State & Community Programs Funded Under the Older Americans Act Policies and Procedures

Service Chapter 650-25

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Purpose 650-25-01

(Revised 1/1/06 ML#2995)

View Archives

This manual outlines the Policies and Procedures governing the administration, management, and implementation of state and community programs funded under the Older Americans Act.

Legal References/Authority 650-25-05

(Revised 10/1/15 ML#3454)

View Archives

- Public Law 109-365, Older Americans Act of 1965, as amended in 2006
- North Dakota Century Code Chapter 50-06 (Department of Human Services)
- Public Law 104-156, Single Audit Act Amendments of 1996, as applicable
- 45 Code of Federal Regulations Part 1321 (Grants for State and Community Programs)
- 2 Code of Federal Regulations Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards)
- North Dakota Department of Human Services Contract, and all attachments
- North Dakota Administrative Code Chapter 33-33-04 (North Dakota Requirements for Food and Beverage Establishments)
- North Dakota Administrative Code Chapter 75-03-23 (Provision of Home and Community-Based Services under the Service Payments for Elderly and Disabled Program and Medicaid Waiver for the Aged and Disabled Program)

Definitions 650-25-10

(Revised 1/1/14 ML#3396)

View Archives

Definitions in this manual include descriptors of Older Americans Act programs/services that must be used in the completion of required Federal reporting

Access Assistance **(National Family Caregiver Support Program)**		A service that assists caregivers in obtaining access to the available services and resources within their communities. A trained Caregiver Coordinator will assess caregiver needs, establish an option plan, and arrange for support services.
Activities of Daily Living (ADL)		Self-care activities performed daily without assistance, stand-by assistance, supervision or cues including eating, dressing, bathing, toileting, and transferring in and out of bed/chair and walking.
Aging & Disability Resource LINK ADRL)		An initiative designed to streamline access to long-term care services and supports for consumers of all ages, incomes, and disabilities, and their families through better coordination and strengthened partnering of existing systems of information, assistance, and access. North Dakota will develop 'no wrong door' models at the community level that can assist individuals in making informed decisions about their service and support options.
Aging & Disability Resource LINK (ADRL) Benefits Counseling		The provision of information designed to help consumers learn about public and private benefits with referral to

		appropriate entities for access to needed benefits. ADRL Benefits Counseling is considered a part of the ADRL Options Counseling service.
Aging & Disability Resource LINK (ADRL) Futures Planning		The process of assisting consumers in planning for their future long-term care needs with referral to appropriate entities for retirement planning, long-term care insurance, etc. ADRL Futures Planning is considered a part of the ADRL Options Counseling service.
Aging & Disability Resource-LINK Information and Referral/ Assistance (ADRL I & R/A)		A one-on-one service that (a) provides consumers with information on opportunities and services available within their communities; (b) assesses problems and capabilities of the individuals; (c) links the consumers to the services and opportunities that are available; and (d) to the maximum extent practicable, establishes adequate follow-up procedures.
Aging & Disability Resource LINK (ADRL) Operating		Day-to-day activities necessary to implement and maintain an ADRL.
Aging & Disability Resource LINK (ADRL) Options Counseling		A person-centered, interactive, decision-support process whereby consumers, family members and/or significant others are supported in determining appropriate long-term care choices based on the consumer's needs, preferences, values, and individual circumstances.
Aging Services Division		The designated state agency in North Dakota to carry out the provisions of the Older Americans Act of 1965, as amended.
Advocacy		Actions taken on behalf of older individuals to secure their rights or benefits.

Alzheimer's Disease and Related Disorders		Any form of dementia characterized by neurological or organic brain dysfunction.
Assistive Safety Device		An adaptive and preventive health aid that will assist individuals in their activities of safe daily living.
At Risk for Institutional Placement		With respect to an older individual, such individual is unable to perform at least 2 activities of daily living without substantial assistance (including verbal reminding, physical cuing, or supervision) and is determined by the State to be in need of placement in a long-term care facility.
Caregiver **(National Family Caregiver Support Program)**		(See Family Caregiver)
Child **(National Family Caregiver Support Program)**		An individual who is not more than 18 years of age or who is an individual with a disability.
Client		An individual who meets eligibility requirements to receive services under the Older Americans Act.
Congregate Meals		A service that provides meals that assure a minimum of one-third of the recommended dietary allowances for a client who will be eating in a group setting.
Contract Entity		A legal entity that has entered into a contract with the Department of Human Services to receive funds under the Older Americans Act for service

		provision to eligible clients.
Cost Sharing		Process that allows clients to share in the cost of service provision through the use of a sliding fee scale and self-declaration of income.
Counseling **(National Family Caregiver Support Program)**		Counseling to caregivers to assist them in making decisions and solving problems relating to their caregiver roles. This includes counseling to individuals, support groups, and caregiver training (of individual caregivers and families).
Dietary Reference Intakes **(DRIs)**		Quantitative estimates of nutrient intakes for use in planning and assessing healthy diets. The DRIs include several nutrient based reference value sets including: a. Estimated Average Requirement (EAR): "the average daily nutrient intake level estimated to meet the requirements of half the healthy individuals in a particular life stage and gender group"; b. Recommended Dietary Allowances (RDA): "the average daily nutrient intake level sufficient to meet the nutrient requirements of nearly all (97 to 98%) healthy individuals in a particular life stage and gender group"; c. Adequate Intake (AI): "a recommended average daily nutrient intake level based on observed or experimentally determined approximations or estimates of nutrient intake by a group (or groups) of healthy people

		that are assumed to be adequate – used when RDA cannot be determined"; d. Tolerable Upper Intake Level (UL): "the highest average daily nutrient intake level that is likely to pose no risk of adverse health effects to almost all individuals in the general population. As intake increases above the UL, the potential risk of adverse effects may increase"; and e. Acceptable Macronutrient Distribution Range (AMDR): "range of intake for a particular energy source (macronutrients include carbohydrates, proteins, fats) that is associated with reduced risk of chronic disease while providing intakes of essential nutrients. If an individual consumes in excess of the AMDR, there is a potential of increasing the risk of chronic diseases and/or insufficient intakes of essential nutrients.
Disability		A condition attributed to mental or physical impairment, or a combination of mental and physical impairments that results in substantial functional limitations in one or more of the following areas of major life activity: (1) self care, (2) receptive and expressive language, (3) learning, (4) mobility, (5) self direction, (6) capacity of independent living, (7) economic self sufficiency, (8) cognitive functioning, and (9) emotional adjustment.
Disease Prevention and Health Promotion		Services funded under Title III-D of the Older Americans Act including health

		risk assessments; routine health screening, which may include hypertension, glaucoma, cholesterol, cancer, vision, hearing, diabetes, bone density, and nutrition screening; nutritional counseling and educational services; evidence-based health promotion programs, including programs related to the prevention and mitigation of the effects of chronic disease (including osteoporosis, hypertension, obesity, diabetes, and cardiovascular disease), alcohol and substance abuse reduction, smoking cessation, weight loss and control, stress management, falls prevention, physical activity and improved nutrition; programs regarding physical fitness and group exercise; home injury control; screening for the prevention of depression and coordination of community mental health services; medication management services; information concerning diagnosis, prevention, treatment and rehabilitation of age-related diseases and chronic disabling conditions; and gerontological counseling. Service priority shall be given to areas of the state that are medically underserved and have a large number of older individuals who have the greatest economic need for such services.
Economic Need		(See Greatest Economic Need).
Eligible Client		(See Client).
Equipment		Tangible nonexpendable personal property, including exempt property, charged directly to a Contract having a

		useful life of more than one year and an acquisition cost of $5000 or more per unit.
Escort/Shopping Assistance		An allowable service activity under Outreach Services that consists of accompanying and personally assisting or arranging for someone to accompany and personally assist a client with physical or cognitive difficulties obtain a service outside the home environment. Shopping assistance may include purchasing items for homebound clients.
Evidenced-Based Program		A research-based program that demonstrates that a specific practice(s) increases the likelihood of a positive outcome(s). The Administration for Community Living has outlined a three-tiered evidence-based criterion for Title III-D programs and services under the Older Americans Act.
Exploitation		The fraudulent or otherwise illegal, unauthorized, or improper act or process of an individual, including a caregiver (an individual who has the responsibility for the care of an older individual, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law and means a family member or other individual who provides, on behalf of such individual or of a public or private agency, organization, or institution, compensated or uncompensated care to an older individual) or fiduciary, that uses the resources of an older individual for monetary or personal benefit, profit, or

		gain, or that results in depriving an older individual of rightful access to, or use of, benefits, resources, belongings, or assets.
Family Caregiver **(National Family Caregiver Support Program)**		An adult family member, or another individual, who is an informal provider of in-home and community care to an older individual or to an older individual with Alzheimer's disease or a related disorder with neurological and organic brain dysfunction. "Informal" means that the care is not provided as a part of a public service program or payment is received through a private service program.
Fiduciary		A person or entity with the legal responsibility to make decisions on behalf of and for the benefit of another person and to act in good faith with fairness. This includes a trustee, a guardian, a conservator, an executor, an agent under a financial power of attorney or health care power of attorney, or a representative payee.
Focal Point		A facility established to encourage the maximum co-location and coordination of services for older individuals. The eight Regional Human Service Centers have been designated as focal points.
Functionally Impaired		A condition characterized by the inability of an individual to perform a number of activities of daily living (ADL) and/or instrumental activities of daily living (IADL) without assistance.
Governor's Committee on Aging		A fourteen member committee appointed by the Governor that serves

		in an advisory capacity to the Governor and to Aging Services Division; provides local input, acts as an advocate for the service needs of older individuals, and sponsors Statehouse Conferences on Aging and/or Governor's Forums on Aging.
Grandparent or Older Individual Who is a Relative Caregiver **(National Family Caregiver Support Program)**		A grandparent or step-grandparent of a child, or a relative of a child by blood or marriage, or adoption who is 55 years of age or older and (a) lives with the child; (b) is the primary caregiver of the child because the biological or adoptive parents are unable or unwilling to serve as the primary caregiver of the child; and (c) has a legal relationship to the child, such as legal custody or guardianship, or is raising the child informally.
Greatest Economic Need		The need resulting from an income level at or below the poverty line [as defined by the Office of Management and Budget, and adjusted by the Secretary in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)].
Greatest Social Need		The need caused by non-economic factors which include: (a) physical and mental disabilities; (b) language barriers; and (c) cultural, social, or geographic isolation, including isolation caused by racial or ethnic status, that (i) restricts the ability of an individual to perform normal daily tasks; or (ii) threatens the capacity of the individual to live independently.
Health Maintenance		A combination of services provided in

		an effort to determine and maintain the health and well being of clients, which includes monitoring and screening procedures for early detection of disease processes, health education, referral, and follow-up.
High Nutritional Risk		Any client determined through the use of the Nutrition Screening Checklist to be at high nutritional risk. High nutritional risk is defined as a score of 6 or higher using the checklist.
Home and Community-Based Services		An array of services that are essential and appropriate to sustain individuals in their homes and communities, and to delay or prevent institutional care.
Homebound		Unable to leave a place of residence due to limited physical mobility; emotional or psychological impairments that prohibit participation at a meal site or health screening site; remote geographic location where no meal site or health maintenance site exists; or a geographic location is so remote that transporting a client to and from a site is prohibitive.
Home-Delivered Meals		A service that provides meals that assures a minimum of one third of the recommended dietary allowances for a client who is homebound.
Ineligible Participant		Individuals who do not meet Older Americans Act eligibility requirements. Ineligible participants are required to pay the full cost of a service.
In Home Services		Includes homemaker and home health aide; visiting and telephone reassurance; chore maintenance; in-

		home respite care and adult day care as a respite service for families; minor modification of homes; personal care services, and other in-home services as defined in by the State/Area Agency in the State Plan.
Information and Assistance		A one-on-one service for older individuals that (a) provides individuals with information on opportunities and services available within their communities, including information relating to assistive technology; (b) assesses problems and capabilities of the individuals; (c) links the individuals to the services and opportunities that are available; (d) to the maximum extent practicable, establish adequate follow-up procedures; and (e) serve the entire community of older individuals, particularly older individuals with greatest economic need, greatest social need, and older individuals at risk for institutional placement.
Information Services **(National Family Caregiver Support Program)**		A service for caregivers that provides the public and individuals with information on resources and services available to the individuals within their communities.
Instrumental Activities of Daily Living (IADL)		Independent living tasks that typically require mental/cognitive (memory, judgment, intellect) and/or physical ability such as: preparing meals, shopping for personal items, medication management, managing money, using telephone, doing heavy housework, doing light housework, transportation ability. Transportation

		ability refers to the individual's ability to make use of available transportation.
Legal Assistance		Legal advice and representation provided by an attorney to older individuals with economic or social needs and includes (i) to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and (ii) counseling or representation by a nonlawyer where permitted by law.
Licensed Registered Dietitian		A person licensed to practice dietetics as provided in North Dakota Century Code Chapter 43-44.
Limited English Proficiency		An individual who is not fluent in the spoken English language.
Living Alone		A one-person household where the householder lives by his or herself in an owned or rented place of residence in a non-institutional setting.
Local Contact Agency (LCA) Operating		Day-to-day activities necessary to implement and maintain Local Contact Agency services.
Local Contact Agency (LCA) Services		Activities provided in conjunction with the Department of Human Services Medical Services Division and the Money Follows the Person (MFP) initiative to assist in the required review of nursing home consumers through the Minimum Data Set (MDS) – Section Q to inform the consumers of available services and supports for potential transition to community living. LCA services follow the ADRL Options Counseling principles and core competencies.

Long-Term Care		Any service, care, or item (including an assistive device), including disease prevention and health promotion service, an in-home service, and a case management service (a) intended to assist individuals in coping with, and to the extent practicable compensate for, a functional impairment in carrying out activities of daily living; (b) furnished at home, in a community care setting , or in a long-term care facility; and (c) not furnished to prevent, diagnose, treat, or cure a medical disease or condition.
Long-Term Care Facility		A facility defined in North Dakota Century Code Chapter 50-10.1, as any assisted living facility, any skilled nursing facility, basic care facility, nursing home as defined in subsection 3 of the North Dakota Century Code section 43-34-01, or swing bed hospital approved to furnish long-term care services.
Long-Term Care Ombudsman		An individual who identifies, investigates, and resolves complaints made by or on behalf of residents of long-term care facilities and tenants of assisted living facilities. The ombudsman also works in other ways to protect the health, safety, welfare, and rights of residents/tenants.
Minority Elderly		Individuals 60 years of age or over who are confined to the following designations: American Indian or Alaskan Native; Asian; Black or African American, not of Hispanic origin; Hispanic or Latino; origin; American

		Indian or Alaskan Native, and Asian American/Pacific Islander and Native Hawaiian or other Pacific Islander.
Modified Atmosphere Packaging (MAP) Meal		Modified Atmosphere Packaging (MAP) is a technology that has been developed to ensure that packaged food products stay fresh and attractive for as long as possible. MAP extends the shelf life and preserves the quality of food without additives or preservatives. Shelf life of fresh food is significantly extended, while spoilage and waste are reduced.
Multipurpose Senior Center		A community facility for the organization and provision of a broad spectrum of services, which includes the provision of health (including mental health), social, nutritional, educational, and recreational activities.
National Aging Program Information System (NAPIS)		Annual performance reporting requirements established by the Administration on Aging for Older Americans Act programs. The system includes the State Program Report.
National Family Caregiver Support Program		Provides for a multifaceted system of support services for family caregivers and for grandparents or older individuals that are relative caregivers. Support services include information to caregivers about available services; assistance to caregivers in gaining access to the services; individual counseling, organization of support groups, and caregiver training to caregivers to assist the caregivers in making decisions and solving problems relating to their care giving roles; respite care to enable caregivers to be temporarily relieved from their care

		giving responsibilities and supplemental services, on a limited basis, to complement the care provided by the caregivers. Priority for services shall be given to older individuals with greatest social and economic need (with particular attention to low-income older individuals) and older individuals providing care and support to older individuals with mental retardation and related developmental disabilities (as defined in 42 U.S.C. 6001). Services are funded under Title III-E of the Older Americans Act.
Neglect		The failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an older individual; or self neglect.
New Client		Any client who has never been previously registered as a client for the service, either in the current fiscal year or a prior fiscal year by a contract entity funded with Older Americans Act funds in the planning and service area.
Non-Minority		Any individual who is not considered a minority.
Nutrition Counseling		Provision of individualized advice and guidance to individuals, who are at nutritional risk, because of their health or nutritional history, dietary intake, medications use or chronic illnesses, about options and methods for improving their nutritional status, performed by a licensed registered dietitian in accordance with North Dakota Century Code Chapter 43-44.

