

Family Alzheimer's In-Home Respite (FAIR) Program



Policies and Procedures Manual

May 2008

WEST VIRGINIA BUREAU OF SENIOR SERVICES FAMILY ALZHEIMER'S IN-HOME RESPITE (FAIR) PROGRAM

POLICIES

I. INTRODUCTION

Caring for someone with Alzheimer's disease or a related dementia can be extremely stressful, and family caregivers need a regular break from the demands of the job. To address this need, the FAIR Program was created, building on a similar respite program implemented in sixteen counties since 2002 through an Administration on Aging Alzheimer's Disease Demonstration Grant. Funding for FAIR was proposed by Governor Joe Manchin III and passed by the 2006 Legislature. The program began July 1, 2006. FAIR is state-funded, administered by the West Virginia Bureau of Senior Services, and available in all fifty-five counties. The respite service is delivered by county aging providers (senior centers).

II. DESCRIPTION

FAIR is designed to provide a regular break for caregivers of individuals with Alzheimer's disease or a related dementia. The client in the FAIR program is the family (unpaid) caregiver. FAIR supplements but does not replace the care provided by the unpaid caregiver. The in-home respite service is provided by a trained worker employed by a county aging provider after the care receiver has been determined to be medically eligible (written diagnosis of Alzheimer's disease or a related dementia).

III. DEFINITIONS

- A. Caregiver – Family member or other unpaid person who gets a break from caregiving responsibilities through FAIR. The caregiver is the person most responsible for the care of a loved one with Alzheimer's disease or a related dementia. 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 this respite service.
- B. Care receiver – Person with a diagnosis of Alzheimer's disease or a related dementia for whom the respite care is provided
- C. Worker – In-home worker employed by the county provider agency

IV. FAIR SERVICES

FAIR is an in-home respite service for unpaid caregivers of individuals with a written diagnosis of Alzheimer's disease or a related dementia. It also provides socialization and stimulation for the individual with dementia, through an activities plan developed for that individual, based on his/her interests and abilities. In approved instances, congregate respite services may also be provided through FAIR.

V. ELIGIBILITY FOR SERVICES

There are three criteria for eligibility:

- A. The care receiver must have a written diagnosis of Alzheimer's disease or a related dementia.
- B. There must be an unpaid caregiver.
- C. The care must be provided in West Virginia.

VI. HOURS OF SERVICE

A FAIR client can receive up to sixteen hours of respite service per week.

VII. SERVICE PROVISION

The service will 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 client's spouse or primary caregiver.

VIII. SLIDING FEE SCHEDULE

Since FAIR is a state-funded program, there is a requirement that clients be charged (if applicable), using a sliding fee schedule based on the individual income of the care receiver. All monies collected are to be used to provide additional services in the FAIR program at the same hourly rate.

IX. MATCH

The provider match is \$1,000 annually and can be cash or in-kind non-federal sources not used to match other programs.

X. WORKER TRAINING

Workers will receive a minimum of 32 hours of training within twelve months of beginning date of employment. Before providing care, FAIR workers must receive the 8-hour dementia care training, *The Person Comes First: A Practical Approach to Alzheimer Care*, and eight hours in the following training areas:

- CPR and First Aid
- OSHA standards related to blood-borne pathogens
- Care of homebound clients, to include bed making, feeding, bathing, grooming, toileting, transferring, positioning, and ambulation

Additional areas of training to be completed within 12 months of beginning date of employment must include the following Title III-E training requirements:

- Communication skills
- Psycho-social needs of clients (geriatric, social and psychological needs)
- Client rights
- Role of the respite worker

XI. JOB DESCRIPTION

Providers will have a job description specifically for respite workers or incorporate language into an existing job description for workers that relates to respite duties.

XII. REPORTING

FAIR services must be reported to the Bureau of Senior Services Client Tracking Program, using Service Code 2006 and Funding Code 29. A BIF on the family (unpaid) caregiver is required to enter the client into Client Tracking's system. Form S-1 must be completed also.

XIII. RE-EVALUATION

Each client (caregiver) in the FAIR Program will be re-evaluated at least annually (more frequently if the needs of the caregiver and/or the care receiver change) through an onsite visit and completion of a new Bureau of Senior Services Intake Form (BIF) by appropriate provider staff.

XIV. BILLING

Services will be billed monthly. The monthly invoices will be sent to the appropriate Area Agency on Aging in the format provided by the Bureau of Senior Services on the In-Home Services Invoice. Additionally, an Invoice Attachment is required that lists the names of clients and hours served during the period covered.

XV. MONITORING

Providers of FAIR services will be monitored at least annually by the Bureau of Senior Services. Monitoring may include home visits or telephone interviews with clients (family caregivers) and/or interviews with respite workers.

XVI. PROGRAM RESTRICTIONS

Neither the primary caregiver nor the spouse of the individual with dementia may be the FAIR worker.

No sub-contracting is allowed without prior approval of the Area Agency on Aging and Bureau of Senior Services.

Personal care and chores are not provided as part of the FAIR Program, unless they are delivered in the context of an activity plan for the care receiver.

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WEST VIRGINIA BUREAU OF SENIOR SERVICES FAMILY ALZHEIMER'S IN-HOME RESPITE (FAIR) PROGRAM

PROCEDURES

The following process in its entirety shall occur:

I. REFERRAL AND FOLLOW-UP

After a referral is received, the provider agency FAIR Coordinator will determine appropriateness of the FAIR Program either by telephone conversation with the applicant or by home visit. At this time, all avenues of in-home services should be explored, including Veterans Administration, Medicaid Personal Care, Medicaid Aged and Disabled Waiver, Lighthouse, private insurance, and any other in-home care programs, to ensure that caregivers and individuals with dementia can remain in their homes and communities for as long as possible.

II. HOME VISIT, COMPLETION OF BIF, DETERMINATION OF ELIGIBILITY

If the applicant is determined to be appropriate for FAIR, the FAIR Coordinator shall make a home visit (if initial contact has been by phone only). The Bureau of Senior Services (BoSS) Intake Form (BIF) shall be completed on *the caregiver*. (See BIF Instructions for further details.) The Personal History, Facts and Insights form should be completed to the extent possible on *the care receiver*. A request for diagnosis form must be sent to the care receiver's physician. It shall be filled out, signed by the physician, and returned to the provider before services can be provided in the FAIR Program. Once the diagnosis form is returned, provider will notify family caregiver of eligibility for FAIR and set a schedule and starting date.

III. SLIDING FEE SCHEDULE

After eligibility is established, the sliding fee schedule and provider agency's policy for payment shall be discussed with applicant. (Note: Only the *care receiver's* income is to be counted when determining payment for services. Household income is not considered.) Even if the applicant is not liable for payment, he/she may wish to contribute to the program.

IV. CAREGIVER RESPONSIBILITY

Prior to receiving services through FAIR, the caregiver (client) must read and sign the Caregiver Responsibility Agreement, thereby agreeing to the terms and conditions set forth in the agreement. The client will be given a copy, and the original will be placed in the client's file.

