respite Guidelines	No
16	FAIR Sample Letter to Physician	Yes
17	FAIR Job Description Congregate	No
18	FAIR Job Description In-Home	No
19	FAIR Personal History	Yes
20	FAIR Worker Notes	Yes
21	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 is 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 two Administration on Aging Alzheimer's Disease Demonstration Grants. 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. **Therefore, 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. This in-home respite service is delivered 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 activity plan developed for that individual, based on his/her interests and abilities as determined by the Personal History. In approved instances, congregate respite services may also be provided through FAIR.

FAIR services are available to individuals 18 and older 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 (and spouse when the individual with dementia is married), minus all medical expenses. (Refer to Policy Section XXIV 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, individuals at risk for institutional placement and individuals residing in rural areas. (Refer to Section II, Definitions: Target Population for FAIR and Policy Section XXIII, Prioritization of Services and Waitlists.)

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, **if** 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 provides care to an individual with Alzheimer's or a related dementia and 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 unpaid caregiver** (not the individual with a diagnosis of Alzheimer's or a related dementia).

Care Receiver - Person for whom care is provided, 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. If granted by the provider agency, a hardship waiver must be kept in the service recipient's chart. Hardship waivers do not exempt the provider agency's obligation to average 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 personal history.

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

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 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 – 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 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 with listed experience that would designate that individual as a specialist in a designated area.

Domestic Partner – Adult 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 that details who is responsible for what in the event of an emergency, whether natural or human-caused.

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.

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 queueing, 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) & (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 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. 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 assist an individual with living independently in a community. Examples: light housework, ability to use a phone, access to transportation, managing money and grocery shopping.

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

Lighthouse – A state funded program to provide in-home personal care services for individuals over 60 who meet functional eligibility requirements and do not qualify for Medicaid in-home care programs.

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 county aging 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 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 name, Social Security number, biometric records, etc., alone or

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 given 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 to those with the highest need, based on the SAEF, plus 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'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. For FAIR, a fully completed SAEF is Levels 1, 2 and 4.

Social Assistance Management System (SAMS) – The Bureau's official web-based data collection application utilized for service recipient tracking, 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 use of a state cost share fee schedule and self-declaration of income. For FAIR, 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, 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 legislature to administer, manage, design and advocate for benefits, programs and services for the elderly and their families.

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 online.

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 provider 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 (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 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 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. 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 FAIR Coordinator position within two days of ending employment of a FAIR Coordinator.
7. Have written policies and procedures for processing service recipient grievances, including the service recipient's right to appeal denial or reduction of services.
8. Have written policies and procedures for processing staff grievances.
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 the 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 (40) hours per week. Observation of state and federal holidays is at the provider agency's discretion. The main focal point center for the delivery of comprehensive services must be open at least forty (40) hours per week.
17. Contain space for securely maintaining service recipient and personnel record and have written policies regarding a service recipient's right to request those records.
18. Maintain a contact method during any hours-of-service provision.
19. Provide the Bureau with a contact phone number for the Director and a 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 required fields of the SAEF must be fully completed 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 operating system.
27. Follow the Bureau policy regarding prioritization of services. (Refer to Policy Section XXIII.)
28. Ensure that services are delivered and documentation meets regulatory and professional standards before an invoice is submitted.
29. Must have computer(s) for staff with HIPAA secure email accounts, UMC web portal software, internet access, and current (within the last five years) software for spreadsheets.
30. Follow the WV Bureau of Senior Services' state cost share policy (Refer to Policy Section XXIV).
31. Develop and submit to the Bureau an annual budget for FAIR and Lighthouse, 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-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 the 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. Utilize any database system, software, etc., compatible with/approved and/or mandated by the Bureau.
38. Must have written policies and procedures for the use of personally and agency owned electronic devices which include, 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.

39. Must participate in all mandatory meeting/training sessions.
40. 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.
41. 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 Records/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 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 the best interests of the service recipient. 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. An electronic signature or a faxed signature is acceptable to initiate FAIR services. A fully completed Services Assessment and Evaluation Form (SAEF) is also required for reimbursement. (Refer to Attachment 3 for SAEF completion instructions).

Provider agencies may utilize electronic signatures in accordance with this policy and state and federal regulations regarding such. 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, 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.