Nutrition Education		The provision of scheduled learning experiences on topics related to the improvement of health and nutritional well being. A program to promote better health by providing accurate and culturally sensitive nutrition, physical fitness, or health (as it relates to nutrition) information and instruction to participants, caregivers, or participants or caregivers in a group or individual setting overseen by a dietitian or individual with comparable expertise.
Nutrition Screening		Completion of a nutrition screening checklist by eligible clients to determine if they are at nutritional risk. Nutritional screening data is a federal collection requirement of the National Aging Program Information System (NAPIS), found in the Federal Register, Volume 59, No. 188, September 29, 1994.
Nutrition Services		Services funded under Title III-C of the Older Americans Act including congregate and home-delivered meals, nutrition counseling, nutrition screening, and nutrition education.
Nutrition Services Incentive Program (NSIP)		Receipt of cash and/or commodities as an incentive to encourage and reward effective performance in the efficient delivery of nutritious meals to older individuals.
Nutrition Services Incentive Program (NSIP) Meal		A meal served in compliance with all the requirements of the Older Americans Act (OAA), which means at a minimum that: 1) it has been served to a participant who is eligible under the OAA and has not been means-tested for participation (i.e. meals provided to

		individuals through means-tested programs such as Medicaid Title XIX waiver meals or other programs such as state-funded means-tested programs are excluded from the NSIP meals); 2) it is compliant with the nutrition requirements; 3) it is served by an eligible agency; and 4) it is served to an individual who has an opportunity to contribute. NSIP Meals include all OAA eligible meals including those served to persons under age 60 where authorized by the OAA.
Older Individual (Person)		An individual who is 60 years of age or older.
Older Americans Act of 1965		Public Law 89-73, first enacted in 1965, amended 13 times between 1965 and 2006; directed to improving the lives of America's older individuals, particularly in relation to income, health, housing, employment, long-term care, retirement and community services. The Act also established the Administration on Aging within the United States Department of Health and Human Services.
Person with Comparable Expertise		For Nutrition Services, includes the following: licensed nutritionist, dietary technician or certified dietary manager.
Poverty		An individual with an annual income at or below the Federally established poverty level.
Program Income		Income received as a service contribution from eligible clients and income from ineligible participants (must pay the full cost of a meal).

		Program income must be used towards the cost of the service to expand and/or enhance services.
Program Income Carryover		Program income that is not expended during the contract period.
Rapid Inspection		Nursing task accomplished by limited observation of a client to detect status of visible health conditions.
Respite Care **(National Family Caregiver Support Program)**		Services that offer temporary, substitute supports or living arrangements for older persons in order to provide a brief period of relief or rest for caregivers. Respite Care includes: (1) In-home respite (personal care and other in-home respite); (2) respite provided by attendance of the care recipient at a senior center or other nonresidential program; and 3) institutional respite provided by placing the care recipient in an institutional setting such as a nursing home for a short period of time as a respite service to the caregiver.
Rural		Any area that is not defined as urban. Urban areas comprise (1) urbanized areas (a central place and its adjacent densely settled territories with a combined minimum population of 50,000) and (2) an incorporated place or a census designated place with 20,000 or more inhabitants.
Self-Directed Care		An approach to providing services (including programs, benefits, supports, and technology) under the Older Americans Act intended to assist an individual with activities of daily

		living in which (a) such services (including the amount, duration, scope, provider, and location of such services) are planned, budgeted, and purchased under the direction and control of such individual; (b) such individual is provided with such information and assistance as are necessary to and appropriate to enable such individual to make informed decisions about the individual's care options; (c) the needs, capabilities, and preferences of such individual with respect to such services, and such individual's ability to direct and control the individual's receipt of such services, are assessed by the State/Area Agency (or other agency designated by the State/Area Agency) involved; (d) based on the assessment made under subparagraph (c), the State/Area Agency develops together with such individual and the individual's family, caregiver or legal representative, (i) a plan for services for such individual that specifies which services such individual will be responsible for directing; (ii) a determination of the role of family members (and others whose participation is sought by such individual) in providing services under such plan; and (e) the State/Area Agency provides for oversight of such individual's self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under the Older Americans Act.
Self-Neglect		An adult's inability, due to physical or

		mental impairment or diminished capacity, to perform essential self-care tasks including (a) obtaining essential food, clothing, shelter, and medical care; (b) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or (c) managing one's own financial affairs.
Senior Companion Services		A service that offers periodic companionship and non-medical support by volunteers (who receive a stipend) to adults with special needs.
Service Contribution		See Program Income.
Severe Disability		A severe, chronic condition attributable to mental or physical impairment, or a combination of mental and physical impairments that (a) is likely to continue indefinitely; and (b) results in substantial functional limitation in three or more of the following major life activities: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living; and economic self-sufficiency.
Shelf Stable Meal		A combination of pre-portioned foods that can be stored and consumed at room temperature. Shelf stable meals are distributed for use in emergency situations, such as when meals cannot be delivered due to severe weather. Each meal must provide one-third of the Recommended Dietary Allowances.
Social Need		(See Greatest Social Need).
State Plan on Aging		A planning and compliance document that is required by the Older Americans

		Act for the provision of services for older individuals.
Supportive Services		Services funded under Title III - B of the Older Americans Act, including but not limited to health maintenance, information and assistance, ADRL options counseling, assistive devices, senior companion services, tribal home visits, and legal services.
Supplemental Services **(National Family Caregiver Support Program)**		Services provided on a limited basis to complement the care provided by caregivers.
Targeting		A concentrated effort to provide services and programs to a specific group.
Transportation		A service that provides a method of travel from one specific location to another specific location. All transportation services will be provided through the Department of Transportation.
Tribal Home Visit		Periodic visits to isolated older individuals residing on a Reservation to monitor their health and well-being, and identify service needs with an emphasis on referral and linkage to available services.
Unduplicated Client Count		For NAPIS purposes, the counting an eligible individual only one time during a federal fiscal year, regardless of the number of services the individual receives.

Vulnerable Adult		An adult who has a substantial functional or mental impairment. [(A) Substantial functional impairment is a significant limitation in the adult's ability to live independently or provide self-care. This limitation is due to physical incapabilities that are determined through observation, diagnosis, evaluation or assessment. (B) Substantial mental impairment is a significant disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, or ability to live independently or provide self-care. It is determined through observation, diagnosis, evaluation or assessment.]
Vulnerable Adult Protective Services		Remedial social, legal, health, mental health, and referral services provided for prevention, correction, or discontinuation of abuse or neglect which are necessary and appropriate under the circumstances to protect an abused or neglected vulnerable adult, and ensures that the lease restrictive alternatives provided prevent further abuse or neglect, and promote self-care and independent living. (Reference: North Dakota Century Code Chapter 50-25)

Overview of the Older Americans Act 650-25-15

(Revised 1/1/08 ML#3121)

View Archives

The Older Americans Act of 1965 provides assistance in the development of new or improved programs to help older persons through grants to states for community planning and services. It also provides for training, research, and discretionary projects. Further, it establishes, within the United States Department of Health and Human Services, an operating agency designated as the Administration on Aging.

The Older Americans Act of 1965, as amended in 2006, contains the following Titles:

1. Title I outlines objectives to improve the lives of older Americans in the areas of income, physical health, mental health, housing, long-term care services, employment, retirement, education and recreation opportunities, and community services.
2. Title II establishes the Administration on Aging, headed by an Assistant Secretary for Aging, within the Office of the Secretary of Health and Human Services. The Assistant Secretary for Aging is appointed by the President of the United States with the advice and consent of the Senate. The Title further establishes within the Administration on Aging, an Office for American Indian, Alaskan Native, and Native Hawaiian Aging; and an Office of the Long-Term Care Ombudsman Program. The 2006 amendments broaden the role of the Administration on Aging in the following areas: elder abuse and prevention services, mental health services authorized under the Act, expansion of Aging and Disability Resource Centers to all states; coordination with the Centers for Medicare and Medicaid and other federal agencies to promote self-directed care, build awareness of federal programs and benefits, and establish a National Center on Senior Benefits Outreach and Enrollment; and coordinate with the Corporation for National and Community Service to encourage volunteer and civic engagement activities for all ages in supportive services and community capacity building initiatives. Authority is also given for a Federal Interagency Coordinating Committee on Aging to focus on a broad range of aging issues, with emphasis on housing,

supportive services, data collection, technology, and streamlining access to all services.

3. Title III provides funding for the development of comprehensive and coordinated service systems that allow older persons to lead independent, meaningful, and dignified lives in their own homes and communities. Imbedded throughout the title are the principles outlined in the "Choices for Independence" initiative including consumer empowerment, flexible options and more choices for high-risk individuals, healthy lifestyles, evidence-based disease prevention initiatives, Aging and Disability Resource Centers, and emergency/disaster preparedness. Part A outlines the purpose and administration of this Title; Part B allows for the provision of supportive services and senior centers; Part C allows for the provision of nutrition services; Part D allows for disease prevention and health promotion services; Part E addresses the National Family Caregiver Support Program. Services provided under this title must be coordinated with services under Title VI, if applicable.
4. Title IV provides funding for grant awards to design, test, and promote the use of innovative ideas and best practices in programs and services addressing health, independence, and longevity.
5. Title V promotes useful community service and employment opportunities for unemployed, low-income persons who are age fifty-five and older.
6. Title VI provides funding for the delivery of supportive services and nutrition services to American Indians, Alaskan Natives, and Native Hawaiians that are comparable to services provided under Title III. The Native American Caregiver Support Program is also provided under this title. Grants under this Title are administered by the Administration on Aging.
7. Title VII provides funding for elder rights protection activities for vulnerable adults.

Department of Human Services Mission Statement 650-25-20

(Revised 1/1/06 ML#2995)

View Archives

Our mission is to provide quality, efficient, and effective human services, which improve the lives of people.

To carry out this mission, Aging Services Division will, in a leadership role, advocate for individual life choices and develop quality services in response to the needs of vulnerable adults, persons with physical disabilities and an aging society.

Division of Administrative & Management Functions 640-25-25

(Revised 1/1/06 ML#2995)

View Archives

The Department of Human Services, Aging Services Division, is designated by the Governor as the sole state agency to administer programs and services under the Act.

Planning and Service Area 650-25-25-01

(Revised 1/1/06 ML#2995)

View Archives

The State of North Dakota requested and received designation as a single planning and service area (PSA) from the Administration on Aging. Single PSA status requires the State to carry out the functions of both the State Agency and the Area Agency on Aging as outlined in the Older Americans Act.

Regional Aging Services Program Administrators, located within each of the State's Planning Regions, work directly with Aging Services Division in program administration. The eight Human Service Centers have been designated as focal points.

State Plan on Aging 650-25-25-05

(Revised 1/1/06 ML#2995)

View Archives

The State Plan on Aging serves as a planning and compliance document for the provision of services for North Dakota's older individuals. Developed as a four-year plan, it outlines specific focus areas, goals and objectives to implement the Plan. Addendums to the Plan include Assurances and the Older Americans Act Budget.

Committee on Aging 650-25-25-10
(Revised 10/1/15 ML#3454)

View Archives

The Committee on Aging is the designated advisory committee for Aging Services Division. Members are appointed by the Governor to serve a three-year term. Periodically, the Committee conducts Statehouse Conferences on Aging and/or Governor's Forums that identify and address major issues affecting North Dakota’s older persons.

Advocacy 650-25-25-15

(Revised 1/1/06 ML#2995)

View Archives

Aging Services Division advocates for the needs of older individuals as appropriate and as time, resources, and Department policies permit. The State Plan on Aging outlines specific advocacy efforts.

Technical Assistance 650-25-25-20

(Revised 1/1/06 ML#2995)

View Archives

Aging Services Division provides technical assistance to organizations, agencies, associations, or individuals representing the needs of older persons.

Confidentiality 650-25-25-25

(Revised 1/1/06 ML#2995)

View Archives

Aging Services Division is governed by the confidentiality policies of the Department of Human Services, Service Chapter 110-01.

Hearings 650-25-25-30

(Revised 1/1/06 ML#2995)

View Archives

Aging Services Division conducts public hearings to obtain input to develop the State Plan on Aging. Other public hearings are scheduled as requested and as necessary. Public input is also received through regional Council on Aging meetings.

Grievances 650-25-25-35

(Revised 1/1/07 ML#3061)

View Archives

A recipient of Older Americans Act funds/services may file a grievance in writing to the Director of the Aging Services Division. The grievance statement must list the facts related to the grievance, the nature of the grievance, and any request for resolution. The grievance should be made in writing within thirty (30) days of the action. A response to the grievance will be made within five (5) working days of receipt of the grievance.

All contract entities are required to include grievance procedures for older individuals who are dissatisfied with or denied services in their Program Policies and Procedures Manual.

Poverty Guidelines 650-25-25-45

(Revised 1/1/06 ML#2995)

View Archives

Poverty guidelines are based on the definition of poverty maintained by the Office of Management and Budget and the Bureau of Census. Poverty thresholds are adjusted by the Secretary of the United States Department of Health and Human Services before being converted into poverty guidelines. The Secretary provides an annual update of the poverty guidelines to be used in assessing low-income status for recipients of Older Americans Act funded services. Updated poverty guidelines will be issued upon receipt.

Records 650-25-25-50

(Revised 1/1/06 ML#2995)

View Archives

1. The Department, the Federal Government, and their duly authorized representatives shall have access to the books, documents, papers, and financial and program records, (both electronic and hard copy) of the contract entity and subcontract entity which are pertinent to the services provided under the Contract for the purposes of making an audit, examination, or making excerpts and transcripts as well as for the purpose of conducting assessments/reviews. All contract entity and subcontract entity books and records pertinent to the services provided under the Contract must be available upon request at the contract entity address as identified on the Identifying Data Form. Access shall be available during normal business hours or at pre-arranged times.
2. Upon termination of the Contract for non-performance, or any other breach, or termination subject to notice provided in the Contract, or upon expiration of the term of the Contract and if requested by the State, the contract entity shall deliver to the Department, or any other person designated by the Department, original copies of all client records, including the completed SAMS assessment forms, and service delivery/utilization reports records. This includes client records of the contract entity and the subcontract entity.
3. Financial and program books and records shall be available for a period of three years from the date of submission of the final federal expenditure report or if subject to audit, until such audit is completed and closed, whichever occurs later. A hard copy must be on file prior to purging electronic files.
4. Records for senior center acquisition must be retained for ten years following acquisition.
5. Records for senior center construction must be retained for twenty years following the completion of the project.

Equipment 650-25-25-55

(Revised 1/1/06 ML#2995)

View Archives

1. Equipment procured with funds derived from the contract and/or program income is considered federal property.
2. Equipment purchases cannot be made with Older American Act funds or program income unless written approval is granted by the Department.
3. Upon request, each contract entity must submit to Aging Services Division an inventory listing of equipment purchased with Older Americans Act funds, including program income, which has a unit acquisition cost of $5000 or more. The inventory listing must include a description of the equipment, the serial number or other identification number (if applicable), source of the equipment, including contract award number, the acquisition date, acquisition price, OAA fund portion, local fund portion, the location and condition of the equipment, and ultimate disposition data including the date of disposal and sales price or the method used to determine current fair market value where a contract entity compensates the Department for its share. Original invoices for equipment purchases should be kept on file.
4. The Department reserves the right to transfer any equipment in accordance with applicable federal regulations.
5. When equipment is no longer used in a program currently or previously sponsored by the Federal Government, disposition of the equipment must be made in accordance with applicable federal regulations.

Priority Services 650-25-25-60

(Revised 1/1/06 ML#2995)

View Archives

Service priorities are based on needs assessments, public hearings, client and provider surveys, outcomes from pilot projects, related studies, and federal regulations governing Older Americans Act funds.

Target Groups 650-25-25-65

(Revised 1/1/08 ML#3121)

View Archives

Services will be targeted to older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English-proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and their caretakers; and older individuals at risk for institutional placement.

Direct Services 650-25-25-70

(Revised 1/1/13 ML#3359)

View Archives

Aging Services Division provides the following direct services:

- Information and Assistance Services: Aging Services Division operates the North Dakota Aging and Disability Resource-LINK, a toll free line that provides information and assists the caller in accessing programs and services across the state (North Dakota Department of Human Services Manual Chapter 650-50, North Dakota Aging and Disability-LINK).
- Ombudsman Services: The State Ombudsman, along with Regional Ombudsmen, receive, investigate and resolve concerns on behalf of residents in long-term care facilities and tenants of assisted living facilities. Community Volunteer Ombudsmen have been certified to assist with the program. (North Dakota Department of Human Services Manual Chapter 695-01, Long-Term Care Ombudsman Program.)
- Vulnerable Adult Protective Services: The State Legal Assistance Developer, along with regional staff, have implemented a system to respond to concerns of abuse, neglect, and exploitation. (North Dakota Department of Human Services Manual Chapter 690-01, Vulnerable Adult Protective Services.)

Legislative Directives 650-25-25-75

(Revised 1/1/06 ML#2995)

View Archives

Aging Services Division is actively involved in interim legislative studies as directed by the State Legislature.

Services/Program Service Standards 650-25-25-80

(Revised 1/1/13 ML#3359)

View Archives

Aging Services Division contracts through a request for proposal for provision of ADRL options counseling, health maintenance, legal, and nutrition services. Aging Services Division also contracts for the provision of senior companion services, family caregiver support services, tribal home visits, and other needed services as funding allows.

Contract entities must meet minimum standards for each service of the program. The following Program Service Standards are included in this chapter: ADRL options counseling, family caregiver support services, health maintenance, legal, nutrition, senior companion, and tribal home visits. Standards for other services are included with the Contract document.

Aging & Disability Resource LINK (ADRL) Options Counseling Service Standard, including Local Contact Agency (LCA) Services 650-25-26

(Revised 1/1/14 ML#3396).

View Archives

ADRL Options Counseling is a person-centered, interactive, decision-support process whereby consumers, family members and/or significant others are supported in determining appropriate long-term care choices based on the consumer's needs, preferences, values, and individual circumstances. Options counselors ensure that consumers have considered a range of possibilities when making a decision about long-term services and supports, and they encourage planning for the future.

The foundation for ADRL Options Counseling is a strong information and assistance system. It is important to keep in mind that information should be customized based on the needs and preferences communicated by the consumer, and the options available in the community.

Another building block of ADRL Options Counseling is person-centered planning. Within person-centered planning, the options counselor and the consumer work in full partnership to guarantee that the consumer's values, experience, and knowledge drive the creation of an action plan as well as the delivery of services. Person-centered planning requires that the options counselors respect the consumer's autonomy when choosing services, even if the options counselor disagrees with the consumer's choices.