V. WORKER TRAINING

At least one staff person from each provider agency must have the train-the-trainer, dementia care course, *The Person Comes First: A Practical Approach to Alzheimer Care*. The training can be provided by Bureau of Senior Services staff or by the Alzheimer's Association. Staff who have received this training are then qualified to provide the training for all FAIR workers and for any other in-home workers deemed appropriate by the agency.

VI. PLAN OF CARE

FAIR is a respite program, and a Plan of Care is not required for this program. However, the Personal History, Facts and Insights form must be completed to the extent possible on *the care receiver* and an *Activity Plan* developed that incorporates the care receiver's interests and abilities, likes and dislikes, individual needs, and stage of the disease. The Activity Plan should indicate the types of activities the worker will engage in with the care receiver, based on the

information contained in the Personal History. Worker notes will indicate which activities they engaged in on any given day, keeping in mind that anything can be considered an activity, *as long as the focus is on the care receiver and that person, to the extent possible, is included in everything the worker does.*

VII. WORKER NOTES

Worker will keep a daily log of hours worked and what she/he did while with the care receiver. Worker notes will indicate which activities they engaged in together on any given day, keeping in mind that anything can be considered an activity, *as stated above.* The log should be signed weekly by the caregiver for whom the respite is being provided and turned in to the provider's FAIR Coordinator, who then signs and begins the billing process.

VIII. RE-EVALUATION

Each client will receive a home visit at least annually, and a new BIF will be completed on the *caregiver.* The new BIF, with correct name of client, birth date, client number, and any changes in client information, will be sent to client tracking. *If there are no changes in client's information, the new BIF will **not** be sent to client tracking.* In all cases, a copy of the BIF must be maintained in client's file. At the time of the annual home visit, any new information on the care receiver will be added to the Personal History, Facts and Insights Form.

IX. CLIENT FILES

Each client's file must include the following:

- A copy of the BIF on the caregiver
- Caregiver Responsibility Agreement
- Alzheimer's or related dementia diagnosis of the care receiver
- Personal history of the care receiver
- Activity plan for the care receiver
- A copy of the in-home worker's notes
- A copy of the BIF from each re-evaluation

FAIR SERVICE DEFINITION

Following is the definition of FAIR that will be added to the Client Tracking Dictionary when it is revised.

Name – FAIR (**F**amily **A**lzheimer's **I**n-home **R**espite)

Unit – 1 Hour

Service Code – 2006

Funding Code – 29

Form – S1

Definition – To provide brief periods of relief or rest in the home for caregivers of individuals who have Alzheimer's or related dementia.

Agency Name
Family Alzheimer's In-Home Respite (FAIR) Worker

Job Description

The Family Alzheimer's In-Home Respite Worker will report to _____ and is responsible for doing the following:

1. Complete orientation and any training required for this position.
 - Attend agency orientation
 - Take the 8-hour dementia care training from qualified instructor
 - Complete 24 hours of Title III-E training that includes CPR, first aid, OSHA training, care of homebound clients, communication skills, psycho-social needs of client, client rights, and role of the respite worker
 - (Add any other initial requirements here)

2. Get to know the care receivers assigned to you.
 - Review the completed personal history of each care receiver.
 - Add information to personal history as you learn it from caregivers and/or care receivers

3. Spend designated number of hours with the care receiver, to provide respite for the caregiver and quality time for the care receiver.
 - Monitor individual's needs in the caregiver's absence
 - Provide socialization and stimulation through selected activities (to be determined by person's interests, likes and dislikes, and abilities).
 - Assist with care as allowable in the context of the activity plan (Ex: serving a snack or prepared lunch, transferring person, assisting person to the bathroom, brushing hair, etc.)

4. Document tasks and activities engaged in with the care receiver.

5. Add any other requirements here – reporting, in-services, etc.

BUREAU OF SENIOR SERVICES INTAKE FORM (BIF)

INSTRUCTIONS FOR FAIR

1. The BIF must be completed in full, except as noted below.
2. The BIF must be completed on the *unpaid caregiver*.
3. If the caregiver is an existing client, use the current Client Number.
4. The BIF can be completed in the home or in the office.
5. The following sections of the BIF must be completed as follows (**changes are in bold print**):

CLIENT/FAIR/III-E CAREGIVER

Enter the **FAIR** Caregiver's last name, first name, and middle initial. *Use only a proper name.*
Do not use a nickname.

DATE OF BIRTH

Enter the month, day and year of the **FAIR caregiver's** birth. If the client (caregiver) is not age 60 or older, check **FAIR caregiver** in the "Eligible Under 60" section.

IF FAIR/III-E CAREGIVER

If **FAIR** caregiver, provide relationship to the *care receiver*: Husband, Wife, Son/Son-in-law, Daughter/Daughter-in-law, Other Relative, or Non-Relative.

INCOME

Check the appropriate income range *for the care receiver, or note the care receiver's income in the "Remarks" section of the BIF.* *The sliding fee schedule for FAIR is based on the individual income of the care receiver.*

ACTIVITIES OF DAILY LIVING and INSTRUMENTAL ACTIVITIES OF DAILY LIVING

For FAIR, this information does not have to be collected, unless the client (caregiver) needs assistance in any of these areas.

REMARKS

Provider agency's FAIR Coordinator must sign and date in the Remarks section.

TOTAL SCORE (ADL's and IADL's)

This does not have to be calculated, unless there is indication in the Activities of Daily Living section that the caregiver needs assistance.

TOTAL SCORE (NUTRITIONAL HEALTH ASSESSMENT)

The Nutritional Health Assessment does not need to be completed for FAIR.

Note: It may be helpful during the intake process to also do a BIF on the care receiver and keep it in the client's (caregiver's) file.

SPECIFIC INSTRUCTIONS FOR COMPLETING A BoSS INTAKE FORM (BIF)

If the client is able to complete the form on his own, let the client do so but offer assistance if asked. Should the client be unable to complete the form, the worker is to complete the form with the client's assistance. After the form is completed, please check to make sure ALL questions have been answered. If they have not, complete the blanks that were inadvertently missed. Should a client refuse to answer questions, complete the form to the best of your knowledge. If a service is provided to a client without completing a BIF, a "Dummy Demographic" is created.

ACTION

Indicate whether the client is an Add, Change, Delete, or Inactive.

CLIENT NUMBER

Leave the Client Number section blank on the NEW clients. For other clients, refer to the Master Client List.

DATE OF INTAKE

Enter the date the BIF is completed or the date that changes are being submitted.

PROVIDER NUMBER

Enter the **Provider Number** of your program. A provider number can be from three (3) to eight (8) characters. (Examples: 311 for Barbour County; 10007115 Family Service/Brooke County)

TYPE OF CONTACT

Check the box with an "✓" mark whether contact with the client was made in the office, by a field visit or by telephone. Select only one answer.