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. Rubber stamps are prohibited as a means of signature and/or for authenticating a record.

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 service records by law.

For documentation that requires service recipient's signature, if the service recipient is unable to sign, a representative may sign for her/him. The representative must sign the service recipient's name and then the representative's name.

Providers must keep documentation for services provided to service recipients such as rosters, SAEFs, In-Home Respite Activity Plans, Congregate Activity Schedules, signature sheets, log sheets, Personal History documents, and any other required service documentation for a period of five years after discontinuation/closure of FAIR services. If 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. Keep all service recipient records if *not* discontinued or closed.

V. Personnel Record Requirements

Personnel documentation, including training records, licensure, confidentiality agreements, driver's licenses, criminal investigation background checks (CIB), and Form I-9's, 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 on individual professional license requirements. They must be kept current. Social workers and RN's must have a current license at the time of providing services, 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 all records pertaining to recipients' services available to any audit or desk review. Providers 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.

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 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 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 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 needs; to be made aware of available supports; and to respect their desire to live where and with whom they choose.

B. Service Recipient (Unpaid 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, not home due to an appointment, trip, etc.).
6. To maintain a safe home environment for the provider agency to provide in-home respite.
7. To maintain safe access to the home for provider agency staff who are providing in-home respite.
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 WV Bureau of Senior Services.
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 comply with the Personal Conduct Policy. (Refer to Policy Section XI.).

14. To adhere to all policies specific to FAIR In-Home and/or FAIR Congregate Programs.

The Service Recipient Responsibility Agreement for FAIR In-Home (Attachment 4A) or Service Recipient Responsibility Agreement for FAIR Congregate (Attachment 4), 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 Responsibility Agreement. The above list of service recipient responsibilities must be posted at provider agency location(s) in a visible area that can be seen by all who enter.

VII. Service Recipient Grievance Rights and Procedures

Applicants who are denied eligibility and service recipients who have had a reduction of FAIR in-home or FAIR congregate services or denial of those 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 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 for FAIR who are denied 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 FAIR 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). 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 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, provider may choose to bypass the grievance procedure and instead contact local law enforcement 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:

A. Level One: FAIR Provider Agency

The 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. 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 its 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.

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 make an initial contact to schedule a meeting by telephone (or in person if all parties are in agreement), 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 Board of Directors 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.

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 make an initial contact to schedule a meeting by telephone (or in person if all parties are in agreement), 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).

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 FAIR Program must contact the State Director of Alzheimer's Programs within fourteen (14) days of hiring date to schedule a phone training on the FAIR policy and procedures manual, to be conducted 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 new 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, other staff approved by the State Director of Alzheimer's Programs, documented specialist in the content area and volunteers who are approved by the Bureau to provide the training.

A. Initial Training: All FAIR Direct Care Workers

Direct care staff who will provide FAIR In-Home Respite and/or 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 **in-person** 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 skills-based physical demonstration. An online CPR course is allowed, if it contains a post test that includes a skills-based physical demonstration. 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 First Aid training maintained in their personnel files.

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** – 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 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.

6. **Health Insurance Portability and Accountability Act (HIPAA)** – Training must include agency staff responsibilities for securing Protected Health Information (PHI). Training must be provided by the agency RN, social worker/counselor, 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 this training annually.

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 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.

B. Ongoing training

FAIR workers must have the following additional training, provided by the FAIR Coordinator or other qualified agency staff, **within twelve months of their beginning date of employment:**

- **Communication skills** - ways to effectively communicate, both verbally and non-verbally, with individuals who have dementia
- **Psycho-social needs of service recipients** (geriatric, social and psychological needs) - recognition and management of depression, anxiety, fear, disability, pain and limitations in daily living activities
- **Service recipient rights** (See Attachments 4 and 4A and Policy Section VI)
- **Role of the respite worker** - importance of giving the unpaid caregiver a break; responsibilities of workers to individuals with dementia – engaging in activities together to the extent possible, assisting with personal hygiene, providing companionship, etc.