Examples of when ADRL Options Counseling is appropriate include, but are not limited to: an individual who prefers to remain at home but needs supports to do so, or when a family caregiver needs help to continue providing care in the community.

Options counseling is not a long-term service. For the most part, ADRL intensive options counseling relationships are short term, usually no more than 90 days.

Six core competencies of options counseling have been identified by the Aging and Disability Resource Center Technical Assistance Exchange (ADRC-TAE):

1. Determining the need for options counseling;
2. Assessing needs, values and preferences;
3. Understanding and educating about public and private sector resources;
4. Facilitating self-direction/self-determination;
5. Encouraging future orientation; and
6. Following-up.

ADRL Options Counseling training addresses strategies for each of the core competencies.

LCA Services follow the ADRL Options Counseling principles and core competencies.

Performance Standards 650-25-26-01

Eligible Consumers 650-25-26-01-01

(Revised 1/1/14 ML#3396)

View Archives

1. Individuals 60 years of age and older.
2. Adults 18 years of age and older with a physical disability.
3. LCA only: Nursing facility residents who may require assistance in securing medical and long-term supports and services to return to community living. Residents must be referred by the nursing facility staff.

Location of Services 650-25-26-01-05

(Revised 1/1/14 ML#3396)

View Archives

Initial contact may occur through telephone contact and is often the gateway to options counseling. ADRL Options Counseling usually occurs in a face to face interaction. In-person conversations can be more effective than telephone consultation, especially when it offers the opportunity to involve family members as well as the consumer.

LCA Services are initiated through referral by a nursing facility after a Minimum Data Set (MDS) – Section Q review indicates a potential transition to the community. Initial consultation for possible transition to the community and follow-up occur with the resident/family in the nursing facility.

ADRL Operating Activities & LCA Operating Activities 650-25-26-01-10

(Revised 1/1/14 ML#3396)

View Archives

ADRL Operating and LCA Operating are billable units of service that addresses staff time necessary to perform the day-to-day activities to implement and maintain an ADRL or complete LCA Services. Examples include answering the phone, data entry/billing, program marketing and promotion activities, training, travel time, etc.

ADRL Operating does not include ADRL activities outlined in the Service Delivery Procedures section 650-25-26-10.

LCA Operating does not include LCA Services outlined in the Service Delivery Procedures section 650-25-26-11.

Contract entities will be required to report completed ADRL Operating and LCA Operating activities on a monthly basis. Reporting requirements will be outlined in the contractual document with the Department of Human Services.

ADRL Operating and LCA Operating units of service must be entered in the SAMS data system by the 15th of the month following the activity.

ADRL Service Delivery Characteristics/Activities 650-25-26-01-15

(Revised 1/1/14 ML#3396)

View Archives

ADRL Information & Referral/Assistance (I & R/A) and ADRL Options Counseling must be delivered throughout the service area.

1. All requests for ADRL I & R/A must be responded to within two working days.
2. Provide ADRL I & R/A services. Requests for I & R/A may be received from an individual, family member, ADRL partner, another agency, etc. Determine if the request requires only I & R/A or if options counseling is needed. Completion of the ADRL Options Counseling Referral/Intake form may assist in making the determination.

    a. If it is determined that only I & R/A is needed, information should be given or a referral(s) made. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
    b. If it is determined that options counseling is needed, the ADRL Options Counseling Referral/Intake form must be completed. If completed by another staff person, the information must be forwarded to an options counselor.
    c. Enter the ADRL Options Counseling Referral/Intake form information in the SAMS data system by the 15th of the month following service delivery.

3. If it is determined that ADRL Options Counseling is needed, the options counselor shall:

    a. Complete the SAMS ADRL Options Counseling assessment form. The options counselor must attempt to obtain necessary data to determine consumer needs, preferences, values, and individual circumstances using person-centered planning strategies.
    b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of

both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.

c. Develop an action plan.
d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
e. Enter the completed SAMS ADRL Options Counseling assessment form data, including the action plan, referrals, and narratives in the SAMS data system by the 15th of the month following service delivery.

4. A follow-up contact (face-to-face, telephone, written correspondence or e-mail) must be made within 30 days of the assessment to finalize the consumer action plan or assure the consumer has made a successful connection to the needed supports and is satisfied with the services and choice of service provider(s). All contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form by the 15th of the month following service delivery. Documentation of each contact shall include:

   - The specific purpose of the contact;
   - A brief descriptive statement of the interaction including consumer satisfaction (if applicable), and any service needs identified;
   - Options discussed; and
   - An action plan.

   Documentation in the narrative section must support any subsequent contacts that are made.

   If ADRL Benefits Counseling and/or ADRL Futures Planning are provided, the activity must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-up Contact [Service Delivery Procedure #4].

5. At the time that all action steps are completed or if there is no activity within 90 days, the SAMS ADRL Options Counseling record must be updated to reflect "inactive"; the Narrative section must be updated to reflect that Options Counseling is no longer being provided. If the consumer is enrolled in other Title III or HCBS services, the record

must remain active; the Narrative should be updated to reflect that Options Counseling is no longer being provided.

6. If, after the consumer record has been made inactive, a consumer and/or a new referral indicates the need for additional options counseling, the options counselor shall re-open the consumer record, review, and update the existing SAMS ADRL Options Counseling assessment form, and complete the action steps as identified in Section 650-25-26-01-15(3)(a-e); (4); and (5).
7. Complete disaster/emergency contacts upon request from Aging Services Division.
8. Complete ADRL Evaluation/Quality Assurance activities as outlined in Section 650-25-26-01-15 (8).
9. A signed release of information document must be on file before information is shared or released.
10. Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program. At a minimum, the record should include the initial contact information, the SAMS ADRL Options Counseling assessment form, all documentation, and the release of information form(s) as applicable.

LCA Service Delivery Characteristics/Activities 650-25-26-01-16

(Revised 1/1/14 ML#3396)

View Archives

LCA Services must be delivered throughout the service area.

1. All requests for LCA Services must be responded to within three working days. A face-to-face visit (if applicable) must be completed within 15 working days.
2. Provide LCA Services: Requests for LCA Services can only be received from a nursing facility. Determine if the request requires only information and assistance or if LCA Community Transition is needed.

    a. If it is determined that only information and assistance is needed, requested information should be given or assistance/consultation provided. Time spent on the call shall be billed to LCA Operating.
    b. If it is determined that LCA Community Transition is needed, the nursing facility social worker or designated staff shall fax the LCA Referral Form to the options counselor.

3. If it is determined that LCA Community Transition is needed, upon receipt of the LCA Referral Form, the options counselor shall:

    a. Contact nursing facility social worker or designated staff to discuss referral and other pertinent information. Determine a date/time for an on-site visit (to be conducted within 15 days of the referral) with the resident, other identified individuals, and the nursing facility social worker/designee. (Note: The nursing facility social worker/designee is responsible for handling logistics, setting up the visit with the resident and other identified individuals, etc.).
    b. Conduct an on-site visit within 15 days of the referral. The options counselor must attempt to obtain necessary data to determine the resident's needs, preferences, values, and individual circumstances using person-centered planning strategies. (Note: The nursing facility social worker/designee is

responsible for the discharge plan; the options counselor provides information on options that are available based on the resident's preferences).

c. Complete the LCA Service Activity Summary form. Documentation must include, at a minimum:

    - Summary of the interaction and options discussed;
    - Determination as to whether or not the resident's needs can be met in a community setting;
    - Potential referrals to the MFP program or Medicaid (county social services), if applicable;
    - Potential referrals to community-based services; and
    - Next steps.

d. Follow-up to determine if/when discharge will take place. The nursing facility social worker/designee is responsible for developing the discharge plan that includes a referral to ADRL Options Counseling, if the options counseling service is needed after discharge.
e. Fax a copy of the LCA Referral Form and the LCA Service Activity Summary form to the MFP administrator. If the resident is eligible for MFP services, the MFP administrator will contact the applicable Center for Independent Living (CIL).
f. LCA services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit).
g. Enter information obtained from the LCA Referral Form and the LCA Service Activity Summary form in the SAMS ADRL Options Counseling assessment form; in the narrative section, document referral information, summary of the on-site visit, follow-up activities, and next steps in SAMS data system.
h. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

4. If a referral is made to the MFP program or county social services, the narrative section of the SAMS ADRL Options Counseling assessment form must be updated to reflect referral information and service delivery posted to reflect 'inactive'.
5. A signed release of information document must be on file before information is shared or released.

6. Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program. At a minimum, the record should include the initial contact information, the SAMS ADRL Options Counseling assessment form, all documentation, and the release of information form(s) as applicable.

Billable Unit of Service 650-25-26-05

(Revised 1/1/14 ML#3396)

View Archives

For billing purposes, an ADRL Operating and LCA Operating unit of service is based on a 15-minute increment. Unit cost reimbursement is outlined in the contract entity's contractual document with the Department of Human Services.

The maximum amount of funding available for ADRL Operating and LCA Operating activities is outlined in the legal entity's contractual document with the Department of Human Services.

ADRL and LCA Operating units of service must be entered in the SAMS data system by the 15th of the month following the activity.

When delivering individual ADRL consumer and individual LCA resident services, the contract entity must use the service billing unit system for each service procedure identified in the Service Delivery Procedures 650-25-26-10 and 650-25-26-11.

ADRL Information & Referral Activity (ADRL I & R/A) that does not result in options counseling is not a billable unit of service.

If ADRL Benefits Counseling and ADRL Futures Planning are provided, the activity must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-up Contact [Service Delivery Procedure #4].

Each billable unit of service received by a consumer/or a resident must be recorded in the consumer's individual record in the SAMS data system by the 15th of the month following service delivery.

ADRL Service Delivery Procedures 650-25-26-10

(Revised 10/1/15 ML#3454)

View Archives

The following service delivery procedures must be used for reimbursement through the contract:

1. ADRL Information & Referral/Assistance (ADRL I & R/A) – 1 Unit of Service (only if activity results in ADRL Options Counseling).

    a. Complete the ADRL Options Counseling Referral/Intake form. If completed by another staff person, the information must be forwarded to an options counselor.
    b. Enter the ADRL Options Counseling Referral/Intake form information in the SAMS data system.
    c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.
    d. If a consumer record is re-opened [Service Delivery Procedure #6], the ADRL Information & Referral/Assistance (ADRL I & R/A) [Service Delivery Procedure #1] may be billed in addition to the four units of service to re-open the consumer record, as applicable.

2. ADRL Initial Options Counseling Assessment – 8 Units of Service

    a. Complete the SAMS ADRL Options Counseling assessment form. The options counselor must attempt to obtain data necessary to determine consumer needs, preferences, values, and individual circumstances using person-centered planning strategies.
    b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.
    c. Develop an action plan.

d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
e. Enter the completed SAMS ADRL Options Counseling assessment form data, including the action plan, referrals, and narratives in the SAMS data system.
f. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

3. ADRL Telephone Contact, E-mail, Written Correspondence, or Brief Face-to-Face Visit – 1 Unit of Service

   a. If needed to complete the ADRL options counseling process, a referral entity or consumer may be contacted via telephone, e-mail, written correspondence, or through a brief face-to-face visit (outside of the home) regarding a needed service or receipt of services.
   b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief descriptive statement of the interaction, including consumer satisfaction (if applicable) with the service.
   c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

4. ADRL Options Counseling Follow-Up Contact – 2 Units of Service

   a. A follow-up contact (telephone, e-mail, written correspondence, or through a brief face-to-face visit) must be made within 30 days of the assessment to finalize the consumer action plan or assure the consumer has made a successful connection to the needed supports and is satisfied with the services and choice of service provider(s).
   b. If provided, ADRL Benefits Counseling and/or ADRL Futures Planning must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-up Contact [Service Delivery Procedure #4].
   c. Up to two additional contacts may be made. Documentation in the narrative section must support any subsequent contacts that are made. Billing for ADRL Options Counseling Follow-up Contact beyond the two additional contacts must be approved by the Options Counseling Program Administrator.

d. All contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form. Documentation of each contact shall include:

- The specific purpose of the contact;
- A brief descriptive statement of the interaction including any service needs identified;
- Options discussed; and
- An action plan.

e. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

5. ADRL Options Counseling Inactivity – 1 Unit of Service

a. At the time that all action steps are completed or if there is no activity within 90 days, the SAMS ADRL Options Counseling record must be updated to reflect "inactive"; the Narrative section must be updated to reflect that Options Counseling is no longer being provided.
b. If the consumer is enrolled in other Title III or HCBS services, the record must remain active; the Narrative should be updated to reflect that Options Counseling is no longer being provided.
c. The ADRL Options Counseling Satisfaction Survey and cover letter must be given or mailed to the consumer along with a Department of Human Services self-addressed envelope.
d. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

6. ADRL Options Counseling Re-Open Consumer Record – 6 Units of Service

a. If, after the consumer record has been made inactive, a consumer and/or a new referral indicate the need for additional options counseling, the options counselor shall re-open the consumer record, review, and complete a reassessment using the SAMS ADRL Options Counseling assessment form (in SAMS copy, review, and update assessment information). If applicable, Service Delivery Procedure #1, [ADRL Information & Referral/Assistance (ADRL I & R/A)] may be billed in addition to the four units of service to re-open the consumer record.

b. Provide customized information and assistance based on information communicated by the consumer, allowing the consumer to explore alternatives and make independent choices of both the service(s) to be received and the entity to provide the service. Assist the consumer in planning for future long-term care support needs.
c. Develop an action plan.
d. Make referral(s), if indicated, to other agencies. Services must be coordinated with other agencies to eliminate duplication and assure seamless access for optimal service delivery.
e. If provided, ADRL Benefits Counseling and/or ADRL Futures Planning must be recorded in SAMS as a subservice of ADRL Options Counseling Follow-up Contact [Service Delivery Procedure #4].
f. Enter the completed SAMS ADRL Options Counseling form data, including the action plan, referrals, and narratives in the SAMS data system.
g. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

7. Disaster/Emergency Contact – 1 Unit of Service

a. At the direction of the Aging Services Division, contact a consumer to assist in planning to assure the consumer's safety in the event of a disaster/emergency.
b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief description of the consumer's plan for safety.
c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

8. ADRL Evaluation/Quality Assurance - 1 unit of Service

Aging Services Division seeks to determine the length of time a consumer who used the options counseling service to explore alternatives to nursing home placement (i.e. considered nursing home placement; was on a waiting list for nursing home placement; referred from a nursing home; referred from a home health agency; referred from a physician; or other) is able to maintain in the community after the options counseling process is completed

(consumer has been made inactive and is no longer receiving options counseling).

a. On a six-month basis, contact the consumer to determine if he/she is still living in the community.
b. Select the appropriate sub-service of SAMS ADRL Evaluation/Quality Assurance Service Delivery. If "Other" is selected, include referral source in documentation.
c. Document in the Narrative section of the SAMS ADRL Options Counseling form the purpose of the contact and whether or not the consumer continues to reside in the community.
d. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

LCA Service Delivery Procedures 650-25-26-11

(Revised 1/1/14 ML#3396)

View Archives

The following service delivery procedures must be used for reimbursement through the contract:

1. LCA Community Transition – 8 Units of Service

   Upon receipt of the LCA Referral Form, the options counselor shall:

   a. Contact nursing facility social worker or designated staff to discuss referral and other pertinent information. Determine a date/time for an on-site visit (to be conducted within 15 days of the referral) with the resident, other identified individuals, and the nursing facility social worker/designee. (Note: The nursing facility social worker/designee is responsible for handling logistics, setting up the visit with the resident and other identified individuals, etc.).
   b. Conduct an on-site visit within 15 days of the referral. The options counselor must attempt to obtain necessary data to determine the resident's needs, preferences, values, and individual circumstances using person-centered planning strategies. (Note: The nursing facility social worker/designee is responsible for the discharge plan; the options counselor provides information on options that are available based on the resident's preferences).
   c. Complete LCA Service Activity Summary form. Documentation must include, at a minimum:

      - Summary of the interaction and options discussed;
      - Determination as to whether or not the resident's needs can be met in a community setting;
      - Potential referrals to MFP program or Medicaid (county social services), if applicable;
      - Potential referrals to community-based services; and
      - Next steps.

d. Follow-up to determine if/when discharge will take place. The nursing facility social worker/designee is responsible for developing the discharge plan that includes a referral to ADRL Options Counseling, if the options counseling service is needed after discharge.
e. Fax a copy of the LCA Referral Form and the LCA Service Activity Summary form to the MFP administrator. If the resident is eligible for MFP services, the MFP administrator will contact the applicable Center for Independent Living (CIL).
f. LCA Services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit).
g. Enter information obtained from the LCA Referral Form and the LCA Summary Activity form in SAMS ADRL Options Counseling assessment form; in the narrative section, document referral information, summary of the on-site visit including interactions and options discussed, needs determination, referrals, and next steps.
h. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

2. LCA Telephone Contact, E-mail, Written Correspondence, or Brief Face-to Face Visit – 1 Unit of Service

   a. If needed to complete the LCA Community Transition process, a referral entity, resident, or family member may be contacted via telephone, e-mail, written correspondence, or through a brief face-to-face visit regarding a needed service or receipt of services.
   b. Document in the Narrative section of the SAMS ADRL Options Counseling assessment form the specific purpose of the contact and a brief descriptive statement of the interaction and outcome(s).
   c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

3. LCA Follow-Up Contact – 2 Units of Service

   a. A follow-up contact (telephone, e-mail, written correspondence, or face-to-face visit) with the nursing facility may be needed to

determine if discharge will take place or to complete the LCA Community Transition process.

b. All follow-up contacts must be documented in the narrative section of the SAMS ADRL Options Counseling assessment form. Documentation of each contact shall include:

- The specific purpose of the contact;
- A brief descriptive statement of the interaction; and
- Outcome of the follow-up contact.

c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

4. LCA Community Transition Inactivity – 1 Unit of Service

a. If a referral is made to the MFP program or county social services, the narrative section of the SAMS ADRL Options Counseling assessment form must be updated to reflect referral information and service delivery posted to reflect 'inactive'.
b. LCA Services end when the resident is discharged to the community (if indicated in discharge plan, ADRL Options Counseling will contact consumer to schedule options counseling visit). The Narrative section of the ADRL Options Counseling assessment form must be updated to reflect that the resident transitioned to the community.
c. Documentation and posting of Service Delivery must be completed by the 15th of the month following service delivery.