WORKER

Enter the worker's initials. (Lighthouse Program; RN initials required)

CLIENT

Enter the client's last name, first name, and middle initial. **Use only a PROPER name.** Do not use a nickname. Client is defined as person 60 or over, spouse of eligible client, volunteer, handicapped who live with eligible client (60+), III-E caregiver, FAIR caregiver, and Lighthouse Program.

DATE OF BIRTH

Enter the month, day and year of the client's birth. If the client is not age 60 or over, provide a reason for completing the BIF in the "**Eligible Under 60**" section.

GENDER

Check appropriate box.

ELIGIBILITY

Check appropriate answer: Spouse of eligible client, Volunteer, Handicapped person who resides with an eligible client, III-E Caregiver, FAIR caregiver, or Lighthouse Program.

IF III-E CAREGIVER

If III-E or FAIR caregiver, provide relationship to the eligible client: Husband, Wife, Son/Son-In-Law, Daughter/Daughter-In-Law, Other Relative, or Non-Relative.

ADDRESS

Enter complete client address.

TELEPHONE

Enter the client's telephone number. If the client does not have a telephone, enter "NONE." Do not enter a neighbor or friend's telephone number. Report this information on the back of the BIF or in the "Remarks" section.

SPEAKS ENGLISH

Check "Yes" or "No." If "No," indicate what language the client speaks or understands.

LANGUAGE LIMITATIONS

Check only one (1) answer. If client has no limitations, leave this section blank.

MARITAL STATUS

Check only one (1) answer.

RACE

Check the correct answer. The answer should reflect the race as stated by the client. If "Other" is checked, a client is NOT classified as a Minority for statistical purposes.

ETHNICITY

Check the correct answer.

HOUSEHOLD COMPOSITION

Check all that apply. If a client is a resident of a personal, nursing, or boarding facility, "Lives with Non-Relative" is to be checked.

INCOME

Check the appropriate income range in which the client's **household** income falls.

Household refers to the client and spouse. When the client lives with other family members, staff must make a determination if the client is financially independent

from the family, or, if the client is financially dependent on the family. (If the client has income and pays all expenses, the client is in a financial household of its own. If the family meets the client's financial obligations due to limited income, all family income is considered.)

NUMBER IN HOUSEHOLD

Indicate the number of people in client's household.

GEN (GREATEST ECONOMIC NEED)

Check Yes or No.

The U. S. Department of Health and Human Services issue poverty guidelines yearly (each spring). If the client's income falls below the guideline categories, the client is considered to be GEN (below poverty).

TRANSPORTATION

Check only one answer. If client has more than one means of transportation, choose the form he most frequently uses.

RURAL

Check Yes or No.

See definition under Program Descriptors and West Virginia Zip Codes Indicating Rurality.

✓ = YES

GSN

A client is classified as GSN if the client is a resident of a long-term facility (nursing home, personal care home), or has a disability not fully corrected or needs assistance to leave the home.

OR

A client is classified as GSN if **ANY TWO** of the following apply:

- The client is a member of a racial or ethnic minority
- Is 75+
- Lacks a telephone
- Has a language/literacy barrier
- Lives alone
- Lacks means of transportation

Low Income Minority

This box is checked if the client is a member of a racial or ethnic minority group and is GEN (Greatest Economic Need). **DO NOT CHECK if the client is White.**

At Risk

A client is described to be ***At Risk*** if the client is in jeopardy of institutionalization due to a documented mental or physical impairment, or a combination of both, which results in substantial functional limitations in **two or more** of the “Activities of Daily Living” (ADLs) or “Instrumental Activities of Daily Living” (IADLs), as listed in the next section of the BIF form. Individuals potentially able to be deinstitutionalized with the availability of adequate support systems who meet this criterion would also be defined as ***At Risk***.

A client with Alzheimer’s disease or a related disorder is considered to be ***At Risk***.

A client with a permanent physical disability that **severely** limits independent activities (i.e., blind, confined to a wheelchair) is classified as being ***At Risk***.

ACTIVITIES OF DAILY LIVING

Next to each Activity of Daily Living, indicate by number (from 1 to 4) the degree of assistance needed.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Next to each Instrumental Activity of Daily Living indicate by number (from 1 to 4) the degree of assistance needed.

REMARKS

Enter comments in this area.

TOTAL SCORE (ADL’s AND IADL’s)

This score is automatically calculated. However, the individual completing the BIF may wish to total manually.

TOTAL SCORE (NUTRITIONAL HEALTH ASSESSMENT)

Enter the total number of points obtained from the completed ***NUTRITIONAL HEALTH ASSESSMENT FORM***.

BoSS Intake Form

04/08

ACTION: <input type="checkbox"/> 1= Add <input type="checkbox"/> 2= Change <input type="checkbox"/> 3= Delete <input type="checkbox"/> 4= Inactive				Client Number: _____			
Date of Intake: _____			Type of Contact:		Worker:		
Provider Number: _____			<input type="checkbox"/> In Office <input type="checkbox"/> In Field <input type="checkbox"/> By Telephone				
Client Name: Last: _____		First: _____		MI: _____			
Date of Birth: / /		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		Eligibility: <input type="checkbox"/> Spouse <input type="checkbox"/> Volunteer <input type="checkbox"/> Handicapped <input type="checkbox"/> III-E Caregiver <input type="checkbox"/> FAIR Caregiver <input type="checkbox"/> Lighthouse			
If FAIR/III-E Caregiver, Relationship to Client:				<input type="checkbox"/> 1= Husband <input type="checkbox"/> 2= Wife			
<input type="checkbox"/> 3= Son/Son-in-Law <input type="checkbox"/> 4= Daughter/Daughter-in-Law				<input type="checkbox"/> 5= Other relative <input type="checkbox"/> 6= Non relative			
Address: Street _____		City _____		State _____	Zip _____		
Telephone: (____) _____ - _____			Speaks English: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Language Limitations: <input type="checkbox"/> 1=Does Not Read <input type="checkbox"/> 2=Reads Only <input type="checkbox"/> 3=Writes Only <input type="checkbox"/> 4=Reading/Writing Limited							
Marital Status: <input type="checkbox"/> 1=Married <input type="checkbox"/> 2=Single <input type="checkbox"/> 3=Widowed <input type="checkbox"/> 4=Separated							
Race: <input type="checkbox"/> 1=White, Non-Hispanic <input type="checkbox"/> 2=White, Hispanic <input type="checkbox"/> 3=American Indian/Alaskan Native <input type="checkbox"/> 4=Asian <input type="checkbox"/> 5=Black or African American <input type="checkbox"/> 6=Native Hawaiian or other Pacific Islander <input type="checkbox"/> 7=Other							
Ethnicity: <input type="checkbox"/> 1= Hispanic or Latino <input type="checkbox"/> 2=Not Hispanic or Latino							
Household Composition - Lives: <input type="checkbox"/> Alone <input type="checkbox"/> W/Spouse <input type="checkbox"/> W/Child <input type="checkbox"/> W/Relative <input type="checkbox"/> W/Non-Relative							
Income Range:		<input type="checkbox"/> 1=\$0 - \$867 <input type="checkbox"/> 2=\$868 - \$1167		<input type="checkbox"/> 3=\$1168 - \$1467 <input type="checkbox"/> 4=\$1468 - \$1767			
		<input type="checkbox"/> 5=\$1768 - \$2067 <input type="checkbox"/> 6=\$2068 - \$2367		<input type="checkbox"/> 7=\$2368 - \$2667 <input type="checkbox"/> 8=\$2668 - \$2967			
Number in Household: _____			G.E.N.: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Transportation: <input type="checkbox"/> 1. Have Car <input type="checkbox"/> 2. Public <input type="checkbox"/> 3. Senior Citizens Transportation <input type="checkbox"/> 4. Family/Friends <input type="checkbox"/> 5. None							
Rural: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> =Yes: <input type="checkbox"/> GSN <input type="checkbox"/> Low Income Minority <input type="checkbox"/> At Risk					
Activities of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>			Instruments of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>				
Bathing	1 2 3 4	Transferring		Cooking	1 2 3 4		
Dressing	1 2 3 4	in/out of bed	1 2 3 4	Heavy Housework	1 2 3 4		
Eating	1 2 3 4	Getting Places	1 2 3 4	Shopping	1 2 3 4		
Walking	1 2 3 4	Toileting	1 2 3 4	Light Housework	1 2 3 4		
				Business Affairs	1 2 3 4		
				Medication Management	1 2 3 4		
REMARKS: 							
Total Score (ADL's and IADL's) _____			Total Score (NUTRITIONAL HEALTH ASSESSMENT) _____				