Every year thereafter, FAIR direct care workers must receive four (4) more hours of continuing training each year on topics related to caring 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. Topics may include but are not limited to

- Effective communication
- Understanding how to respond to specific challenging behaviors
- Safety at home
- Assistance with bathing and/or other ADLs
- Breaking tasks into smaller steps
- Keeping the focus on the person with dementia
- Writing worker notes
- Working with family members

These training requirements apply to all employees providing FAIR in-home or FAIR congregate 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.

C. Annual Direct Care Worker Training

CPR; First Aid; Universal Precautions; Recognizing and Reporting Abuse, Neglect, and 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 file. The employee must sign the card before it is placed in her/his 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 (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 months or less. Training will be determined current in the month it initially occurred.

D. 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.

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 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 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.

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 in 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 FAIR in-home service recipients. It must be maintained in 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 and/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 review and approval by 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 FAIR and Lighthouse 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 FAIR 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 participating in the FAIR 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 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 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 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 (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 representatives of agencies (with senior interests) 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 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, 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 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 and financial reports are to be sent to the AAA within one week, seven calendar days, of approval.

9. Annually complete a Board Certification Form (Attachment 10) and submit it to the AAA by October 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, 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. The 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. 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 services 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 (Ex: 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 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 FAIR service allowed per week is sixteen (16). If a service 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, in-home or congregate, 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. 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, both in-home and congregate, 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-E respite are recorded separately and handled according to each program's policies.

XVIII. Legislative Initiative 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 a state fiscal year (July 1 to June 30) basis and do not have a match requirement. 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 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 offer private pay programs and 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 FAIR services must be made aware of those FAIR 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 in SAMS

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 payback of funds for services, unless permission is granted by the Director of Alzheimer's Programs at the Bureau.

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

In SAMS, each FAIR and III-E service recipient must be linked to the care receiver. This is a requirement from the Administration for Community Living (ACL) for Title III-E and state-funded in-home caregiver programs. Each caregiver's relationship to the care receiver and other demographic data must also be completed in SAMS. All services must be entered into SAMS by the tenth 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

FAIR services are to be billed monthly. Invoices will be sent to the Bureau. All invoices are due to the Bureau by the 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 sixteen hours of FAIR services per week, even when that week includes days at the end of one month and the beginning of the next month. Any hours above the limit of sixteen per week will be billed as private pay, or the agency will cover the cost of those hours.

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 = 1.00 unit

[Examples: If a service recipient received a service for eight (8) minutes, the Roster would reflect .25 units (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 Waitlists

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 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 FAIR program, there must be a completed SAEF entered into SAMS for all persons on the FAIR In-Home or FAIR Congregate waitlist. For an individual to be counted as part of a county's FAIR 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

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 Chart (Attachment 11), 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. (Assets, savings, other property owned by the individual or any allowance or stipend that the individual or married couple receive for other services provided to them are not included.) Only income of the care receiver or care receiver and spouse is to be considered. During state review of provider records, documentation of care receiver income may be requested. Other household members' incomes are not to be considered. If there is a legal separation, spouse's income is not counted. 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% state

cost share fee may be charged. The same applies if service recipients refuse to provide documentation of care receiver income upon request.

All FAIR monies collected are to be pooled with Lighthouse state cost share funds and utilized 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 sixteen hours per week. FAIR state cost share income should be expensed for approved Lighthouse and FAIR expenses. (See Approved Program Expenses, Attachment 13.)

Fees collected and deposited from July through December of each fiscal year may be utilized for approved expenses beginning January 1 of that fiscal year. Fees collected and deposited from January through June of that fiscal year may be used beginning July 1 of the next fiscal year. 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.)

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). 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.

In addition, state cost share approved program expenses will be reported to the Bureau quarterly on the In-Home Services Budget. Reports will be due to the Bureau by October 15, January 15, April 15 and July 15 for each fiscal year.

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, unless granted a waiver by the Bureau. 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 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 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 Board approved policy, will determine whether to continue services for that service recipient, discontinue the services or 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. 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 must be reevaluated annually. Hardship waivers should be limited, when possible, based on income minus expenses.

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 the starting point.

XXV. 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.

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). Provider agency will determine whether to employ and properly train family members other than the spouse and primary caregiver to be direct care workers.

Each provider agency will also determine whether, 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) for 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 the worker engaged in with the care receiver must be completed and maintained by the provider agency in the service recipient's file.