Staffing Requirements 650-25-26-15

(Revised 1/1/14 ML#3396)

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1. Minimum educational requirement: Bachelor's degree in a human service or related field, or three years experience working in a direct service capacity in a human service or related field;
2. Possess the knowledge of or willingness to learn of available community resources within the service area;
3. Possess the ability to develop rapport with older individuals and adults with physical disabilities;
4. Possess the ability to develop rapport with other agencies that provide assistance to older individuals and adults with physical disabilities;
5. Possess a valid driver's license and have access to an automobile;
6. Possess effective verbal, writing, and computer skills; and
7. Complete the Department's ADRL Options Counseling Training, MDS - Section Q training, and participate in additional trainings as required.

Prohibited Activities 650-25-26-20

(Revised 1/1/12 ML#3303)

View Archives

1. Activities that are provided by another entity in the community.
2. Breach of confidentiality.

Administrative Requirements 650-25-26-25

(Revised 1/1/14 ML#3396)

View Archives

Medical Services Division has administrative and financial responsibility for LCA Services; Older Americans Act requirements differ from MDS-Section Q and LCA requirements; therefore, the entity's Program Policies and Procedures Manual should address the Older Americans Act ADRL Options Counseling Service.

Administration 650-25-26-25-01

(Revised 1/1/12 ML#3303)

View Archives

1. Develop and adhere to a written Program Policies and Procedures Manual to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency; and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and older individuals at risk for institutional placement.
    c. Frequency, method, and timeframe for delivery of services as appropriate.
    d. Assure that service options are accessible to all eligible consumers, independent, semi-independent, and totally dependent, regardless of income levels.
    e. Procedures to assure the confidentiality of consumer specific information.

        i. No information about a consumer is disclosed by the contract entity unless a release of information is received from the consumer or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.
        ii. An appropriate release of information document is signed and on file before consumer records are released.

iii. All consumer specific information is maintained in a locked file, locked area, or an access coded computer program.

f. Service contribution (program income) procedures that assure:

i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a sealed envelope given to the options counselor or returned by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.
ii. No client is denied service due to inability or unwillingness to contribute.
iii. Measures are taken to protect the privacy of each client with respect to his or her contribution.
iv. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to the funds.
v. Service contributions for ADRL options counseling are used to expand ADRL options counseling services.

g. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.
h. Written emergency disaster preparedness plan approved by the local governmental official(s) having responsibility for disaster planning and designate an individual who is responsible to carry out provisions of the plan.
i. Procedures to assure the provision of information and referral services.
j. Non-discrimination towards consumers.
k. Grievance procedures for consumers.
l. Referral process.
m. Records retention.
n. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

3. Initially and on an annual basis, provide or make available training to paid personnel concerning the provision of services to older individuals.

At a minimum, paid personnel must receive training on the following: overview of the Older Americans Act, service contributions, review of applicable service standards or service requirements and necessary training to deliver the specific service, confidentiality, and fire safety.

Legal Requirements 650-25-26-25-05

(Revised 1/1/12 ML#3303)

View Archives

Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.

1. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-26-25-10

(Revised 1/1/14 ML#3396)

View Archives

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Advocacy Requirements 650-25-26-25-15

(Revised 1/1/12 ML#3303)

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1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

Family Caregiver Support Program (FCSP) Service Standard 650-25-30

(Revised 10/1/15 ML#3454)

View Archives

The family caregiver support program provides for a multifaceted system of support services for family caregivers and for grandparents or older individuals that are relative caregivers. Priority for services shall be given to:

1. Older individuals with low income including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas.
2. Older individuals providing care and support to persons with developmental disabilities (as defined in 42 U.S.C. 6001) who are not eligible for existing North Dakota Department of Human Services Developmental Disability services.
3. Family caregivers who provide care for individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction.
4. Grandparents or older individuals who are relative caregivers who provide care for children with severe disabilities.

Performance Standards 650-25-30-01

Eligible Clients 650-25-30-01-01

(Revised 10/1/15 ML#3454)

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All caregivers must reside with the care recipient (24-hour care) and meet one of the following criteria:

1. Family caregivers age 18 and older caring for older individuals age 60 and older.
2. Grandparents and relative caregivers age 55 and older who care for children not more than 18 years of age.
3. Grandparent or relative caregivers providing care for adult children with a disability who are between 19 and 59 years of age. These caregivers must be 55 years and older and cannot be the child's parent.
4. Individuals age 18 and older caring for a person with Alzheimer's disease or a related dementia, regardless of the age of the person with dementia.

Repealed

Eligible Clients - Alzheimer's Demonstration Project 650-25-30-01-05

(Repealed 8/1/09 ML#3186)

View Archives

Location of Service 650-25-30-01-10

(Revised 10/1/15 ML#3454)

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The majority of services will be provided in the home where the caregiver and care recipient resides. Respite care may also be delivered in the home of the qualified service provider, adult and child day care setting, licensed adult or child foster care homes, community settings, or institutional settings.

Educational opportunities, support groups, and other services may be delivered in the community.

Service Categories 650-25-30-01-15

(Revised 10/1/15 ML#3454)

View Archives

The following service categories identify services available through the Family Caregiver Support Program and require reporting through the SAMS system.

1. Access Assistance – a service that assists caregivers in obtaining access to services and resources available within their communities.
    - Case Management – includes completion of a SAMS Caregiver Assessment to identify caregiver needs; development/renewal of the Caregiver Option Plan; providing individuals with information on available services; linking the individual to services and opportunities that are available within the community; authorizing services, and follow-up for as long as the individual is eligible to receive program services
2. Counseling – a service that assists caregivers in making decisions and solving problems relating to their caregiving tasks. Services in this category include:
    - Counseling – individual and family
    - Support groups
    - Caregiver training for individual caregivers and families

3. Information Services – a service that provides the public and individuals with information on resources and services available within their communities. Services in this category are directed to large audiences and include activities such as disseminating publications, conducting media campaigns, participating in health fairs, and other similar activities.

4. Respite Care – a service that offers temporary, substitute supports, or living arrangements for care recipients in order to provide a brief period of relief for caregivers. Respite care can be provided in the following settings:
    - FCSP Adult Day Care Respite

- FCSP Caregiver In-Home Respite
- FCSP Institutional Respite
- FCSP Respite Child Care

5. Supplemental Services – a service provided on a limited basis to complement the care provided by caregivers. Reimbursement can be made for:
   - Incontinent supplies including pads, diapers, wipes, and other protective products
   - Assistive safety devices including adaptive and preventive health aids

6. FCSP Disaster/Emergency Contact – a service to assure the caregiver and care recipient's safety in the event of a disaster/emergency.

Delivery Characteristics 650-25-30-01-20

(Revised 1/1/14 ML 3403)

View Archives

Caregiver support services must be available statewide.

1. All referrals must be contacted within two working days.
2. The Caregiver Assessment Tool must be completed in the Harmony for Aging Social Assistance Management System (SAMS) data collection system to document need. The tool is available through the web-based SAMS data collection system.
3. Individuals seeking services must be provided with service options. The individual has the right to make an independent choice of service providers.
4. All contacts, including telephone calls, must be documented in the narrative section of the SAMS data collection system. The documentation shall include a brief descriptive statement of the interaction, including any service needs identified, alternatives explored, and service delivery options offered.
5. Each client and provider case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or a restricted computer program.
6. Coordinate service activities with existing community agencies and voluntary organizations to maximize service provision and avoid duplication.
7. All services must be promoted through a variety of social service networks i.e., churches, service organizations, schools, professional conferences, etc.
8. A signed release of information document for every service provider must be on file before information can be shared or released.
9. A Notice of Privacy Practices (DN 900) will be given to every caregiver and a signed Acknowledgement of Receipt of the Notice of Private Practices (SFN 936) will be kept in the record.
10. Determine eligibility for rural differential rate as per the standard NDFCSP Rural Differential Unit Rate for Qualified Service Providers and complete the Rural Differential Authorization form (SFN 225). The rural differential unit rate should be designated on the individual Caregiver Option Plan. Caregiver Coordinators must notify the

NDFCSP Program Administrator via email every time a caregiver has been authorized to receive the rural differential unit rate and again when their enrollment has been terminated.

Billable Services 650-25-30-05

(Revised 10/1/15 ML#3454)

View Archives

The following outlines billable services provided by the program:

1. Counseling/Support Groups/Training
    - One counseling service equals one session per participant (FCSP Counseling - Individual and FCSP Counseling – Family). Reimbursement for counseling is based on the current statewide human service center rate for individual or family counseling
    - One support group equals one session per participant (FCSP Support Groups). Reimbursement can be made for initial start-up costs for support groups that have a caregiver component for a six-month period
    - One caregiver training equals one session per participant (FCSP Training for Caregiver). Reimbursement for caregiver training shall not exceed the maximum Medicaid rate for that service as established by the Department. Rates for training needs not addressed by Medicaid shall be negotiated with the NDFCSP Program Administrator

2. Respite Services
    - Respite Services are based on actual hours spent doing respite care. Reimbursements for individuals and agencies are based on the same rate as the current 15-minute unit rate established by the Department's Medical Services Division or their established rate

3. Supplemental Services
    - Reimbursement is made to a caregiver based on actual cost of the item(s)

Reimbursement for other services must be completed in accordance with Human Service Center procedures. Reimbursements must be processed no later than 15 days after the end of the monthly service period.

Access Services, Information Services, and FCSP Disaster/Emergency Contact are not considered billable units of service. Time spent completing those activities must be documented monthly in the Department's Workforce system. Information Services must be recorded in a SAMS Consumer Group. FCSP Disaster/Emergency Contacts are recorded as Service Delivery in the individual client record.

Service Activities 650-25-30-10

(Revised 10/1/15 ML #3454)

View Archives

1. Access Assistance – Case Management includes the following activities:
    - Accept and respond to referrals to the program
    - Make home visits or arrange for visits in a location convenient for the caregiver
    - Complete individual caregiver assessments on all eligible caregivers using the SAMS Caregiver Assessment Tool to determine need. Caregiver assessments must be updated on an annual basis
    - Using the SAMS Caregiver Assessment Tool, develop and implement an individualized Caregiver Option Plan (SFN 165) that address the needs unique to the individual providing care. The plan must identify services to be received, the entity providing the service, and the expected outcomes. The effective date on the Caregiver Option Plan (SFN 165) will not exceed the 12 month enrollment period (July 1 to June 30)
    - The Caregiver Option Plan (SFN 165) must be reviewed to monitor service usage and assure caregiver goals and outcomes are being met
    - The Caregiver Option Plan (SFN 165) may be terminated if the caregiver has not accessed services within a review period (at a minimum of quarterly). The termination will be issued in writing with the use of the NDFCSP Notice of Service Denial, Closure or Termination (SFN 331)
    - Completion of required Department forms needed to authorize services (i.e. SFN 135 – North Dakota Family Caregiver Support Program Provider Service Log – Individual, SFN 492 - North Dakota Family Caregiver Support Program Provider Service Log – Agency, SFN 549 – Respite Home Evaluation, and SFN 225 – NDFCSP Rural Differential Unit Rate Authorization)
    - New Caregiver Option Plans (SFN 165) must be completed when the effective date expires. Caregiver Option Plan (SFN 165) updates may be completed by meeting with or making phone contact with caregivers and acquiring signatures via the mail. A copy of the Caregiver Option Plan must be mailed to the caregiver

after each review date if there were changes in services or providers
- Caregivers must receive a minimum of four contacts per year including a face-to-face visit within each six month period
- Create/maintain working partnerships with other agencies and organizations that provide services to support caregivers

2. Counseling/Support Groups/Caregiver Training – Individual and Family
   A. Counseling
      - Identify and arrange for payment for qualified professionals to complete up to four sessions during a 12-month enrollment period for individual or family counseling of eligible caregivers. If it can be demonstrated that the caregiver has an extraordinary need for additional counseling beyond the four sessions, a written request must be submitted to the NDFCSP Program Administrator. A one-time extension of the four sessions will be considered on a case-by-case basis. Caregivers who require on-going counseling will be referred as needed. A qualified professional includes a psychologist, licensed social worker, and counselors as defined by North Dakota Century Code. Counseling may include, but not be limited to the following topics:
        - Caregiver Stress and Coping
        - End of Life Issues/Grief Counseling
        - Family Relations/Dynamics
        - Substance Abuse
        - Decision Making and Problem Solving
   B. Support Group
      - Facilitate development/maintenance of caregiver support groups. Reimbursement may be provided for start-up costs for support groups that have a caregiver component for a period of up to six months. The goal is to encourage each group to become self-sustaining. Educational materials may be provided as needed
   C. Caregiver Training
      - Identify and arrange payment for qualified professionals to complete individualized caregiver training that meets

the needs of the eligible caregiver. Qualified professionals include, but are not limited to:
  - Nurses
  - Occupational therapists
  - Physical therapists
  - Dietitians

Whenever possible the training should be held in the home where care is being provided

- Training may include but not be limited to the following areas:
  - Generally accepted practices of personal care tasks and personal care endorsements
  - Assistive technology
  - Planning for long term care needs
  - Health and nutrition counseling
  - Behavior management
  - Financial literacy
- For the provision of the department approved caregiver dementia trainings, sessions must be scheduled with the department approved provider. The trainings should be limited to caregivers enrolled in the NDFCSP and their providers. A copy of the list of caregivers and respite providers attending department approved caregiver dementia trainings must be sent to the NDFCSP Program Administrator

3. Information Services – Public education, information, and training activities directed to large audiences including but not limited to the following:
   - Booths at health fairs
   - Mailing out NDFCSP brochures
   - Posting NDFCSP flyers
   - Public service announcements advertising the NDFCSP and services
   - Church bulletin inserts
   - Media events which advertise the NDFCSP and services
   - Public newsletters promoting the NDFCSP and services
   - Participate in coalitions and/or planning committees which focus on aging/caregiving service needs, issues, events

- Public presentations regarding caregiving and grandparent issues
- Newsletters/newspaper articles which provide information on caregiving or grandparent issues
- Public caregiver trainings that focus on caregiving or grandparent issues; i.e. Dementia Training

4. Respite Care

- A caregiver is eligible to receive funding for respite services if they are providing 24-hour care and the care recipient has two or more activities of daily living (ADL) limitations or a cognitive impairment which makes it unsafe for them to be left alone. The ADL impairment requirement for respite services eligibility does not apply to children ages 18 and under
- Identify and arrange for payment of a qualified respite care provider for the temporary relief of the primary caregiver.
- A qualified respite care provider may include an individual, registered nurse, licensed practical nurse, certified nurse assistant who is enrolled as a respite care qualified service provider (QSP) with the Department of Human Services, an adult/child day care facility, a licensed adult or child foster care home, long term care facility, or a qualified family member who is related to the individual receiving care. Biological, adoptive parents and stepparents are not eligible to receive NDFCSP respite care payments when caring for their own biological, adopted or stepchildren
- Respite care that will be provided in the home of a qualified service provider (QSP) cannot be authorized until a home visit and Respite Home Evaluation (SFN 549) has been completed with the QSP. The SFN 549 is not required when respite services are being provided in the home of a qualified family member or in a licensed adult or child foster care home
- Respite Home Evaluations (SFN 549) are valid for no longer than 24 months from the date of issuance or the date of expiration of the provider's status as a qualified service provider (QSP), whichever comes first. The QSP expiration date can be obtained from Aging Services Division. A copy of the evaluation form must be provided

to the QSP and the original should be maintained in the provider's file

- Individual [i.e. qualified family members and qualified service provider (QSP)] rates for respite care services shall not exceed the current maximum Medicaid QSP rate. A qualified family member is the spouse of or one of the following relatives, or the current or former spouse of one of the following relatives of the care recipient: parent, grandparent, adult child, adult sibling, adult grandchild, adult niece, or adult nephew
- Respite care services must be prorated on a three month allocation or if less than three months, the number of months the Caregiver Option Plan is in effect. The Caregiver Option Plan must be reviewed a minimum of every three months to assess caregiver use of respite care
- Respite care services available to a primary caregiver cannot exceed the established service cap for respite care service in a twelve-month period (July 1 to June 30). The Aging Services Division staff determines the service cap for each 12-month enrollment period. Updated service cap information will be issued as changes occur. A written request to exceed the established service cap must be sent to the Aging Services Division NDFCSP Program Administrator for approval. Approval will be determined on a case-by-case basis and will be limited to a one-time allocation
- Respite care service allocations may exceed the quarterly prorated cap if the caregiver's need has been established and documented in the caregiver record and does not exceed the twelve month service cap
- Providers who have an individual QSP rate different from the state maximum Medicaid QSP rate shall be paid at their established individual rate, not the maximum Medicaid QSP rate
- Agency unit respite rates shall not exceed the current maximum rate for the service under Medicaid. Agency providers who have an agency QSP rate different from the maximum state Medicaid QSP rate shall be paid at their established agency rate, not the maximum Medicaid QSP rate