BoSS Intake Form

Sample

04/08

ACTION: <input checked="" type="checkbox"/> 1= Add <input type="checkbox"/> 2= Change <input type="checkbox"/> 3= Delete <input type="checkbox"/> 4= Inactive Client Number: _____			
Date of Intake: 5/1/08		Type of Contact: <input type="checkbox"/> In Office <input checked="" type="checkbox"/> In Field <input type="checkbox"/> By Telephone	
Provider Number: 56		Worker: Anna Banana	
Client Name: Last: Lilly		First: Lilly MI: _____	
Date of Birth: 10/16/50	Gender: <input checked="" type="checkbox"/> Female <input type="checkbox"/> Male	Eligibility: <input type="checkbox"/> Spouse <input type="checkbox"/> Volunteer <input type="checkbox"/> Handicapped <input type="checkbox"/> III-E Caregiver <input checked="" type="checkbox"/> FAIR Caregiver <input type="checkbox"/> Lighthouse	
If FAIR/III-E Caregiver, Relationship to Client: <input type="checkbox"/> 1= Husband <input type="checkbox"/> 2= Wife <input type="checkbox"/> 3= Son/Son-in-Law <input checked="" type="checkbox"/> 4= Daughter/Daughter-in-Law <input type="checkbox"/> 5= Other relative <input type="checkbox"/> 6= Non relative			
Address: Street 21 Diamond Rd. City Gemstone State WV Zip 25000			
Telephone: (304) 555-1234		Speaks English: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Language Limitations: <input type="checkbox"/> 1=Does Not Read <input type="checkbox"/> 2=Reads Only <input type="checkbox"/> 3=Writes Only <input type="checkbox"/> 4=Reading/Writing Limited			
Marital Status: <input checked="" type="checkbox"/> 1=Married <input type="checkbox"/> 2=Single <input type="checkbox"/> 3=Widowed <input type="checkbox"/> 4=Separated			
Race: <input checked="" type="checkbox"/> 1=White, Non-Hispanic <input type="checkbox"/> 2=White, Hispanic <input type="checkbox"/> 3=American Indian/Alaskan Native <input type="checkbox"/> 4=Asian <input type="checkbox"/> 5=Black or African American <input type="checkbox"/> 6=Native Hawaiian or other Pacific Islander <input type="checkbox"/> 7=Other			
Ethnicity: <input type="checkbox"/> 1= Hispanic or Latino <input checked="" type="checkbox"/> 2=Not Hispanic or Latino			
Household Composition - Lives: <input type="checkbox"/> Alone <input checked="" type="checkbox"/> W/Spouse <input type="checkbox"/> W/Child <input type="checkbox"/> W/Relative <input type="checkbox"/> W/Non-Relative			
Income Range: <input type="checkbox"/> 1=\$0 - \$867 <input type="checkbox"/> 2=\$868 - \$1167 <input checked="" type="checkbox"/> 3=\$1168 - \$1467 <input type="checkbox"/> 4=\$1468 - \$1767 <input type="checkbox"/> 5=\$1768 - \$2067 <input type="checkbox"/> 6=\$2068 - \$2367 <input type="checkbox"/> 7=\$2368 - \$2667 <input type="checkbox"/> 8=\$2668 - \$2967			
Number in Household: 3		G.E.N.: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Transportation: <input checked="" type="checkbox"/> 1. Have Car <input type="checkbox"/> 2. Public <input type="checkbox"/> 3. Senlor Citizens Transportation <input type="checkbox"/> 4. Family/Friends <input type="checkbox"/> 5. None			
Rural: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		<input checked="" type="checkbox"/> =Yes: <input type="checkbox"/> GSN <input type="checkbox"/> Low Income Minority <input type="checkbox"/> At Risk	
Activities of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>		Instruments of Daily Living: Circle One For Each <small>1=No Assistance, 2=Some Assistance, 3=Much Assistance, 4=Cannot Perform</small>	
Bathing ① 2 3 4 Dressing ① 2 3 4 Eating ① 2 3 4 Walking ① 2 3 4	Transferring in/out of bed ① 2 3 4 Getting Places ① 2 3 4 Toileting ① 2 3 4	Cooking ① 2 3 4 Shopping ① 2 3 4 Light Housework ① 2 3 4 Business Affairs ① 2 3 4	Heavy Housework ① 2 3 4 Use of Telephone ① 2 3 4 Medication Management ① 2 3 4
REMARKS: Income of care receiver - \$1,050/mo. Anna Banana - 5/1/08			
Total Score (ADL's and IADL's) _____		Total Score (NUTRITIONAL HEALTH ASSESSMENT) _____	

FAIR Program

Instructions for Supplemental Service Recording Log

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

- Provider code
- Site code
- Service code
- Funding source
- Month services were provided
- Name of person completing form
- Names of clients
- Birth date of client
- Units of service and the days on which units of service were provided
- Total units of service for that month

A sample Supplemental Service Recording Log is included with this manual. You may use it as is, adapt it for your own use, or use one you already have that meets the above requirements.