Prior to beginning FAIR services, the provider agency must complete the following documentation, which will be placed in service recipient's file:

- **Personal History** (Attachment 19) for the care receiver – As much information as possible about the care receiver, gathered at the initial assessment, drawing on input from the unpaid caregiver and, to the extent possible, the individual with dementia (care receiver). Information can be added as you learn more.
- **Activity Plan** (Attachment 14) for the care receiver, based on the Personal History.
- **In-Home Service Recipient Responsibility Agreement** (Attachment 4A) – This agreement must be read, agreed to and signed by the service recipient and by the agency representative. The service recipient will receive a copy of the signed Service Recipient Responsibility Agreement.
- **In-Home Personal Conduct Policy** – This policy must also be read, agreed to and signed by the service recipient, who will receive a copy of the signed Policy.
- **A fully completed SAEF** (Level 1, Level 2 and Level 4) is required to enter the service recipient (unpaid caregiver) into the SAMS system.

Reassessment Requirements: Each service recipient will be reassessed at least annually, and more frequently if needs of the service recipient or income of the care receiver (or spouse) change or if deemed necessary by the Bureau. Reassessment includes a home visit, completion of a new SAEF and determination of appropriate state cost share. The Personal History must be updated annually, more frequently if the care receiver's personal information changes. The Activity Plan will be updated at least annually, more frequently if a 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 FAIR 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 activities 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). Provider agency will determine whether to employ and properly train family members other than the spouse and primary caregiver to be direct care workers.

To be approved to provide congregate respite through FAIR, the provider agency must submit documentation that meets criteria established by the Bureau of Senior Services, including

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 and staffing ratio of no more than 6:1, ideally 4:1, with plan for a second staff person to be available with as few as two care receivers.

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) for 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.

Provider agency must complete the following documentation, which will be placed in the service recipient's file, prior to providing FAIR congregate services:

- **Personal History** (Attachment 19) for the care receiver – As much information as possible about the care receiver, gathered at the initial assessment, drawing on input from the unpaid caregiver and, to the extent possible, the individual with dementia (care receiver). All fields of the Personal History that apply to the congregate setting are to be completed, if possible. Information can be added as you learn more.

- **Congregate Service Recipient Responsibility Agreement** (Attachment 4), which must be read, agreed to and signed by the service recipient and by the agency representative. The service recipient will receive a copy of the signed Service Recipient Responsibility Agreement.

- **Congregate Personal Conduct Policy** for senior center attendees – Which must also be read, agreed to and signed by the service recipient, who will receive a copy of the signed policy.

- **A fully completed SAEF** (Level 1, Level 2 and Level 4), which is required to enter the service recipient (unpaid caregiver) into the SAMS system.

- **An Activity Schedule** which has daily activities that take into account each care receiver's interests and abilities. The Activity Schedule must be maintained by the provider agency and posted in the congregate respite center.

Reassessment Requirements: Each service recipient will be reassessed at least annually (every 12 months), more frequently if needs of the service recipient or income of the care receiver (or spouse) change or if deemed necessary by the Bureau. Reassessment can be conducted in the congregate setting. It must include completion of a new SAEF. The Personal History must be updated annually, 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 Schedule will be reviewed at the reassessment, and adjustments made, if necessary, to accommodate changes in the care receiver's needs and/or preferences. Activities should be appropriate for varying levels of ability and interest. **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 you learn new information about a care receiver, that information should be added to his/her personal history.

Direct care workers should have access to any information in the care receiver's personal history that is relevant to providing care for the individual. In all cases, a copy of the personal history must 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.

For in-home respite, 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. The service recipient must be informed of all proposed changes. Document that the service recipient (unpaid caregiver) approved the updates; then initial and date the changes.

The Activity Schedule for congregate respite should be constructed so that individuals with dementia with varied interests and differing levels of functionality may all participate.