- For reimbursement purposes, overnight 24-hour respite care is based on the hours of 12 am (midnight) to 11:59 pm
- Payment for overnight/24-hour, in-home respite provided by an enrolled QSP, qualified family member or agency shall not exceed the current Medicaid hospital swing bed rate. Payment for one day of respite care cannot exceed the current Medicaid hospital swing bed rate whether or not the person received overnight care
- Overnight/24 hour respite care provided in a hospital swing bed or long-term care facility shall not exceed the current Medicaid swing bed rate
- Overnight respite care services for eligible grandchildren may be provided in a licensed child foster care home. Approval from the local county social service case manager working with the child foster care home must be obtained prior to making arrangements for respite services
- Authorization or use of respite services for time while the caregiver is at work is prohibited. If a care recipient is staying home alone during the time the caregiver is at work, the caregiver is not eligible to receive NDFCSP respite services
- Caregivers who receive respite or in-home care services from a source other than a public funded program (i.e. Hospice, Veteran's Services, insurance, etc.) may receive NDFCSP program respite services but the amount of the respite service allocation should be carefully considered based on amount of respite services other programs are providing
- Caregivers and their providers who meet the eligibility for the NDFCSP Rural Differential QSP unit rate will receive a service cap adjustment over the established service cap for the enrollment period. Rural differential service cap information will be issued as changes occur. The NDFCSP Program Administrator must be notified via email every time a caregiver has been authorized to receive the rural differential unit rate and again when their enrollment has been terminated
- Caregivers eligible for the NDFCSP rural differential respite care services unit rate will receive an

overnight/24-hour care rate that exceeds the current Medicaid hospital swing bed rate. The Aging Services Division, in conjunction with Medical Services Division, will establish the maximum daily rate based on rural differential care services unit rate for the current enrollment period. Overnight/24-hour care rates will be issued as changes occur

- Individuals providing care for a person with Alzheimer's disease or a related dementia are eligible to receive an enhancement of $600 over the established service cap for the enrollment period if they and at least one of their respite providers have successfully completed the NDFCSP approved caregiver dementia training
- Individuals who receive Alzheimer's disease or related dementia enhanced respite service funding are not eligible to receive an additional respite allocation beyond the service cap established for the enrollment period

5. Supplemental Services

- Identify and arrange for up to $300 per household per twelve-month enrollment period (July 1 to June 30) in reimbursement for assistive devices not available through the Aging Services Assistive Devices contract and/or incontinent supplies. Consideration will be given to a one-time additional allocation of $200 for supplemental services if it can be demonstrated the caregiver has an extraordinary need Additional allocation requests must be submitted in writing to the Program Administrator and approvals shall be determined on a case-by-case basis
- Assistive safety devices include adaptive and preventive health aids that will assist individuals and/or their caregivers in their activities of safe daily living. Nutritional supplements are not covered under Supplemental Services
- Incontinent supplies include pads, diapers, and other protection products
- The $300 supplemental service cap cannot be used as a partial payment for an assistive safety device

6. Disaster/Emergency Planning

- At the direction of the Aging Services Division, contact the caregiver to assist in planning to assure the caregiver and care recipient's safety in the event of a disaster/emergency
- Document in the Narrative Section of the SAMS NDFCSP Assessment the stated purpose of the contact and a brief description of the caregiver's plan for safety

Documentation Requirements 650-25-30-10-05

(Revised 10/1/15 ML#3454)

View Archives

INITIAL ASSESSMENT:

Assessment data must be documented in the SAMS web-based data system. Document the following in the Narrative section of the SAMS Caregiver Assessment form:

- The date and source of the referral;
- A brief descriptive statement of the interaction with the caregiver, including any identified service needs;
- Alternatives explored;
- Service delivery options offered;
- Services accepted or refused by the caregivers;
- The caregiver's choice of provider(s).

FOLLOW-UP CONTACTS:

Document in the Narrative section of the SAMS Caregiver Assessment form all activities and contacts with caregivers, family, agencies, respite providers, etc. in relation to the caregiver.

Documentation must include:

- The purpose of the contact;
- Condition of or changes in the caregiver or care recipient situation;
- Observations and/or concerns regarding caregiver home conditions;
- Outcome(s) of any referrals provided to or made on behalf of the caregiver;
- Impact of the NDFCSP involvement for the caregiver; and
- Reports of any caregiver concerns from other parties involved with caregiver, as applicable

Service Delivery Reporting Requirements
650-25-30-10-10

(Revised 10/1/15 ML#3454)

View Archives

For reporting purposes, document service delivery in the web-based SAMS data collection system, on a monthly basis.

Document the following in the individual client record:

1. Access Assistance
   One case management service equals one contact (FCSP Case Management)
   - Case management services includes all interactions that are directly related to the caregiver (i.e. initial assessment, completion authorization of services, contacts with individuals or agencies to arrange for services, and all follow-up contacts with the caregiver)

2. Counseling - includes counseling, support groups, and caregiver training
   Select the respective service provided:
   - One counseling service equals one session per participant (FCSP Counseling - Individual and FCSP Counseling – Family)
   - One support group equals one session per participant (FCSP Support Groups); participation by caregivers in other community caregiver support groups may be included as service delivery
   - One caregiver training equals one session per participant (FCSP Training for Caregiver)

3. Respite Care
   Select the respective service provided:
   - FCSP Adult Day Care Respite – Full Day
   - FCSP Adult Day Care Respite – Half Day
   - FCSP Adult Day Respite – Hourly
   - FCSP Caregiver In-Home Respite – Hourly

- FCSP Caregiver In-Home Respite – Overnight
- FCSP Institutional Respite – Overnight
- FCSP Respite Child Care – Overnight
- FCSP Respite Child Care – Full Day
- FCSP Respite Child Care – Hourly

4. Supplemental Services
   Enter actual reimbursement amount in Unit Price.

5. FCSP Disaster/Emergency Contact
   One disaster/emergency contact equals one unit of service.

Document the following in the SAMS Consumer Group:

Information Services – activities directed to larger audiences
One information service equals one activity (Consumer Group: RASPA/FCSP PUB ED-TRNG)

- Record activities in the SAMS Consumer Group Comments Section indicating the date, location where activity occurred, audience, and number of participants

Rural Differential Unit Rate for Qualified Service Providers 650-25-30-10-15

(Revised 10/1/15 ML 3454)

View Archives

Purpose

The purpose of the rural differential rate is to create greater access to home and community based services for caregivers who reside in rural areas of North Dakota by offering a higher rate to Qualified Service Providers (QSPs) who are willing to travel to provide services. QSPs that are willing to travel at a minimum distance of 21 miles round trip to provide care to authorized individuals in rural areas will be reimbursed at a higher rate to provide respite care services for NDFCSP caregivers. Rural differential unit rates vary based on the round trip mileage. QSPs are not paid for the time they drive to or from the client's home; the rural differential rate may only be used for the time spent actually providing services.

Standards for Providers

Only enrolled agencies or individual QSPs authorized to provide NDFCSP services are eligible to receive the rural differential rate. Family members are not eligible to receive rural differential rate unless they enroll as a QSP with the NDFCSP.

Service Activities, Authorized

The rural differential rate is based on the physical address of the eligible caregiver and must be identified on the Caregiver Option Plan (SFN 165).

The NDFCSP Rural Differential Rate Authorization (SFN 225) will be completed upon enrollment for each caregiver and QSP provider who meet the eligibility criteria for the rural differential rate. The SFN 225 will be completed upon closure to include the date of case closure.

Copies of the NDFCSP Rural Differential Rate Authorization when both opening and closing a case will be distributed as follows:

- Original to the QSP
- Copy in the caregiver file
- Copy to the Qualified Service Provider file
- Copy to the NDFCSP Program Administrator
- NDFCSP Program Administrator will forward a copy to Medical Services

The rural differential rate will be added on the NDFCSP Caregiver Option Plan as providers become eligible for the rate.

The NDFCSP Program Administrator must be notified via email of every caregiver and QSP who are eligible for the rural differential rate upon sign up and case closure.

Service Eligibility, Criteria for

The rural differential rate is caregiver specific. A NDFCSP caregiver receiving services paid at the rural differential rates will meet the following criteria:

1. Must be eligible for NDFCSP services.

2. Reside outside the city limits of Fargo, Bismarck, Grand Forks, Minot, West Fargo, Mandan, Dickinson, Jamestown, and Williston.

3. Needs respite care services and does not have access to a QSP of their choice, within a minimum of a 21 mile round trip distance of their residence who is willing to provide care.

The distance between the caregiver's home and the QSPs home base must be verified by using the following website: www.mapquest.com. The most reasonable route must be used. A printed copy of the MapQuest results must be kept in the caregiver file. A copy of the MapQuest mileage verification must be sent with the SFN 225 to the NDFCSP Program Administrator.

If there is a discrepancy in what is considered city limits, notify the NDFCSP Administrator. The Rural Differential Program Administrator, Medical Services Division, will make the final determination.

Service Delivery

The rural differential rate is based on the number of miles (round trip) a QSP travels from their home base to provide services at the home of an authorized NDFCSP caregiver.

- Home base is either the individual QSPs physical address, or the Agencies home office, satellite office, or employees physical address (if they are not required to report to the home office each day because of distance) whichever is closer.
- If an agency employee is not required to report to the home office each day because of distance and they live 21 or more miles (round trip) from the client's home the rural differential rate may be used. If the employee lives less than 21 miles (round trip) from the client's home than the rural differential may not be used. Rural differential unit rates vary based on the number of round trip mileage.
- Rural differential rates are based on the distance it takes to travel to each individual client's home even if the QSPs serve more than one caregiver in the community or in the same home.
- Information on the rural differential unit rate will be provided as changes occur.

Addresses

The physical address (PO BOX is not acceptable) listed on the QSP list or NDFCSP Provider Agreement must be used when determining which rural differential rate to use for individual QSPs and Agency providers.

Staffing Requirements 650-25-30-10-15

(Revised 10/1/15 ML 3454)

View Archives

Minimum qualifications include:

- Bachelor degree in Social Work, Nursing, Sociology, Psychology, Human Services, Business Administration, Gerontology, or two years related professional work experience or a Master's degree in one of the fields listed above
- Public speaking experience
- Ability to effectively communicate both verbally, to include active listening, and in writing
- Basic understanding of fiscal management
- Marketing and/or outreach experience
- Ability work with and willingness to learn various computer software programs
- Valid driver's license required
- Knowledge of or willingness to learn of available community resources within a defined service area

Prohibited Activities 650-25-30-20

(Revised 10/1/15 ML#3454)

View Archives

1. Duplication of services.
2. Breach of confidentiality.
3. Provision of caregiver services to a caregiver who is caring for an older individual who resides in an institutional setting.
4. Use of Older Americans Act funds to provide caregiver services to a caregiver, who does not meet the definition of a grandparent or relative caregiver, who is providing support to an individual between the ages of 19 and 59 regardless of disability or cognitive status.
5. Provision of NDFCSP respite or supplemental services to individual caregivers who are receiving services as part of a public program or being paid by private arrangement to provide care.
6. Provision of NDFCSP services to a caregiver who resides with the care recipient in an assisted living setting.
7. Provision of NDFCSP services to a caregiver and/or recipient who has been determined eligible to receive services as part of a public pay program but chooses not to access those services.
8. Provision of NDFCSP services to a caregiver or care recipient who has private long term care insurance coverage of home care services if the insurance provides coverage for respite services.
9. Provision of respite care services when the care needs of the care recipient exceed the standards for service delivery and allowable tasks/activities for respite (QSP) providers as contained in the "Individual Qualified Service Provider Handbook." The caregiver may be enrolled to access counseling or training services.
10. Provision of continued enrollment of caregivers who temporarily relocate their residence (2 months or longer) outside of North Dakota. An individual who meets the FCSP eligibility criteria may be enrolled in the FCSP and receive services during the period of time they physically reside in the state.
11. Provision of caregiver services to an individual who is providing care and assistance on a daily basis but does not live with the care recipient.

Qualified Service Provider Complaints 650-25-30-25

(Revised 10/1/15 ML#3454)

View Archives

A complaint against a qualified service provider, family or agency NDFCSP provider may be made to the Human Service Center or to the Aging Services Division of the North Dakota Department of Human Services. A recipient of NDFCSP services or a friend, family member, guardian, legal representative or neighbor of the recipient or any other interested/anonymous party may file a complaint.

When a complaint is received about a NDFCSP service provider follow these steps:

1. Ask for the name of the person who is making the complaint, the name of the caregiver or care recipient and the name of the qualified service provider, family or agency provider. Ask for a complete description of the problem or complaint.
2. If there are reasonable grounds to believe that the recipient's health or safety is at risk of harm, and if deemed appropriate by the designated Vulnerable Adult Service worker a home visit will be made to further assess the situation and take necessary action. If the vulnerable adult is in immediate danger, contact law enforcement immediately and then make a report to the regional Vulnerable Adult Protective Services office.
3. If there is no immediate risk but a problem exists, Aging staff will work with the caregiver and other interested parties to resolve the complaint.
4. The complaint must be reported to the Aging Services Division NDFCSP Program Administrator. When applicable, Aging Services Program Administrator will notify the provider in writing of the changes that they must make in order to maintain their provider status or Aging Services will remove a qualified service provider, family or agency provider from the list of approved providers if the seriousness and nature of the complaint warrant such action.
5. Complaints regarding a Qualified Service Provider enrolled with the Department of Human Services and the NDFCSP will be handled by the NDFCSP Program Administrator and the Home and Community

Based Services Program Administrator regarding the investigation and resolution of the complaint. A qualified service provider whose enrollment with the Department of Human Services is either terminated or closed will not be eligible to receive payment from the NDFCSP.

Denial and Termination of Services 650-25-30-30

(Revised 10/1/15 ML #3454)

View Archives

1. The Department through Aging Services Division must consider termination of NDFCSP services when:

    - Service to the caregiver presents an immediate threat to the health or safety of the caregiver, care recipient, the provider of services, or others.
    - Services that are available through the NDFCSP are not adequate to prevent a threat to the health or safety of the caregiver or care recipient, the provider of services, or others. Examples of health and safety threats include physical abuse of the provider by the caregiver or care recipient, caregiver or care recipient self-neglect, an unsafe living environment for the caregiver or care recipient, inability of caregivers to provide care in critical areas, or contraindicated practices, including smoking while using oxygen.

2. NDFCSP services will be terminated when the care recipient moves into an institutional setting or the caregiver or recipient, or both, no longer meet the program eligibility requirements.
3. A client will be notified in writing of the reason for the termination, the right to submit a grievance, and the grievance process through the NDFCSP Notice of Service Denial, Closure or Termination (SFN 331). The SFN 331 is not required if the closure is due to the death of the caregiver or the care recipient.
4. If a grievance is submitted, as outlined on SFN 331, the process will include a conference with the NDFCSP Program Administrator and/or a review by Aging Services Division Director. Following the review, a written response will be sent to the caregiver submitting the grievance by the Division.
5. Consult with the NDFCSP Program Administer when termination of services is being considered.

Administrative Requirements 650-25-30-35

Administration 650-25-30-35-01

(Revised 10/1/15 ML#3454)

View Archives

1. All caregivers enrolled in the NDFCSP must be provided the opportunity to contribute to the cost of the service. Acceptable format for receipt of contributions is limited to the use of self-addressed envelopes. Contributions received must be used to expand NDFCSP services.
2. All staff time used to complete FCSP activities must be documented in Workforce on a monthly basis.
3. SAMS consumer data records, assessments, and service delivery for both individual caregivers and consumer groups must be completed no later than 25 days after the end of the monthly service period.
4. Upon request, submit fiscal data in the form and manner described by Aging Services Division.
5. Payment for services provided by eligible providers must be completed in accordance with Human Service Center procedures and processed no later than 15 days after the end of the monthly service period. Final payments shall be processed no later than 30 days after the end of the annual service period.
6. Provider service logs received for services provided later than 30 days after the end of the annual service period must be discussed with the Aging Services Division NDFCSP Administrator prior to payment.
7. Individual respite care providers are required to have caregivers co-sign on every entry of respite services on the North Dakota Family Caregiver Support Program Provider Service Log - Individual (SFN 135) to verify services have been provided. If the Provider Service Log is lacking a signature, the service log must be returned to the provider to obtain the caregiver signature prior to approval for payment.
8. Enrolled caregivers accessing Supplemental Services will be required to purchase the assistive safety device or incontinent supplies. The caregiver must submit a receipt of purchase of safety devices or incontinence supplies and use the NDFCSP Provider Service Log-

Individual (SFN 135) to access reimbursement through Supplemental Services.

9. Agency, institutional and adult day care providers of respite, training or counseling services will use North Dakota Family Caregiver Support Program Provider Service Log – Agency (SFN 492) for billing for respite, training and counseling services. Providers using SFN 492 for billing purposes are not required to obtain caregiver co-signatures on the provider service log.

Legal Requirements 650-25-30-35-05

(Revised 7/1/13 ML#3379)

View Archives

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs
2. The North Dakota Family Caregiver Support Program (NDFCSP) shall apply the Department of Human Services rules, policies, and procedures regarding competency requirements for qualified service providers and termination of qualified service provider status to the NDFCSP respite care providers.
3. The North Dakota Family Caregiver Support Program (NDFCSP) shall apply the Department of Human Services rules, policies, and procedures regarding recovery of funds from providers upon establishment of noncompliance.

Health Maintenance Program Service Standard 650-25-35

(Revised 8/1/09 ML#3186)

View Archives

Health maintenance is a combination of services provided in an effort to determine and maintain the health and well being of clients. Priority for services shall be given to:

- older individuals residing in rural areas;
- older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with severe disabilities;
- older individuals with limited English proficiency;
- older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and
- older individuals at risk for institutional placement.

Performance Standards 650-25-35-01

Eligible Clients 650-25-35-01-01

(Revised 1/1/06 ML#2995)

View Archives

Individuals age 60 years and older.