FAIR Program

Instructions for Completing the Letter to Physician

1. “From” Section: Either use your letterhead, or place your agency’s name and address here.
2. “Re” Section: The name and address of the person with Alzheimer’s disease or a related dementia (the care receiver) goes here.
3. “The family caregiver of _____”: Fill in the blank with the name of the care receiver.
4. The original letter with physician’s signature, date of signature and physician’s address must be in the client’s file. A faxed copy is acceptable to begin services, but the doctor’s office must send the original with signature to the FAIR Coordinator.

PHYSICIAN LETTER

Date: _____

From: _____

Re: _____

Address: _____

Dear Dr. _____:

The family caregiver of _____ has applied to receive respite services through our Family Alzheimer's In-Home Respite Program. In order to receive services from this program, the above named individual must have a diagnosis of Alzheimer's disease or a related dementia. If it is your professional opinion that this person qualifies, please sign below and return to (FAIR Coordinator's name) at (agency name and address). Thank you for your prompt attention to this matter.

Doctor's signature

Date

Address _____

FAIR PROGRAM

SAMPLE PHYSICIAN LETTER

Date: 4/8/08
From: Best County Commission on Aging
123 4th St
Wonderful, WV 25099
Re: Ruby Smith
Address: One Sparkle Drive
Gemstone, WV 25000

Dear Dr. B. Moore Caring:

The family caregiver of Ruby Smith has applied to receive respite services through our Family Alzheimer's In-Home Respite Program. In order to receive services from this program, the above named individual must have a diagnosis of Alzheimer's disease or a related dementia. If it is your professional opinion that this person qualifies, please sign below and return to (FAIR Coordinator's name) at (agency name and address). Thank you for your prompt attention to this matter.

BC

Doctor's signature

4/10/08

Date

Address One Doctors Lane
Wild, WV 25098

**WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM**

**Sliding Fee Schedule
Instructions**

1. An individual's income may be determined by voluntary disclosure by the client or by agency estimation; means tests are not required.
2. Only the income of the *care receiver* is to be counted when determining payment. Household income is not considered.
3. The Sliding Fee Schedule and provider agency's policy for payment (if applicable) shall be discussed with the applicant (unpaid caregiver).
4. If it is determined that paying the appropriate fee would cause a hardship for the family, the reasons for the hardship will be documented in the client's file and an hourly fee worked out that is acceptable to both the provider and the caregiver.
5. Even if the individual is not liable for payment, he/she may wish to contribute to the program.

FAIR PROGRAM
Sliding Fee Schedule

Sliding Fee %	Fee per Hour	Individual's Annual Income
0%	\$1.00	Up to \$20,220
25%	\$3.50	\$20,221 to \$30,220
50%	\$7.00	\$30,221 to \$40,220
75%	\$10.50	\$40,221 to \$50,220
100%	\$14.00	\$50,221 and up

FAIR Program

Instructions for Caregiver Responsibility Agreement

Prior to receiving services through FAIR, the client must read, agree to, and sign the Caregiver Responsibility Agreement.

The agreement will then be signed by the FAIR Coordinator. The client will be given a copy of the agreement, and the original will be placed in the client's file.

Caregiver Responsibility Agreement

I, _____, am the primary caregiver for _____.

I understand that the Family Alzheimer's In-Home Respite (FAIR) Program is designed to provide temporary relief from the responsibilities of caregiving and that it is not meant to replace the care and supervision I currently provide. As a recipient of services through FAIR, I agree to the following:

- I am the client in the FAIR Program, which gives me a regular break from my caregiving responsibilities. However, FAIR does not replace the care and supervision that I provide for my loved one.
- I understand that this is not a chore program or a personal care program. The worker is here to provide stimulation and socialization for the care receiver. Any chores or personal care provided through FAIR must be in the context of the Activity Plan established for the care receiver.
- I will notify the agency at least 24 hours prior to the day services are to be provided for any day the service is not needed.
- I will notify the agency immediately if there is a change in status that requires any change in service or disruption of service (Ex: Care receiver goes to hospital or nursing home; care receiver changes residence; care receiver will not be at home due to doctor's appointment, trip, etc.).
- I agree to make myself available for consultation with an agency representative as needed, to discuss issues related to the care being provided to my loved one.
- I understand that I am to initial the worker's log sheet daily and sign it weekly to verify that services are being provided as scheduled.
- If I have any problem with the worker assigned to care for my loved one, I will contact the agency, and, together, we will work to resolve the issue. I understand that if I request a different worker, I may have to change the days I receive the respite service and/or wait until there is a worker available.
- I understand that FAIR is fee-based on a sliding fee scale, and payment is due monthly for those who qualify to pay a fee. Non-payment may result in FAIR services being discontinued.

Signature of FAIR client

Signature of agency representative

**WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM**

**PERSONAL HISTORY
INSTRUCTIONS**

The Personal History, Facts and Insights Form must be completed, to the extent possible, at the time the BIF is completed. The family caregiver, other family members and, whenever possible, the person with dementia, can all provide input into completing this form.

As new information about a care receiver is learned, it should be added to his/her personal history.

Workers should have access to completed personal histories of the individuals for whom they are providing care. The county aging provider will determine whether a copy of the history will be kept in the care receiver's home and/or in an accessible file in the office.

In all cases, a copy of the form should be maintained in the client's (caregiver's) file.

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

Personal History, Facts and Insights

Each of us is a unique person. Getting to know the person for whom you are providing care should help you develop a plan and make your time together more enjoyable and beneficial for both of you. This form will help you find out what is most important to know about this person.

Complete as much of the form as possible during your initial consultation with the caregiver and/or care receiver. As you learn more information, please add it to the form.

Name of care receiver _____

Contact person _____ Phone number _____

Name care receiver prefers to be called _____

Childhood nickname _____

Native language (if other than English) _____

Date of birth _____ Place of birth _____

Family & Friends

Marital status Single Married Divorced Widowed Partner

Spouse/partner's name(s) *(even if divorced or deceased)* _____

List significant family and friends. Use additional paper, if necessary.

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who might stop by to visit? _____

Cognition, Communication, Personality, Temperament

Please check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Repeats or asks the same thing over and over | <input type="checkbox"/> Wears eyeglasses |
| <input type="checkbox"/> Forgets appointments, family occasions, holidays | <input type="checkbox"/> Wears dentures |
| <input type="checkbox"/> Gets lost in familiar places | <input type="checkbox"/> Has difficulty swallowing |
| <input type="checkbox"/> Prefers being alone or with one or two friends/family | <input type="checkbox"/> Likes makeup |
| <input type="checkbox"/> Likes being with a lot of people | <input type="checkbox"/> Wears a wig |
| <input type="checkbox"/> Can use telephone independently | <input type="checkbox"/> Is quiet and/or moody |
| <input type="checkbox"/> Can use telephone with assistance | <input type="checkbox"/> Is anxious |
| <input type="checkbox"/> Cannot or should not use telephone | <input type="checkbox"/> Angers easily |
| <input type="checkbox"/> Has hearing loss | <input type="checkbox"/> Is outgoing and friendly |
| <input type="checkbox"/> Wears hearing aid | <input type="checkbox"/> Likes to be hugged or to hold hands |
| <input type="checkbox"/> Has vision difficulties | <input type="checkbox"/> Does not like to be touched |
| | <input type="checkbox"/> Is right-handed |
| | <input type="checkbox"/> Is left-handed |

Who or what makes this person laugh? _____

Who or what makes this person cry? _____

Who or what makes this person angry? _____

Who or what calms this person down? _____

Daily Routine

Does this person have a daily routine? If so, please describe _____

Favorite Activities or Hobbies – current and former (check all that apply)

Knowing a person's preferences should help you adapt activities to meet his/her level of functioning. Focus your efforts on enjoying the moment, not on finishing an activity or project.