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 4A) and one for congregate respite (Attachment 4). 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/Roster

Each month, a supplemental service recording log 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. Hours of service and the days service was provided
7. Total hours of service for that month

You must use either the FAIR Supplemental Service Recording Log (Attachment 21) or, preferably, a SAMS Monthly Services Roster that includes daily entries. On either form, 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 (or care receiver and spouse)
5. Appropriate signed Service Recipient Responsibility Agreement (in-home or congregate)
6. Correct signed Personal Conduct Policy (in-home or congregate)
7. Personal history for the care receiver
8. Activity plan for in-home respite/Activity schedule for congregate respite
9. Direct care worker's notes for at least the latest three complete months of service for in-home; for congregate, activity log and worker notes for activities the care receiver engaged in and level of participation for the latest three complete months of service
10. Documentation of hardship if state cost share has been reduced or waived
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 unpaid caregiver, and the primary objective is to give the service recipient a regular break, knowing that the care receiver will be safe and cared for by a trained worker. A second objective, however, is just as important – to ensure that the time your worker spends with the care receiver is focused on that individual to the fullest extent possible, making those hours the best they can be, regardless of stage of illness or capability of the care receiver. Therefore, FAIR workers will keep a daily log of activities they engage in with each care receiver. Worker notes (service log) should be brief and, at the same time, reflect activities defined in the care receiver's Activity Plan. The notes should be a record of what the two of them did **together**. Activities do not need to be tied to any specific time increments. For congregate respite, there should 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 20) or a similar form that has the same components, as follows:

1. Agency name
2. Care receiver's name and service recipient's (client's) name
3. Days and hours of service
4. Space for notes – what the worker and care receiver did together
5. Space for signatures – Service recipient (unpaid caregiver), direct care worker and agency representative

For congregate respite, there must be a log for the care receiver that includes the above information (#'s 1, 2, 3 and 5), plus a record of the care receiver's participation in activities of the day.

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 service recipient has read and approved the notes. Worker notes will become a part of each service recipient's file.

1. **Service recipient is there when worker arrives or leaves:** Service recipient initials log at least weekly and signs at least twice monthly.
2. **Service recipient is not there when worker arrives or leaves. Your options:**
   a. 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 be a few days behind, but there will be documentation that the service recipient has read the notes.)
   b. The service log remains in the home only until the worker's next visit. The service recipient signs or initials the log from the previous service day, and the worker returns the log, one service day behind, to her/his supervisor.
   c. 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.
   d. The service recipient can go to the office to read and sign the worker's notes. This would necessitate the service recipient going to the office at least monthly.
   e. The service recipient can designate, in writing, a trusted person to read, initial and sign the notes on the service recipient's behalf. In this instance, a copy of the notes should still be mailed to the service recipient with the monthly invoice
   f. 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 read the worker notes to that service recipient. Documentation of the call – date of call, name of caller and who the caller talked to – is entered into the service recipient's file, including any comments by the service recipient regarding the FAIR program, worker's notes and/or the care loved one is receiving.
3. **For those who use CoPilot21 or other specialized software for in-home care providers**: You still must ensure that the service recipient (unpaid caregiver) has read and

approved the worker's notes. If the unpaid caregiver is not there when it is time for your worker to leave, options c, d or e above would work. Other solutions you may be using with CoPilot21 or other specialized software must document that the unpaid caregiver knows what's in the worker's notes and approves of the activities your worker and their loved one engage in together.

K. Reporting

FAIR services must be reported using the WellSky/SAMS Client Tracking System. A fully completed SAEF (Levels 1, 2 and 4) 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).

XXVI. Monitoring FAIR Services

FAIR 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 Director of Alzheimer's Programs 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 Director of Alzheimer's Programs may include home visits, telephone interviews with service recipients and/or interviews with direct care workers and other agency 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 may 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 issued 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. Providers 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 may 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 grant years.
2. Providing services that do not meet policy, documentation and/or eligibility requirements.
3. Performance deficiencies which show that eligible service recipients in your service area are underserved.
4. Evidence that state cost share is not being spent appropriately.
5. Having employees who do not meet the requirements for the provision of services.
6. Failing 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 thirty-three percent (33%) of your award during two of the last three grant years.
2. Severe performance and review deficiencies, indicating health and safety concerns for service recipients and/or care receivers, that are not corrected immediately.
3. Failing to report and adhere to a specified plan of correction.
4. 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 Director of Alzheimer's Programs.

If you lose the privilege to provide FAIR services within your county, that privilege will be offered to another Title IIIB provider agency within the aging 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 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.

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