Location of Services 650-25-35-01-05

(Revised 1/1/06 ML#2995)

View Archives

1. At a senior center or other community facility, that has the following characteristics:

    a. Meets federal, state, and local fire safety and sanitation codes/standards.
    b. Accessible for individuals with disabilities.
    c. Makes provision for a private area used to conduct health services.
    d. Makes provision for a reception area/waiting area with adequate furniture to comfortably seat waiting clients.

2. In the client's home if homebound.

Delivery Characteristics 650-25-35-01-10

(Revised 1/1/14 ML#3396)

View Archives

1. The SAMS Health Maintenance Assessment form was designed to assist the health care professional to determine the need for health maintenance services. Only trained health care professionals (as outlined in Section 650-25-35-15 Staffing Requirements) may conduct health maintenance assessments. At a minimum, the NAPIS data (Sections I. General Information and Section II. Demographics) of the SAMS Health Maintenance Assessment form must be completed and entered in the SAMS reporting system, as the data is required for federal reporting purposes. The health care professional may elect to assess a client using the entity's own assessment forms or use the SAMS Health Maintenance Assessment form to complete the assessment process. Documentation (in the Narrative section of the SAMS Health Maintenance Assessment form) should indicate if the contract entity is using their form to assess a client. If a client could benefit from nutrition or other support services, a referral should be made to an appropriate entity.

   Information obtained on the SAMS Health Maintenance Assessment form must be reviewed and updated in the SAMS data system (under Assessments, select Copy) within a consecutive 12-month period.

2. Records must be maintained for each client and include at a minimum the following information: date of service; information provided client, as applicable to the service; and other contact with client and/or his/her physician. Contract entities may choose to document each contact in a contract entity specific client record or in the Narrative Section of the web-based SAMS Health Maintenance Assessment form. Each record must be maintained in an individualized file and secured in a locked file cabinet, locked area, or a restricted computer program.

3. Written reports and referrals to client's physician or appropriate agency may be made when indicated by services provided and where appropriate, after the written consent of the client is obtained.
4. Perform health maintenance services as outlined in the Service Delivery Procedures. Information and education must be provided to each client in conjunction with the health service provided.
5. Payment will be made for the following service procedures: blood pressure/pulse/rapid inspection, foot care, home visit, and medication set-up. Foot care must be available a minimum of once per month within each county in the service area.
6. Health maintenance services must be provided throughout the contract period in accordance with the Contract.
7. Any alteration in the pattern of service delivery must be discussed with the Regional Aging Services Program Administrator prior to the change. All service delivery options should be considered/explored.

   After discussions have been held and an alternative plan has been agreed upon, the contract entity must complete and submit to Aging Services Division a revised Service Provision Form as outlined in Section 650-25-75-05-05 of the this service chapter.

Billable Unit of Service 650-25-35-05

(Revised 1/1/13 ML#3359)

View Archives

For billing purposes, the contract entity must use the service billing unit system for each service procedure identified in the Service Delivery Procedures Section of this Standard.

Contract entities must record the type of health maintenance service provided in the Subservice section of SAMS Service Delivery.

Each billable unit of service received by a client must be recorded in the client's individual record in the SAMS data system by the 15th of the month following service delivery.

Service Delivery Procedures 650-25-35-10

(Revised 1/1/14 ML#3396)

View Archives

The following service delivery procedures must be followed for reimbursement through an Older Americans Act contract:

1. Blood Pressure/Pulse/Rapid Inspection – 1 Unit of Service

    a. Preparation for client.
        - Open and/or review client record.

    b. Data gathering.
        - Individual medical and health history.
        - Family history.
        - Review medications and dietary pattern.

    c. Client education.

        - Explain procedure.

    d. Screening procedure.
        - Nursing assessment.
        - Blood pressure measurement.
        - Pulse.
        - Weight.
        - Height (initial and yearly).

    e. Client counseling.

        - Explain test results and implications.
        - Instruction regarding preventive health measures, i.e. diet and lifestyle.

    f. Correspondence/referral/follow-up/phone calls.
    g. Documentation/recording.

2. Foot Care – 7 Units of Service

a. Preparation for client.
   - Open and/or review client record.

b. Data gathering.
   - Individual medical and health history.
   - Family history.
   - Review medications and dietary pattern.

c. Client education.
   - Explain procedure and risk.

d. Procedure.
   - Prepare equipment using established sanitizing procedures.
   - Provide foot and nail care.
   - Clean and sanitize equipment.

e. Client counseling
   - Instruction regarding preventive health measures, i.e. diet and lifestyle.

f. Correspondence/referral/follow-up/phone calls.
g. Documentation/recording.

3. Home Visit – 6 Units of Service

   a. Prepare and assemble equipment and materials needed for client contact.
   b. Review client's chart/record.
   c. Refer to specific screening for number of service units that apply to service(s) provided.
   d. Clean and sanitize equipment.
   e. Correspondence/referral/follow-up/phone calls.
   f. Documentation/recording.

4. Medication Set Up – 4 Units of Service

   a. Preparation for client.
      - Open and/or review client record.

   b. Data gathering.
      - Individual medical and health history.

- Review medications and dietary pattern.

c. Client education.
   - Explain procedure.

d. Procedure.
   - Prepare equipment
   - Set up medications in container.
   - Assess need for refill/reorder of medications.

e. Client counseling.
   - Review purpose and function of medications.
   - Assess compliance to medication regimen.

f. Correspondence/referral/follow-up/phone calls.
g. Documentation/recording.

Staffing Requirements 650-25-35-15

(Revised 8/1/09 ML#3186)

View Archives

1. A nurse supervisor who is a registered nurse, with a minimum of two years of nursing experience preferred, shall direct/coordinate the services and provides nursing supervision to all other health care personnel.
2. The person performing the health service shall be appropriately trained, licensed, and certified.

Prohibited Activities 650-25-35-20

(Revised 1/1/06 ML#2995)

View Archives

1. Provision of medical diagnosis and/or treatment without appropriate licensure and certification.
2. Provision of nursing services unless the services are supervised by a registered nurse, as regulated by the Nurse Practice Act.

Administrative Requirements 650-25-35-25

Administration 650-25-35-25-01

(Revised 1/1/12 ML#3303)

View Archives

1. Develop and adhere to a written Program Policies and Procedures Manual to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and older individuals at risk for institutional placement.
    c. Frequency, method, and timeframe for delivery of services as appropriate.
    d. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
    e. Procedures to assure the confidentiality of client specific information.

        i. No information about a client is disclosed by the contract entity unless a release of information is received from the client or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.

ii. An appropriate release of information document is signed and on file before client records are released.
iii. All client specific information is maintained in a locked file, locked area or access coded computer program.

f. Service contribution (program income) procedures that assure:

i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a locked box in a private area; sealed envelope with on-site deposit in a locked box in a private area or return by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.
ii. No client is denied service due to inability or unwillingness to contribute.
iii. A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.
iv. Each service provider must choose to do one of the following: 1) Publicly display at service locations and provide to clients served at home, the full cost of the health service, with information indicating that clients may, but are not required to contribute for the health service; or 2) Publicly display at service locations and provide to clients served at home, the full cost of the health service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the health service.
v. Measures are taken to protect the privacy of each client with respect to his or her contribution.
vi. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to the funds.

vii. Service contributions for health services are used to expand health services.

g. Fiscal procedures that address receipt of Older Americans Act and related funds; deposit of funds, and payment process.
h. Procedures to assure service delivery in weather-related emergencies.
i. Procedures to assure the provision of information and referral services.
j. Non-discrimination towards clients.
k. Grievance procedures for clients.
l. Referral Process.
m. Records retention.
n. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

2. Provide or make available training to volunteers and paid personnel concerning the provision of services to older individuals. Upon hire and annually thereafter, paid personnel/volunteers must receive training on the following: overview of the Older Americans Act, service contributions, review of applicable service standards or service requirements and necessary training to deliver the specific service, confidentiality, and fire safety.
3. Use of volunteers in the provision of services, as applicable. (Volunteer hours and the estimated value must be reported on the Monthly Data and Payment Report.

Legal Requirements 650-25-35-25-05

(Revised 1/1/06 ML#2995)

View Archives

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.
2. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-35-25-10

(Revised 1/1/14 ML#3396)

View Archives

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered; at what cost; and to what extent goals/objectives were met.
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Advocacy Requirements 650-25-35-25-15

(Revised 1/1/06 ML#2995)

View Archives

1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

Legal Assistance Program Service Standard 650-25-40

(Revised 8/1/09 ML #3186)

View Archives

Legal assistance is legal advice and representation provided by an attorney to older individuals with economic or social needs and includes to the extent feasible, counseling or other appropriate assistance by a paralegal or law student under the direct supervision of an attorney; and counseling or representation by a non-lawyer where permitted by law. Priority for services shall be given to:

- older individuals residing in rural areas;
- older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority, older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with severe disabilities;
- older individuals with limited English proficiency;
- older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
- older individuals at risk for institutional placement.

Performance Standards 650-25-40-01

Eligible Clients 650-25-40-01-01

(Revised 1/1/06 ML#2995)

View Archives

Individuals age 60 and older.

Location of Services 650-25-40-01-05

(Revised 1/1/06 ML#2995)

View Archives

Services must be provided throughout the state.

Delivery Characteristics 650-25-40-01-10

(Revised 1/1/14 ML#3396)

View Archives

1. Provide legal casework within the following categories:

    a. Abuse
    b. Age Discrimination
    c. Guardianship Defense
    d. Health Care
    e. Housing
    f. Income
    g. Long-Term Care

        i. Nursing Home, Basic Care, Swing Bed and Assisted Living Transfer and Discharge casework including payment issues.
        ii. Selected Nursing Home Bill of Rights casework primarily related to admissions and discharges, and least restricted alternatives for clients who want to leave a facility.

    h. Neglect
    i. Nutrition
    j. Protective Services

        i. Advanced Health Care Directives casework .
        ii. Advanced Health Care Directives public education presentations.
        iii. Upon directive from Aging Services Division, protective guardianship services.

    k. Utilities

2. Provide a toll free telephone line as outlined in the Contract.

3. Attempt to involve the private bar in legal assistance activities, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

4. Coordinate service provision with Legal Services Corporation.

Billable Unit of Service 650-25-40-05

(Revised 10/20/08 ML#3160)

View Archives

For billing purposes, a unit of legal casework is equivalent to 15 minutes.

Staffing Requirements 650-25-40-06

(Revised 10/20/08 ML#3160)

View Archives

Legal assistance must be provided by:

1. An attorney licensed to provide services in the State of North Dakota; or
2. A paralegal or law student under the direct supervision of an attorney licensed to provide services in the State of North Dakota.

Administrative Requirements 650-25-40-10

Administration 650-25-40-10-01

(Revised 1/1/08 ML#3121)

View Archives

1. Develop and adhere to a written program manual of policies and procedures to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and older individuals at risk for institutional placement.
    c. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
    d. Procedures to assure the confidentiality of client specific information.

        i. No information about a client is disclosed by the contract entity unless informed consent is received from the client or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.
        ii. An appropriate release of information document is signed and on file before client records are released.

iii. All client specific information is maintained in a locked file, locked area of access coded computer program.

e. Service contribution (program income) procedures that assure:

i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a locked box in a private area; sealed envelope with on-site deposit in a locked box in a private area or return by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.
ii. No client is denied service due to inability or unwillingness to contribute.
iii. A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.
iv. Each service provider must choose to do one of the following: 1) Publicly display at service locations and provide to clients served at home, the full cost of the legal service, with information indicating that clients may, but are not required to contribute for the legal service; or 2) Publicly display at service locations and provide to clients served at home, the full cost of the legal service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the legal service.
v. Measures are taken to protect the privacy of each client with respect to his or her contribution.
vi. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to funds.
vii. Service contributions for legal services are to used expand legal services.

f. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.

g. Procedures to address the provision of legal services if a conflict of interest exists.
h. Non-discrimination towards clients.
i. Grievance procedures for clients.
j. Records retention.
k. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

Legal Requirements 650-25-40-10-05

(Revised 1/1/06 ML#2995)

View Archives

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.
2. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-40-10-10

(Revised 1/1/06 ML#2995)

View Archives

1. Coordinate services within the community to avoid duplication.
2. Evaluate overall program to determine whether or not services were delivered, at what cost, and to what extent goals/objectives were met.

Advocacy Requirements 650-25-40-10-15

(Revised 1/1/06 ML#2995)

View Archives

1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

Nutrition Program Service Standard 650-25-45

(Revised 8/1/09 ML#3186)

View Archives

The purposes of nutrition services are:

1. To reduce hunger and food insecurity;
2. To promote socialization of older individuals; and
3. To promote the health and well being of older individuals in assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior.

Nutrition services include congregate and home-delivered meals, nutrition screening, nutrition education, nutrition counseling, and provide a link to other social and supportive services. Priority for services shall be given to:

- older individuals residing in rural areas;
- older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, older individuals residing in rural areas);
- older individuals with severe disabilities;
- older individuals with limited English proficiency;
- older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and
- older individuals at risk for institutional placement.

Performance Standards 650-25-45-01

Eligible Clients 650-25-45-01-01

(Revised 1/1/14 ML#3396)

View Archives

1. Individuals age 60 and older and their spouses, regardless of age. A home-delivered meal may be provided to the spouse of an eligible client, regardless of the spouse's age or condition, when receipt of the meal is in the best interest of the eligible home-delivered meals client.
2. Individuals under age 60 (except for spouses) must pay the full cost of service unless one of the criteria listed below (3, 4, or 5) is met.
3. Volunteers under age 60 providing meal services during meal hours. The contract entity may make a meal available if a specific criterion is included in the entity's Program Policies and Procedures Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.
4. Individuals with disabilities under age 60. The contract entity may make nutrition services available to individuals with disabilities under age 60 who reside in a housing facility primarily occupied by older individuals where there is a Title III congregate meal site when provision of the service does not prevent the participation of individuals age 60 and older and their spouse. If home-delivered meals are offered at the meal site, the individual with a disability under age 60 must meet eligibility criteria as outlined in Section 650-25-45-01-10(6). The individual is only eligible to receive nutrition services that are provided at the housing facility where he or she resides. Specific housing facility meal sites must be identified in the contract and in the entity's Program Policies and Procedures Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.
5. Individuals under the age of 60 with disabilities residing with eligible clients. The contract entity may make a meal available to an individual with a disability who resides at home with an eligible individual if specific criteria are included in the entity's Program Policies and

Procedure Manual. Individuals under age 60 (except for spouses) may receive a meal only when it will not deprive an eligible client the opportunity to receive a meal.

Location of Services 650-25-45-01-05

(Revised 1/1/12 ML#3303)

View Archives

1. Congregate Meals – At a senior center or designated congregate setting (including schools and other facilities serving meals to children in order to promote intergenerational meal programs) that is in as close proximity as feasible to the majority of eligible individuals' residences. The meal site must meet state and local fire safety and sanitation codes and standards, be accessible to individuals with disabilities, and have planned access to a telephone.
2. Home-Delivered Meals – In the homes of eligible home-delivered meals clients.

Delivery Characteristics 650-25-45-01-10

(Revised 10/1/15 ML #3454)

View Archives

1. Contract entities must meet all applicable state and local laws and regulations regarding the safe and sanitary handling of food, equipment, supplies, and materials used in the storage, preparation, and delivery of meals and services to older persons. (Refer to the "North Dakota Requirements for Food and Beverage Establishments", North Dakota Administrative Code (NDAC) Chapter 33-33-04.)

2. Congregate meals may be provided as hot or cold; home-delivered meals may be provided as hot, shelf stable, frozen, modified atmosphere packaging (MAP), or nutritional supplements.

    a. Hot Food

        i. Hot food must be served at 135 degrees Fahrenheit or higher.
        ii. Document daily monitoring of hot food temperatures for each meal site.
        iii. The hot food portion of a home-delivered meal must be packaged at 135 degrees Fahrenheit or higher and delivered within a two-hour time frame unless packaged and stored in a manner that will maintain the food temperature throughout the route (i.e. a plug-in-heating unit).

    b. Cold Food

        i. Cold food must be served at 41 degrees Fahrenheit or less.
        ii. Document daily monitoring of cold food temperatures for each meal site.
        iii. Working thermometers must be in place in all refrigerators/walk-in coolers. Refrigeration temperatures must be maintained between 35-41 degrees Fahrenheit.

iv. Document weekly monitoring of temperatures of refrigerators/walk-in coolers.
v. The cold food portion of a home-delivered meal must be packaged at 41 degrees Fahrenheit or less and delivered within a two-hour time frame unless packaged and stored in a manner that will maintain the food temperature throughout the route (i.e. a plug-in cooling unit).

c. Shelf Stable

Label must include entrée selection, and the date of expiration.

d. Frozen

i. If commercially frozen meals are not used, frozen meals must be produced using rapid/blast freeze equipment and technology.
ii. Label must include entrée selection, instructions for storage and reheating, and the date of expiration. The date of the expiration should be no longer than three months after the meal was rapid/blast frozen.
iii. Working thermometers must be in place in all freezers. Frozen food must be maintained at zero degrees Fahrenheit or below.
iv. Documentation of weekly monitoring of temperatures of freezers.
v. The provider must assure the client has the ability to store and prepare the frozen meal.
vi. All frozen meals must be recorded only as a sub-service of home-delivered meals.

e. Nutritional Supplement

The provision of any nutritional supplement must be based on a written diet order signed by a physician.

A nutritional supplement (i.e. Ensure) may be counted as a billable unit of service if there is a physician's order, and if the supplement is the only 'meal' the client is receiving. Nutritional supplements served in addition to a meal are not considered a separate meal. The nutritional supplement given in an amount

that equals 1/3 DRI (i.e. two cans of Ensure) cannot be considered as a Title III meal unless it is the only food provided and consumed by the client.