This person's favorite activities include the following:

- | | |
|---|--|
| <input type="checkbox"/> Having hair brushed | <input type="checkbox"/> Feeding and/or watching birds |
| <input type="checkbox"/> Getting a manicure | <input type="checkbox"/> Playing with a pet |
| <input type="checkbox"/> Taking a bubble bath | <input type="checkbox"/> Feeding animals |
| <input type="checkbox"/> Going to the beauty shop or barber | <input type="checkbox"/> Listening to music |
| <input type="checkbox"/> Gardening | Favorite music _____ |
| <input type="checkbox"/> Doing household chores | <input type="checkbox"/> Dancing |
| <input type="checkbox"/> Cooking or other food preparation | <input type="checkbox"/> Singing |
| <input type="checkbox"/> Making household repairs | |
| <input type="checkbox"/> Painting walls or furniture | |

Favorite Activities (contd.)

- Playing an instrument
Which instrument? _____
- Telling stories, talking
- Reading poetry
- Reading a book
- Doing crossword puzzles
- Playing board or card games
Favorites _____
- Playing other games
Favorites _____
- Spending time with children or grandchildren
- Taking a daily walk
- Taking a drive
- Going out to eat
- Visiting friends
- Going to work
- Reading scripture or other religious text
- Praying
- Woodcarving
- Drawing or painting
- Exercising
- Playing and/or watching sports
Favorites _____
- Other _____

Bathing

- Bathes without assistance
- Needs some assistance in bathing
- Needs total assistance to bathe

Prefers Bath Shower Sponge or towel bath

How often? _____ Preferred time of day? _____

Dressing/Grooming

- Gets completely dressed and attends to grooming needs without assistance
- Can get dressed and meet grooming needs with a little assistance
- Is dependent on someone else for all dressing and grooming needs
- Has favorite clothing. Describe _____

Toileting/Continence

- Goes to the bathroom without assistance
- Controls urination and bowel movements
- Needs some assistance in getting to the bathroom, cleaning self, or arranging clothes after elimination
- Has occasional accidents
- Is incontinent
- Uses disposable briefs

Are there specific words or phrases used for going to the bathroom? _____

Is there a schedule for using the bathroom? If so, describe. _____

Transfer

- Moves in and out of bed or chair without assistance
- Needs some assistance getting in or out of bed or chair
- Dependent – doesn't get in or out of bed or chair alone

Eating

- Prepares foods and feeds self without assistance
- Prepares foods and feeds self with minor assistance
- Needs to have meals prepared and served, needs to be fed partly or completely
- Has special dietary needs (*circle all that apply* – low fat, low cholesterol, low sodium, diabetic, pureed foods, supplements, other _____)
- Eats at table
- Has other favorite place to eat. Please specify _____

Food allergies _____

Favorite foods/snacks _____

Foods he/she won't eat _____

Religion/Spirituality

Religious background (*childhood religious affiliation, other relevant information*) _____

Current religious affiliation, if different from above _____

Medications

- Takes medications in correct dosages at correct time
- Takes properly if medications are prepared in advance in separate dosages
- Is not capable of dispensing and taking own medications

Sleeping

- Has difficulty sleeping
- Has a bedtime routine. Describe _____
- Takes a nap. When? _____

Bedtime _____ Wake up time _____

Sexuality

- Is currently capable of being sexually active
- May exhibit inappropriate sexual behavior. Describe _____

Personal History

On the back of this sheet, describe significant events in this person's life (education, pets, hobbies, first job, first home, military service, accomplishments, anything that might help respite workers get to know who he/she really is).

Sample

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

Personal History, Facts and Insights

Each of us is a unique person. Getting to know the person for whom you are providing care should help you develop a plan and make your time together more enjoyable and beneficial for both of you. This form will help you find out what is most important to know about this person.

Complete as much of the form as possible during your initial consultation with the caregiver and/or care receiver. As you learn more information, please add it to the form.

Name of care receiver Ruby Smith

Contact person Lilly Lolly Phone number 304-555-1234

Name care receiver prefers to be called Jewel

Childhood nickname Jewel

Native language (if other than English) —

Date of birth 12/23/24 Place of birth —

Family & Friends

Marital status Single Married Divorced Widowed Partner

Spouse/partner's name(s) (even if divorced or deceased) John Smith (deceased)

List significant family and friends. Use additional paper, if necessary.

<u>Name</u>	<u>Age</u>	<u>Relationship</u>
<u>Lilly Lolly</u>	<u>57</u>	<u>daughter</u>
<u>John Smith, Jr.</u>	<u>59</u>	<u>son</u>
<u>Jane Smith</u>	<u>56</u>	<u>daughter-in-law</u>
<u>Jolly Lolly</u>	<u>60</u>	<u>son-in-law</u>
<u>Holly Lolly (children-Molly-5 + Dolly-3)</u>	<u>29</u>	<u>granddaughter</u>

Who might stop by to visit? Pastor Fred, Ruth & Bill Jones (neighbors)

Cognition, Communication, Personality, Temperament

Please check all that apply.

- | | |
|---|---|
| <input checked="" type="checkbox"/> Repeats or asks the same thing over and over | <input checked="" type="checkbox"/> Wears eyeglasses |
| <input type="checkbox"/> Forgets appointments, family occasions, holidays | <input type="checkbox"/> Wears dentures |
| <input type="checkbox"/> Gets lost in familiar places | <input type="checkbox"/> Has difficulty swallowing |
| <input checked="" type="checkbox"/> Prefers being alone or with one or two friends/family | <input checked="" type="checkbox"/> Likes makeup |
| <input type="checkbox"/> Likes being with a lot of people | <input type="checkbox"/> Wears a wig |
| <input type="checkbox"/> Can use telephone independently | <input type="checkbox"/> Is quiet and/or moody |
| <input checked="" type="checkbox"/> Can use telephone with assistance | <input type="checkbox"/> Is anxious |
| <input type="checkbox"/> Cannot or should not use telephone | <input checked="" type="checkbox"/> Angers easily |
| <input checked="" type="checkbox"/> Has hearing loss | <input checked="" type="checkbox"/> Is outgoing and friendly |
| <input type="checkbox"/> Wears hearing aid | <input checked="" type="checkbox"/> Likes to be hugged or to hold hands |
| <input type="checkbox"/> Has vision difficulties | <input type="checkbox"/> Does not like to be touched |
| | <input checked="" type="checkbox"/> Is right-handed |
| | <input type="checkbox"/> Is left-handed |

Who or what makes this person laugh? great-grand children, old sitcoms

Who or what makes this person cry? Remembering sad events in her life.