However, if there is a physician's order and if two cans of Ensure were provided and consumed (no food provided in addition to the nutritional supplement), the nutritional supplement can be billed as a Title III meal. (The nutritional supplement given in an amount that equals 1/3 DRI (i.e. two cans of Ensure) cannot be considered as a Title III meal unless it is the only food provided and consumed by the client).

Supplements are also available in a frozen state. The contract entity must check with the manufacturer/supplier for the recommended shelf life of thawed supplements if the discard date is not indicated on the package.

f. Modified Atmosphere Packaging (MAP) Meal

Modified Atmosphere Packaging (MAP) is a technology that has been developed to ensure that packaged food products stay fresh and attractive for as long as possible. MAP extends the shelf life and preserves the quality of food without additives or preservatives. Shelf life of fresh food is significantly extended, while spoilage and waste are reduced.

If a MAP meal is used for the home-delivered meal service, the nutrition services contract entity must assure that the client has the ability to store and prepare the MAP meal.

3. The Older Americans Act authorizes the provision of congregate meals and home-delivered meals. There is no provision for carry-out or take-out meals. Meals must be provided five or more days per week in the defined service area. Congregate meals must be served a minimum of three days per week at each congregate meal site. A minimum of five home-delivered meals must be made available per client per week in the client's home. Meals must be served during appropriate meal times.

4. A contract entity may choose not to serve congregate meals on holidays. The contract entity must identify the specific holidays a site(s) will be closed in their Program Policies and Procedures Manual. Site closures must also be included in the menus, the contract entity's newsletter (if applicable), and posted in a visible location at the meal site.

   For home-delivered meals, an alternative option (i.e. shelf stable, frozen, or modified atmosphere packaging (MAP) meal) must be made available to avoid an interruption of service to the home-delivered meals client.

5. Congregate meal service must address the following:

   a. All eligible congregate meals clients who participate or plan to participate shall provide baseline data as outlined in the SAMS Congregate Meals Program Registration form and complete the Nutrition Screening Checklist. If a meal and the client are reported as a part of the State Program Report, baseline data (NAPIS data) and the Nutrition Screening checklist must be completed. Contacts may be documented in the Narrative section of the SAMS Congregate Meal Program Registration form, as appropriate. The Nutrition Screening Checklist must be reviewed and updated in the SAMS data system within a consecutive 12-month period for congregate meals clients.

      Eligible congregate meal clients who may be one-time guests, visiting for a short time, etc., are required to complete the Congregate Registration Form. A SAMS Consumer Group posting cannot be used as service delivery for reimbursement purposes. This assures compliance with federal reporting requirements under NAPIS and the State Program Report.

   b. Clients who request service may be required to sign up in advance of the date of the service as identified in the contract entity's Program Policies and Procedures Manual.
   c. Copies of the menu, and voluntary contribution information must be publicly displayed at all congregate meal sites.
   d. Adaptive equipment to meet special needs must be available.
   e. Food not requiring refrigeration may be taken home by participants.

f. For safety reasons, a contract entity may choose to deliver a meal to a congregate client during inclement weather and/or disaster situations. The contract entity should include this in their Program Policies and Procedures Manual under 'procedures to assure service delivery in weather-related emergencies' and 'written emergency disaster preparedness plan' [Reference: Section 650-25-45-30-01(1)(i) and (j) of this service chapter].

   If a contract entity chooses to deliver a meal to a congregate client during inclement weather/disaster situations, the meal should be recorded in the SAMS service delivery as a congregate meal.

g. A congregate client must be offered all of the required menu components; however, the client may choose not to take a specific menu component. Food should not be placed on the client's tray/plate if he or she does not want the specific food component. A meal is considered eligible based on nutritional content, and not on how much is eaten.

6. Home-delivered meals criteria include:

   a. Client must be homebound because of physical incapacity, mental or social conditions, or isolation. A person is considered homebound when one or more of the following exist:
      - Limited physical mobility;
      - Emotional or psychological impairments that prohibit participation at a congregate site;
      - Remote geographic location where no congregate meal site exists; or
      - Remote geographic location that prohibits accessing the meal site due to transportation issues.

   b. A home-delivered meal may be provided to the spouse of an eligible client, regardless of the spouse's age or condition, when receipt of the meal is in the best interest of the eligible home-delivered meals client.

The only exceptions to the home-delivered meal criteria are provisions for meals in weather-related emergencies and other disasters:

- If a contract entity delivers a meal to a congregate client during inclement weather [Reference: OAA Policies and Procedures Section 650-25-45-01-10(5)(f)]; or
- If provisions for the delivery of a frozen, modified atmosphere packaging (MAP), or shelf stable meal for a congregate client as an emergency meal are included in the contract entity's Program Policies and Procedures Manual assuring service delivery in weather-related emergencies and in their disaster preparedness plan.

c. Eligibility for home-delivered meals must be determined using the SAMS Home-Delivered Meal Program Registration form. If a meal and the client are reported as a part of the State Program Report, baseline data (NAPIS data), the Nutrition Screening Checklist and ADLs/IADLs must be completed. Initial determination of eligibility may be accomplished by telephone. Within two weeks after beginning meal service, a home visit and the SAMS Home-Delivered Meal Program Registration form must be completed to verify eligibility. The Nutrition Services contract entity may accept program registration information from another Older Americans Act entity. Information must be recorded in the SAMS data system. Documentation must include verification of eligibility for individuals under the age of 60.

   For continued home-delivered meal service, redetermination of eligibility must be completed every six months, or sooner, as needed. Redetermination can be accomplished through a home visit or by telephone. At a minimum, one home visit must occur within a consecutive 12-month period. The redetermination must be documented in the SAMS data system. Documentation must indicate the method of redetermination (home visit or telephone) and include verification of continued eligibility for individuals under the age of 60.

d. Initially and on an annual basis, the Nutrition Services contract entity must provide copies and review content of the menu, voluntary contribution information, and home-delivered meals

policies and procedures with the client. The contract entity is encouraged to provide available medical information approved by health care professionals, such as informational brochures and information on how to get vaccines, including vaccines for influenza, pneumonia, and shingles, in the individuals' communities.

e. The Nutrition Services contract entity must limit the amount of time meals spend in transit before they are consumed.
f. A home-delivered meals client must be offered all of the required menu components; however, the client may choose not to take a specific menu component. Client preference should be documented in the narrative section of the client record. A specific food component should not be delivered if the client has chosen not to receive it. A meal is considered eligible based on nutritional content, and not on how much is eaten.

7. Nutrition education must be provided to both congregate and home-delivered meals clients by the Nutrition Services contract entity. A licensed registered dietitian or person with comparable expertise shall be requested to provide input regarding the content of the nutrition education prior to presentation or distribution of materials.

   a. Nutrition education shall be provided at each congregate meal site on a semi-annual basis (minimum). Nutrition related presentations, printed materials, videos, food demonstrations, and cooking classes are acceptable formats for the provision of the service. Documentation indicating the meal site, date, presenter (as applicable), topic presented, number of clients receiving nutrition education, and the number of service units must be maintained. To record Service Delivery in the SAMS data system, a separate Consumer Group should be created for each meal site. Each client attending a presentation equals one unit of service.
   b. Nutrition education for home-delivered clients must be carried out on a semi-annual basis (minimum). Printed materials are an acceptable format for the provision of the service. A copy of the printed nutrition education material and documentation of the date of distribution, number of clients receiving the service must be maintained. To record Service Delivery in the SAMS data system, a separate Consumer Group should be created for each

meal site. Each client receiving the printed material equals one unit of service.

c. Expenses for the provision of nutrition education are included in the unit cost of a congregate and home-delivered meal and are not a separate billable unit.
d. Units of service and the estimated cost must be reported on the Monthly Data & Payment Report.

8. All congregate and home-delivered meals clients must be screened for nutritional risk using the Nutrition Screening Checklist, which is a part of the SAMS Congregate Meals Registration form and the SAMS Home-Delivered Meal Program Registration form.

   a. For congregate meals clients, the screenings must be conducted a minimum of one time within a consecutive 12-month period.
   b. For continued receipt of home-delivered meals, redetermination of eligibility must occur every six months or sooner as applicable. Redetermination must include completion of the Nutrition Screening checklist and ADL/IADL's. The redetermination may be conducted through a home visit or by telephone. At a minimum, one home visit must occur within a consecutive 12-month period. If additional services are indicated, a referral should be made to the appropriate agency and/or to the regional ADRL.
   c. Screening results for all clients must be recorded in the SAMS data system. Clients should be encouraged to 're-check' their nutritional scores as indicated: Score of 0-2 should recheck in 6 months; score of 3-5 should recheck in 3 months; score of 6 or more are at high nutritional risk -- discuss (with the client) the possible referral to their physician or licensed registered dietitian to address nutritional concerns and ways to improve their nutritional health (see information in 7d).
   d. Clients who screen ‘at high nutritional risk’ should consider referral to a doctor or licensed registered dietitian for follow-up and possible nutrition counseling. The Nutrition Services contract entity shall discuss with the client and if written release is obtained, make a referral to the licensed registered dietitian providing services to the Nutrition Services contract entity or to the client’s physician. Documentation of the contact and outcome must be recorded in the Narrative section of the applicable SAMS meal registration form.

9. Nutrition counseling for congregate and home-delivered meals clients identified at high nutritional risk through the Nutrition Screening Checklist can only be provided by a licensed registered dietitian. All nutrition counseling must be recorded as Service Delivery for each individual client in the SAMS data system.

    a. For recording purposes, a unit of service is one session.
    b. Expenses for the referral/provision of nutrition counseling are not a separate billable unit.
    c. Units of service and the estimated cost must be reported on the Monthly Data & Payment Report.

10. Any alteration in the pattern of service delivery must be discussed with the Regional Aging Services Program Administrator prior to the change. All service delivery options should be considered and/or explored.

    After discussions have been held and an alternative plan has been agreed upon, the contract entity must complete and submit a revised Service Provision Form to Aging Services Division as outlined in Section 650-25-75-05-05 of this service chapter.

Billable Units of Service 650-25-45-05

(Revised 10/1/15 ML#3454)

View Archives

1. For billing purposes, one congregate meal equals one unit of service.
2. For billing purposes, one home-delivered meal equals one unit of service.

    a. Nutrition providers must record the type of home-delivered meal provided in the Subservice section of SAMS Service Delivery.
    b. All frozen meals must be recorded only as a sub-service of home-delivered meals. If a frozen meal is prepared for consumption at a congregate site, the meal must be recorded in SAMS Service Delivery as Congregate Meal with the subservice Hot/Cold Meal.
    c. A nutritional supplement is considered as one meal if there is a physician's order and if the client is only provided and consumes liquid food equaling 1/3 of the DRI's..

Each billable unit of service received by a client must be recorded in the client's individual record in the SAMS data system by the 15th of the month following service delivery.

Congregate and home-delivered meal registrations and the provision of nutrition education and nutrition counseling are considered part of nutrition services and are not billable units of service.

Menu Planning 650-25-45-10

(Revised 10/1/15 ML#3454)

View Archives

1. All meals provided must:

    a. Comply with the most recent Dietary Guidelines for Americans (DGAs), published by the Secretary and the Secretary of Agriculture; and
    b. Provide a minimum of 33 1/3 percent of the dietary reference intakes (DRIs) established by the Food and Nutrition Board of the Institute of Medicine of the National Academy of Sciences, if the project provides one meal per day. A minimum of 66 2/3 percent of the allowances must be provided if the project provides two meals per day. If the project provides three meals per day, 100 percent of the allowances must be provided).

    The DGAs describe food choices that promote good health. The DRIs help assure that nutrient needs are met.

2. The South Dakota Division of Adult Services and Aging developed recipes and menus that meet current dietary guidelines and DRI requirements. The menus were developed and nutritional analyses completed by Adele Huls, PhD, RD, LMNT, LN.

    The recipes and menus are posted on the South Dakota website and are available for use by North Dakota contract entities. The recipes and menus can be accessed at: http://dss.sd.gov/elderlyservices/services/seniormeals/menusandrecipes.aspx

3. Contract entities that do not use the menus developed by the South Dakota Division of Adult Services and Aging must address the following:

    a. Develop menus that comply with the most recent Dietary Guidelines for Americans (DGAs) and meet current DRI recommendations. North Dakota will follow guidelines used by

South Dakota in the development of menus to meet current DRI requirements. Guidelines for nutrient values are listed in #4.

b. Use a cycle menu format (minimum of four weeks) that is rotated at set intervals and reflects seasonal availability of foods.
c. To the maximum extent practicable, consider the special dietary needs arising from health requirements, religious requirements, or ethnic backgrounds of eligible clients.
d. The cycle menus, recipes, and nutritional analysis must be submitted to Aging Services Division through the procurement process and/or upon request. The submitted materials must be signed by the contract entity's licensed registered dietitian or licensed nutritionist.

4. The following guidelines for nutrient values must be used in developing menus:

SD Meals Program Nutrient Goals (2010 Dietary Guidelines)

For Planning and Analyzing Menus

1 meal per day

Calorie goal +/- 10% of Value below

Macronutrients (protein, carbohydrate, fat) balanced

(Fat can be lower as long as calories are met)

Micronutrient (vitamins & minerals) 80-100% or more daily except sodium

Present sodium goal 800-1000 mg daily

Nutrient	**Value**
Basic Components *indicates required	
*Calories (kcal)	735.00
Water (g)	1233.30
*Protein (g) actual is 18.8 - our goal is based on 17% of calories and wt/ht/activity of reference person (75 yo male 68" 153#) Lightly Active	31.24
Carbohydrates (g) based on 53% of calories	97.40

Fat (g) can be less (limit or delete solid fats)	24.50
*Dietary Fiber (g) (14g/1000 calories)	10.29
*Fat (g) based on 30% of calories - can be lower	24.50
Net Carbs (g)	87.11
Vitamins	
*Vitamin A RAE	300.00
*Vitamin B-6 (mg)	0.60
*Vitamin B-12 (mcg)	0.80
*Vitamin C (mg)	30.00
*Vitamin D (mcg) (600 IU or more ideal)	15.00
Folate DFE (mcg)	133.30
Minerals	
*Calcium (mg)	400.00
*Magnesium (mg)	140.00
Iron (mg)	2.70
*Potassium (mg) goal: 1567.0 or more ideal	1250.00
*Sodium (mg) goal: 800 or less ideal	1000.00
*Zinc (mg)	3.75

Contract entities should strive to meet nutrient values on a daily basis. Averaging of nutrient values over a 5-day or 7-day period is allowable.

5. A meal pattern is a menu-planning tool that ensures the number/numbers of servings per food group are met at each meal. **Meal patterns do not ensure that nutrient requirements are**

met; therefore, computer-assisted nutrient analysis must be run (see #4). Component meal patterns may be used to design menus; however, a specific menu pattern is not required.

The goal of healthy eating is a balanced diet including all food groups. The following five dietary components must be included in each meal when planning menus:

a. Protein - Meats, Fish, Poultry, Legumes, Eggs, Nuts, and Cheese: Each meal should contain a **minimum** of two ounces of cooked, edible portions of meat, seafood, poultry, cheese, eggs, beans and peas, or unsalted nuts and seeds (or a combination thereof). Providers may choose to serve a larger portion of meat than the required two ounce minimum.
b. Vegetables – choose a variety, especially dark green, red and orange vegetables. Serving sizes: 1/2 cup cooked legumes; ½ cup cooked vegetables; 1 cup raw leafy green vegetables, such as, lettuce or salad.
c. Fruits – choose fresh, frozen, or canned fruit packed in water or juice, light syrup or without sugar. Before serving, rinse fruit packed in heavy sugar syrup. Serving sizes: 1 medium sized whole fruit; ½ cup fresh, chopped, cooked, frozen, or canned fruit; or ½ cup 100 percent fruit juice. The 2010 DGA encourage the consumption of whole fruit rather than 100 percent fruit juice.
d. Breads/Grains – one-half of the daily grain intakes should be from whole grains. Serving sizes: 1 slice bread or ½ cup cooked rice, pasta, or cereal.
e. Milk – each meal should include eight ounces of fat-free, low-fat, 1%, buttermilk, or calcium fortified soy milk or orange juice.

Other menu planning considerations include:

- Fat: Replace solid fats with plant based oils to improve diet quality without added calories. Choose plant based oils that have a high percentage of beneficial monounsaturated and polyunsaturated fatty acids.
- Dessert: Provide desserts occasionally as an optional element of the meal to satisfy caloric requirements or to deliver additional nutrients. Avoid serving desserts that are high in sugar, refined grains, and solid fats. The use of fruit as a dessert is encouraged.

- Sodium: Focus on a stepwise reduction of sodium over time. Prepare foods without adding salt in the cooking process. Use herbal seasonings to replace salt. Provide nutrition education on the health impacts of high sodium intake on older adults.

6. All menu changes/substitutions must be documented on the menu for site review. In making substitutions, consideration must be given to assure dietary compliance is met. It is recommended that a list of approved substitutions be maintained at the meal site.
7. Provision of a special or therapeutic diet to a client requires a signed physician's order. Menus must be planned with the advice of a licensed registered dietitian to establish appropriate nutritional therapy.
8. Nutrition Services contract entities are prohibited from providing vitamin and/or mineral supplements to clients.

Nutrition Services Incentive Program (NSIP) Funds 650-25-45-15

(Revised 1/1/12 ML#3303)

View Archives

Nutrition Services Incentive Program (NSIP) funds must be used to purchase food grown in the United States of America for meals provided during the federal fiscal year for which the funds were authorized.