Who or what makes this person angry? People telling her how to do things or treating her like a child; getting frustrated when she can't do something.

Who or what calms this person down? Music (Nat King Cole) or sitting on the porch.

Daily Routine

Does this person have a daily routine? If so, please describe Gets up at 8:00; has breakfast; gets dressed; does "chores" (wants to feel like she's needed, useful); lunch at noon; likes to be outside, if the weather is nice; in the afternoon; may take a short nap

Favorite Activities or Hobbies – current and former (check all that apply)

Knowing a person's preferences should help you adapt activities to meet his/her level of functioning. Focus your efforts on enjoying the moment, not on finishing an activity or project.

This person's favorite activities include the following:

- | | |
|---|--|
| <input checked="" type="checkbox"/> Having hair brushed | <input type="checkbox"/> Feeding and/or watching birds |
| <input type="checkbox"/> Getting a manicure | <input type="checkbox"/> Playing with a pet |
| <input type="checkbox"/> Taking a bubble bath | <input type="checkbox"/> Feeding animals |
| <input type="checkbox"/> Going to the beauty shop or barber | <input checked="" type="checkbox"/> Listening to music |
| <input type="checkbox"/> Gardening | Favorite music <u>Big band, gospel</u> |
| <input checked="" type="checkbox"/> Doing household chores | <input checked="" type="checkbox"/> Dancing |
| <input checked="" type="checkbox"/> Cooking or other food preparation | <input checked="" type="checkbox"/> Singing |
| <input type="checkbox"/> Making household repairs | |
| <input type="checkbox"/> Painting walls or furniture | |

Favorite Activities (contd.)

- Playing an instrument
Which instrument? _____
- Telling stories, talking
- Reading poetry
- Reading a book
- Doing crossword puzzles
- Playing board or card games
Favorites Rummy, Solitaire
- Playing other games
Favorites _____
- Spending time with children or grandchildren
- Taking a daily walk
- Taking a drive
- Going out to eat
- Visiting friends
- Going to work
- Reading scripture or other religious text
- Praying
- Woodcarving
- Drawing or painting
- Exercising
- Playing and/or watching sports
Favorites _____
- Other _____

Bathing

- Bathes without assistance
- Needs some assistance in bathing
- Needs total assistance to bathe

Prefers Bath Shower Sponge or towel bath

How often? Daily Preferred time of day? Evening

Dressing/Grooming

- Gets completely dressed and attends to grooming needs without assistance
- Can get dressed and meet grooming needs with a little assistance
- Is dependent on someone else for all dressing and grooming needs
- Has favorite clothing. Describe _____

Toileting/Continence

- Goes to the bathroom without assistance
- Controls urination and bowel movements
- Needs some assistance in getting to the bathroom, cleaning self, or arranging clothes after elimination
- Has occasional accidents
- Is incontinent
- Uses disposable briefs

Are there specific words or phrases used for going to the bathroom? Have to go potty

Is there a schedule for using the bathroom? If so, describe. No

Transfer

- Moves in and out of bed or chair without assistance
- Needs some assistance getting in or out of bed or chair
- Dependent – doesn't get in or out of bed or chair alone

Eating

- Prepares foods and feeds self without assistance
- Prepares foods and feeds self with minor assistance
- Needs to have meals prepared and served, needs to be fed partly or completely
- Has special dietary needs (*circle all that apply* – low fat, low cholesterol, low sodium, diabetic, pureed foods, supplements, other _____)
- Eats at table
- Has other favorite place to eat. Please specify _____

Food allergies None

Favorite foods/snacks Spaghetti, pork chops, Hershey's Kisses

Foods he/she won't eat Olives, peas

Religion/Spirituality

Religious background (*childhood religious affiliation, other relevant information*) United Methodist, has always been active in her church

Current religious affiliation, if different from above _____

Medications

- Takes medications in correct dosages at correct time
- Takes properly if medications are prepared in advance in separate dosages
- Is not capable of dispensing and taking own medications

Sleeping

- Has difficulty sleeping
- Has a bedtime routine. Describe _____
- Takes a nap. When? Sometimes - mid-afternoon

Bedtime 10:00 pm Wake up time 8:00 am

Sexuality

- Is currently capable of being sexually active
- May exhibit inappropriate sexual behavior. Describe _____

Personal History

On the back of this sheet, describe significant events in this person's life (education, pets, hobbies, first job, first home, military service, accomplishments, anything that might help respite workers get to know who he/she really is).

**WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM**

**ACTIVITY PLAN
INSTRUCTIONS**

With input from the client (caregiver) and using the completed personal history, determine activities for the care receiver that would encourage socialization and/or stimulation.

Share the activity plan with the client for signature, and maintain a copy of the plan in the client's file.

**FAIR Program
Activity Plan Form**

Agency Name:

Client Name:

Client Address:

Based on information obtained on the Personal History, Facts and Insights form, and together with the caregiver (client), we have determined that the following activities would be appropriate and beneficial for _____, the care receiver, who has Alzheimer's disease or a related dementia:

Our worker will make every effort to engage the care receiver in as many of these activities as possible during the hours they are together.

Signature of client (caregiver)

Signature of FAIR Coordinator

Sample

**FAIR Program
Activity Plan Form**

Agency Name: Any County Commission on Aging

Client Name: Lilly Lolly

Client Address: 21 Diamond Road, Gemstone, WV 25000

Based on information obtained on the Personal History, Facts and Insights form, and together with the caregiver (client), we have determined that the following activities would be appropriate and beneficial for Ruby Smith, the care receiver, who has Alzheimer's disease or a related dementia:

Chores - Help wash the dishes, dust, and sort
and fold laundry

Make her favorite recipes together

Sing and/or dance to her favorite music

Reminisce, using old photo albums

Do stretching exercises together

Brush and style her hair

Read scripture

Our worker will make every effort to engage the care receiver in as many of these activities as possible during the hours they are together.

Lilly Lolly
Signature of client (caregiver)

Anna Banana
Signature of FAIR Coordinator

**WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM**

**WORKER NOTES
INSTRUCTIONS**

Respite is different from most other services. The caregiver is the client, and the primary objective is to give the caregiver a regular break, knowing that the care receiver is safe and well cared for. A second objective, however, is just as important – to ensure that the time spent with the care receiver is focused on that individual to the fullest extent possible.

The purpose is to make the hours spent with the care receiver the best they can be, regardless of the stage of the illness or capabilities of the care receiver.

Therefore, in addition to time sheets required by the provider agency, FAIR workers will keep a daily log of activities engaged in with each care receiver. A worker's notes can be brief but should reflect activities defined in the care receiver's Activity Plan. Activities do not need to be tied to any specific time increments.

Provider agencies may wish to use the attached form or choose to develop one of their own. The form can even be on the back of worker's time sheet.

**WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM**

WORKER NOTES FORM

Client's Name: _____ **Worker's Name:** _____

Date

Activity/What you did together/Other comments

WEST VIRGINIA BUREAU OF SENIOR SERVICES
FAIR PROGRAM

Sample

WORKER NOTES FORM

Client's Name: Ruby Smith Worker's Name: Sue Mayes

Date	Activity/What you did together/Other comments
5/12/08	After Ruby finished breakfast, we did the dishes and sorted laundry. I put a load in the washer. We played music she likes and looked at old photo albums. Then we took a walk, did some stretching exercises and folded the laundry when it was dry.
5/14/08	Ruby & I did the dishes after breakfast. I brushed her hair, and we talked about her mother putting Ruby's hair in pigtails. We did some chair exercises and read some Bible verses that she likes. Ruby seemed a little sad most of the morning.
5/16/08	Ruby was in a better mood today. After we did the breakfast dishes, we dusted the living room furniture. Ruby wanted to make cookies, so we did. Then we sat on the porch and talked. She says I'm a good friend.

WEST VIRGINIA BUREAU OF SENIOR SERVICES FAIR PROGRAM

CONGREGATE RESPITE GUIDELINES INSTRUCTIONS

Provider agencies may use part of their FAIR award for congregate respite services. If interested, **provider agency must submit a proposal to BoSS by June 15** for the following fiscal year. The proposal must meet the criteria described in the social Congregate Respite Guidelines and should be sent to the attention of the Director of Alzheimer's Programs. **BoSS will review proposals and notify provider agencies prior to June 30.**

A proposal for providing congregate respite through FAIR will include the following components, as described in the attached Congregate Respite Guidelines:

- Identification of need
- Description of site
- Maximum number of individuals projected to be served at the congregate respite site at any one time
- Projected hours of operation
- Plan for dementia-specific programs and activities
- Staffing plan, including required training
- Strategy for enlisting volunteers

A county already approved and providing congregate respite through FAIR may continue that service for the next fiscal year, unless otherwise notified by BoSS.

West Virginia Bureau of Senior Services Social Congregate Respite Guidelines

West Virginia county aging providers who submit proposals that address the following criteria will receive consideration for funding for social congregate respite as part of their overall Family Alzheimer's In-Home Respite (FAIR) allocation:

Identification of Need

- Describe how residents of your county with Alzheimer's disease and related dementias will benefit from congregate respite services.

Clients

- There must be a caregiver. The caregiver must be a resident of WV. As with the in-home respite program through FAIR, **the client in the congregate respite program is the caregiver.**
- **Clients may receive a total of 16 hours of respite per week, in-home and congregate respite combined.**
- The person enrolled by the client in the congregate respite program must have a physician's diagnosis of Alzheimer's disease or a related dementia.
- Individuals may be discharged from the program if they exhibit behaviors that may endanger themselves, other congregate respite participants or staff members, or if the behaviors seriously disrupt activities of the program. However, every effort should be made by the staff to manage the disruptive behavior before the person is disqualified from the program.

Site/Space Utilization

- Site should be ADA compliant.
- Proof of adequate liability coverage must be on file.
- The site must be adequate to accommodate the maximum number of individuals projected to be served at any one time and should have activity space, comfortable seating, a quiet place for rest, and a private room for changing clothing.

Hours of Operation

- Specific days/hours of operation will not be required, but a schedule describing projected hours of operation must be submitted with the proposal.
- Evening and weekend hours of operation are encouraged.
- A morning and/or afternoon snack will be served to participants who are there at the time those snacks would normally be served. Participants who are there during lunchtime can be served through the nutrition program.

Programs and Activities

- Provider will have a plan detailing programs and activities that will be included in the congregate respite program.
- Activities should include physical and mental exercises, creative expression (music, art, and/or dance), cultural enrichment, socialization, and, if possible, activities with youth.

Allocation

- The allocation for congregate respite will be a percentage of provider's overall funding for FAIR.
- Providers offering congregate respite through FAIR must still provide in-home respite through this program.

Match

- The match for FAIR will also cover congregate respite and can be cash or in-kind non-federal sources not used to match other programs.

Reimbursement

- Services will be billed monthly on the invoice provided by BoSS. Additionally, an Invoice Attachment is required that lists the names of clients and hours served during the period covered.

Fees

- Fees are based on a sliding fee scale.
- The same income guidelines and percentages that are used for the FAIR in-home respite sliding fee scale will be used for the congregate respite program.
- Client will pay a percentage of the established rate for congregate respite, depending on the individual income of the care receiver, as described in the sliding fee scale.
- If the family has extenuating circumstances, such that paying the rate for which they qualify would be a hardship, a lesser fee can be negotiated with the client. The reasons must be adequately documented.

Staffing

- The center will have a staff person designated as director of the congregate respite program.
- There must be a nurse available during all hours of operation.
- Site should adhere to a staffing ratio of no more than 6:1, with an ideal ratio of 4:1. Even with as few as three participants, there should be a second staff person available in the building, who can help with activities or when an individual requires one-on-one attention.

Volunteers

- To assist the staff, enrich the congregate respite program, and provide meaningful work experience for individuals in the community, efforts should be made to enlist groups of volunteers who would be willing to work at the congregate respite center, including faith groups, civic organizations, schools that require community service hours, nursing schools, and other community groups.
- Volunteers will have the same training that congregate respite staff receives.

Training

- Staff and volunteers will complete the training required for FAIR, including the 8-hour dementia care train-the-trainer course.

Reporting

- Site will follow the same client tracking procedures as with FAIR in-home reporting.

Reviews

- On-site evaluations will be conducted annually by BoSS staff.
- Other announced or unannounced visits may take place as deemed necessary by BoSS and/or provider.
- Quarterly financial reviews will take place within the framework of provider's overall FAIR review.

Center should also consider education programs for caregivers on communication, managing behaviors, caregiver stress, and home care.

Summary

A proposal for establishing or enhancing social congregate respite services will include the following, as described in the above guidelines:

- Identification of need
- Description of site
- Maximum number of individuals projected to be served at the congregate respite site at any one time
- Projected hours of operation
- Plan for dementia-specific programs and activities
- Staffing plan, including required training
- Strategy for enlisting volunteers

New proposals must be submitted to BoSS by June 15.

Provider will be notified of the Bureau's decision by June 30.

The Bureau reserves the right to accept or reject any proposals, in part or whole, at its discretion.

FAIR allocation cannot be used for capital improvements.