Additional information regarding NSIP funds is located in Section 650-25-80-05. Nutrition Services Incentive Program (NSIP).

Staffing Requirements 650-25-45-20

(Revised 1/1/06 ML#2995)

View Archives

1. The contract entity must establish and administer the nutrition services program with the advice of the following:

    - Licensed registered dietitians or individuals with comparable expertise, including a licensed nutritionist, a dietary technician, or a certified dietary manager;
    - Meal participants; and
    - Individuals who are knowledgeable with regard to the needs of older individuals.

Prohibited Activities 650-25-45-25

(Revised 1/1/08 ML#3121)

View Archives

1. Unapproved substitutions that alter the DRI nutrient values/goals.
2. Utilization of home canned, home prepared, or preserved food.
3. Provision of therapeutic diets without the advice of a physician or licensed registered dietitian to establish appropriate medical nutritional therapy.

Administrative Requirements 650-25-45-30

Administration 650-25-45-30-01

(Revised 10/1/15 ML#3454)

View Archives

1. Develop and adhere to a written Program Policies and Procedures Manual to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency; and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and older individuals at risk for institutional placement.
    c. Frequency, method, and timeframe for delivery of services as appropriate.
    d. Criteria for eligible nutrition clients, as applicable [Section 650-25-45-01-01 and Section 650-25-45-01-10(5)(b)].
    e. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
    f. Procedures to assure the confidentiality of client specific information.

        i. No information about a client is disclosed by the contract entity a release of information is received from the client

or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.

ii. An appropriate release of information document is signed and on file before client records are released.

iii. All client specific information is maintained in a locked file, locked area of access coded computer program.

g. Service contribution (program income) procedures that assure:

i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a locked box in a private area; sealed envelope with on-site deposit in a locked box in a private area or return by mail; and self punch meal tickets. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.

ii. Upon initial registration for the service and periodically thereafter, inform the client of the opportunity to voluntarily contribute to the cost of the service.

iii. No client is denied service due to inability or unwillingness to contribute.

iv. A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.

v. Each contract entity must choose to do one of the following: 1) Publicly display at service locations and provide to clients served at home, the full cost of the nutrition service, with information indicating that clients may, but are not required to contribute for the nutrition service; or 2) Publicly display at service locations and provide to clients served at home, the full cost of the nutrition service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the nutrition service.

vi. Measures are taken to protect the privacy of each client with respect to his or her contribution.

vii. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds,

procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to funds.

viii. Ineligible participants are required to pay the full cost of the nutrition service. (These funds are not program income).

ix. Service contributions received for congregate meals must be used to expand congregate meal services. Service contributions received for home-delivered meals must be used to expand home-delivered meal services.

x. Service contributions for nutrition services may include Supplemental Nutrition Assistance Program (SNAP) benefits.

h. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.
i. Procedures to assure service delivery in weather-related emergencies.
j. Written emergency disaster preparedness plan approved by the local governmental official(s) having responsibility for disaster planning and designate an individual who is responsible to carry out provisions of the plan.
k. Procedures to assure the provision of information and referral services.
l. Non-discrimination towards clients.
m. Grievance procedures for clients.
n. Records retention.
o. Reporting food-borne illness.
p. Holiday meal policy.
q. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

2. Provide or make available training to volunteers and paid personnel concerning the provision of services to older individuals. Upon hire and annually thereafter, paid personnel/volunteers must receive training on the following: overview of the Older Americans Act, service contributions, review of applicable service standards or service requirements and necessary training to deliver the specific service, confidentiality, and fire safety.

3. Use of volunteers in the provision of services, as applicable. (Volunteer hours and the estimated value must be reported on the Monthly Data & Payment Report.)

Legal Requirements 650-25-45-30-05

(Revised 1/1/07 ML#3061)

View Archives

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.
2. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-45-30-10

(Revised 1/1/14 ML#3396)

View Archives

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Advocacy Requirements 650-25-45-30-15

(Revised 1/1/10 ML #3216)

View Archives

1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

Nutrition Program Service Standard 650-25-46

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Performance Standards 650-25-46-01

Eligible Clients 650-25-46-01-01

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Location of Services 650-25-46-01-05

(Repealed 1/1/12 ML #3303)

View Archives

REPEALED

Delivery Characteristics 650-25-46-01-10

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Billable Units of Service 650-25-46-05

(Revised 1/1/13 ML #3359)

View Archives

REPEALED

Menu Planning 650-25-46-10

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Nutrition Services Incentive Program (NSIP) Funds 650-25-46-15

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Staffing Requirements 650-25-46-20

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Prohibited Activities 650-25-46-25

(Repealed 1/1/13 ML #3359

View Archives

REPEALED

Administrative Requirements 650-25-46-30

Administration 650-25-46-30-01

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Legal Requirements 650-25-46-30-05

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Planning/Evaluation Requirements 650-25-46-30-10

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Advocacy Requirements 650-25-46-30-15

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Outreach Program Service Standard 650-25-50

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Performance Standards 650-25-50-01

Eligible Clients 650-25-50-01-01

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Location of Services 650-25-50-01-05

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Delivery Characteristics 650-25-50-01-10

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Billable Units of Service 650-25-50-05

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Service Delivery Procedures 650-25-50-06

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Service Activities 650-25-50-10

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Staffing Requirements 650-25-50-15

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Prohibited Activities 650-25-50-20

(Repealed 1/1/13 ML #3359)

View Archives

REPEALED

Administrative Requirements 650-25-50-25

Administration 650-25-50-25-01

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Legal Requirements 650-25-50-25-05

(Repealed 1/1/13 ML#3356)

View Archives

REPEALED

Planning/Evaluation Requirements 650-25-50-25-10

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Advocacy Requirements 650-25-50-25-15

(Repealed 1/1/13 ML#3359)

View Archives

REPEALED

Senior Companion Program Service Standard 650-25-55

(Revised 8/1/09 ML#3186)

View Archives

The senior companion service offers periodic companionship and non-medical support by volunteers (who receive a stipend) to adults with special needs. Priority for services shall be given to:

- older individuals residing in rural areas;
- older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with severe disabilities; older individuals with limited English proficiency;
- older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and
- older individuals at risk for institutional placement.

Performance Standards 650-25-55-01

Eligible Clients - Senior Companion Volunteers 650-25-55-01-01

(Revised 1/1/10 ML #3216)

View Archives

Individuals age 60 and older who meet income requirements at 200% of poverty or below.

Eligible Clients - Recipients of the Senior Companion Service 650-25-55-01-05

(Revised 1/1/06 ML#2995)

View Archives

Individuals age 60 and older who are homebound and do not reside in a long-term care facility.

Location of Service 650-25-55-01-10

(Revised 1/1/06 ML#2995)

View Archives

Services must be provided in the recipient's home.

Delivery of Characteristics 650-25-55-01-15

(Revised 1/1/06 ML#2995)

View Archives

1. Solicit host agencies/volunteer stations that will match eligible senior companion volunteers with recipient's of the senior companion service who meet eligibility criteria.

    a. Enter into a memorandum of understanding with each host agency.
    b. Provide host agencies with orientation to the senior companion program including guidelines for client/recipient selection, development of a volunteer assignment, appropriate and inappropriate volunteer activities, and completion of a volunteer and recipient letter of agreement.
    c. Maintain monthly contact with each host agency to provide on-going support, assistance, and program maintenance.

2. Recruit and place senior companion volunteers.

    a. Select volunteers based on the federal guidelines published by the Corporation for National and Community Service.
    b. Assure that each volunteer has received a physical exam in order to serve without determent to self or those served.
    c. Assure that each volunteer is placed in a volunteer station closest to the companion's residing place.
    d. Provide each volunteer with the stipend and other program benefits.

3. Provide training for senior companion volunteers.

    a. Provide volunteers with basic pre-service orientation within three months of placement.
    b. Assure that each volunteer received in-service training equivalent to 40 hours per year that covers topics that are helpful and supportive to volunteers while on assignment s well as in their personal lives.

c. Assure that the following topics are covered during the in-services: Review of Policies and Procedures from the Senior Companion Handbook, Communication Skills, Safety, and Areas of Health and Human Service Needs.

4. Provide, though senior companion volunteers, supportive person-to-person in-home (non-medical) services including personal care, social recreational activities, nutrition, home management, information and advocacy, and respite care to a minimum of 70 recipients of senior companion services.

Unit of Service 650-25-55-05

(Revised 1/1/06 ML#2995)

View Archives

For reporting purposes, a unit of service equals one visit.

Administrative Requirements 650-25-55-10

Administration 650-25-55-10-01

(Revised 1/1/14 ML#3396)

View Archives

1. Develop and adhere to a written program manual of policies and procedures to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low income older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and older individuals at risk for institutional placement.
    c. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
    d. Procedures to assure the confidentiality of client specific information.

        i. No information about a client is disclosed by the contract entity unless informed consent is received from the client or legal representative; disclosure is required by court order; or for program monitoring by authorized agencies.
        ii. An appropriate release of information document is signed and on file before client records are released.

iii. All client specific information is maintained in a locked file, locked area of access coded computer program.

e. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.
f. Non-discrimination towards clients.
g. Grievance procedures for clients.
h. Records retention.
i. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

Legal Requirements 650-25-55-10-05

(Revised 1/1/06 ML#2995)

View Archives

1. Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.
2. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-55-10-10

(Revised 1/1/14 ML#3396)

View Archives

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost, and to what extent goals/objectives were met.
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Advocacy Requirements 650-25-55-10-15

(Revised 1/1/06 ML#2995)

View Archives

1. Provide leadership relative to aging issues on behalf of all older persons in the defined service area.
2. Evaluate and comment on local regulations and policies that affect older persons.
3. Maintain records that document advocacy efforts and outcomes.

Tribal Home Visit Service Standard 650-25-61

(Revised 1/1/13 ML#3359)

View Archives

Tribal home visits are periodic visits to isolated older individuals residing on a Reservation to monitor their health and well-being, and identify service needs with an emphasis on referral and linkage to available services.

Priority for services must be given to:

- older individuals residing in rural areas;
- older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas);
- older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency; older individuals residing in rural areas);
- older individuals with severe disabilities;
- older individuals with limited English proficiency;
- older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction and the caretakers of such individuals; and
- older individuals at risk for institutional placement.

Performance Standards 650-25-61-01

Eligible Clients 650-25-61-01-01

(Revised 1/1/13 ML#3359)

View Archives

Individuals 60 years of age and older.

Location of Services 650-25-61-01-05

(Revised 1/1/13 ML#3359)

View Archives

A tribal home visit must occur in the individual's home.

Service Delivery Characteristics/Activities
650-25-61-01-10

(Revised 1/1/14 ML#3396)

View Archives

Tribal home visits must be delivered throughout the Reservation.

1. Identify and contact targeted older individuals on the Reservation.
2. Receive referrals, make home visits, identify possible service needs, and make appropriate linkage(s) to services.
3. All referrals must be contacted within two working days.
4. Adhere to the contract entity's written referral process as stated in the contract entity's Policies and Procedures Manual to coordinate service provision with other agencies.
5. For all clients receiving the service, the SAMS Tribal Home Visit Registration Form must be completed and data entered in the SAMS system. The contract entity should attempt to obtain all data requested on the form. NAPIS data is required for federal reporting purposes. Each visit must be documented in the Narrative section of the SAMS Tribal Home Visit Registration form. The documentation shall include:

    - the specific purpose of the home visit;
    - a brief descriptive statement of the interaction; and
    - outcome of the interaction.

    Information obtained on the SAMS Tribal Home Visit Registration Form must be reviewed and updated in the SAMS data system (under Assessments, select Copy) within a consecutive 12-month period.

6. All contacts (telephone calls, e-mail and other written correspondence, and face-to-face visits) must be documented in the Narrative section of the SAMS Tribal Home Visit Registration form. Each contact must have a specific purpose. The documentation shall include:

    - the specific purpose of the contact;
    - a brief descriptive statement of the interaction; and
    - outcome of the interaction.

7. If more than one tribal home visit occurs within a thirty-day period, documentation must clearly justify the reason for the visit and outcome of the visit.
8. Each case record must be maintained in an individualized file and secured in a locked file cabinet, a locked area, or an access coded computer program.
9. A signed release of information document must be on file before information can be shared or released.
10. Any alteration in the pattern of service delivery must be discussed with the Regional Aging Services Program Administrator prior to the change. All service delivery options should be considered/explored.

    After discussions have been held and an alternative plan has been agreed upon, the contract entity must complete and submit a revised Service Provision Form to Aging Services Division as outlined in Section 650-25-75-05-05 of the this service chapter.

Billable Units of Service 650-25-61-05

(Revised 1/1/13 ML#3359)

View Archives

For billing purposes, the contract entity must use the service billing unit system for each service procedure identified in the Service Delivery Procedures Section of this Standard (650-25-61-10).

Each billable unit of service received by a client must be recorded in the client's individual record in the SAMS system by the 15th of the month following service delivery.

Service Delivery Procedures 650-25-61-10

(Revised 1/1/14 ML#3396)

View Archives

The following service delivery procedures must be followed for reimbursement through an Older Americans Act contract:

1. Tribal Home Visit – 4 Units of Service

    a. Conduct a visit in the client's home. Complete the SAMS Tribal Visit Registration form to register the client in SAMS.
    b. If needed services are identified, make appropriate referrals; obtain a release of information, if applicable.
    c. Document the following in the Narrative section of the SAMS Tribal Visit Registration form:

        - The specific purpose of the home visit;
        - A brief descriptive statement of the interaction; and
        - Outcome of the interaction.

    d. Review and update information obtained on the SAMS Tribal Home Visit Registration Form in the SAMS data system (under Assessments, select Copy) within a consecutive 12-month period.

2. Telephone Contact, E-mail, Written Correspondence, or Brief Face-to-Face Visit – 1 Unit of Service

    a. Contact the referral entity or client via telephone, e-mail, written correspondence, or through a brief face-to-face visit regarding the referral, receipt of services, or follow-up.
    b. Document the following in the Narrative section of the SAMS Tribal Visit Registration form:

        - The specific purpose of the contact;
        - A brief descriptive statement of the interaction; and
        - Outcome of the interaction.

Staffing Requirements 650-25-61-15

(Revised 1/1/13 ML#3359)

View Archives

1. Possess the knowledge of or willingness to learn of available community resources within the service area;
2. Possess the ability to develop rapport with older individuals;
3. Possess the ability to develop rapport with other agencies that provide assistance to older individuals;
4. Possess the ability to identify service needs and make appropriate referrals.
5. Possess effective verbal, written, and computer skills.

Prohibited Activities 650-25-61-20

(Revised 1/1/13 ML#3359)

View Archives

1. Breach of confidentiality.

Administrative Requirements 650-25-61-25

Administration 650-25-61-25-01

(Revised 1/1/13 ML#3359)

View Archives

1. Develop and adhere to a written Program Policies and Procedures Manual to include, at a minimum, the following:

    a. Defined service area.
    b. Targeting methods for the following: older individuals residing in rural areas; older individuals with greatest economic need (with particular attention to low income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas); older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency; and older individuals residing in rural areas); older individuals with severe disabilities; older individuals with limited English proficiency; older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and older individuals at risk for institutional placement.
    c. Frequency, method, and timeframe for delivery of services as appropriate.
    d. Service options are accessible to all eligible clients, independent, semi-independent, and totally dependent, regardless of income levels.
    e. Procedures to assure the confidentiality of client specific information.

        i. No information about a client is disclosed by the contract entity unless a release of information is received from the client or legal representative; disclosure is required by

court order; or for program monitoring by authorized agencies.

ii. An appropriate release of information document is signed and on file before client records are released.

iii. All client specific information is maintained in a locked file, locked area, or an access coded computer program.

f. Service contribution (program income) procedures that assure:

i. Clients are provided the opportunity to contribute to the cost of services received. Acceptable formats for receiving contributions include the following: a sealed envelope given to the worker or returned by mail. Any form of periodic correspondence resembling a billing for number of services received by a client is prohibited.

ii. No client is denied service due to inability or unwillingness to contribute.

iii. A suggested contribution schedule that considers the income ranges of older individuals may be developed. Means tests shall not be used for any service supported by Older Americans Act funds.

iv. Each service provider must choose to do one of the following: 1) Provide to clients served at home, the full cost of the service, with information indicating that clients may, but are not required to contribute for the service; or 2) Provide to clients served at home, the full cost of the service and the suggested contribution, with information indicating that clients may, but are not required to contribute for the service.

v. Measures are taken to protect the privacy of each client with respect to his or her contribution.

vi. Appropriate procedures are established to safeguard and account for all contributions. At a minimum, the following must be addressed: format used for receipt of funds, procedure for deposits, verification of receipt of funds, location of funds prior to deposit, and program staff who have access to funds.

vii. Service contributions for tribal home visits are used to expand the service (tribal home visits).

g. Fiscal procedures that address receipt of Older Americans Act and related funds, deposit of funds, and payment process.
h. Procedures to assure the provision of information and referral services.
i. Non-discrimination towards clients.
j. Grievance procedures for clients.
k. Referral process.
l. Records retention.
m. A plan to review and update manual as necessary but at least 90 days after the beginning of each contract period.

2. Provide or make available training to volunteers and paid personnel concerning the provision of services to older individuals. Upon hire and annually thereafter, paid personnel/volunteers must receive training on the following: overview of the Older Americans Act, service contributions, review of applicable service standards or service requirements and necessary training to deliver the specific service, confidentiality, and fire safety.
3. Use of volunteers in the provision of services, as applicable. (Volunteer hours and the estimated value must be reported on the Monthly Data & Payment Report.)

Legal Requirements 650-25-61-25-05

(Revised 1/1/13 ML#3359)

View Archives

Comply with all applicable federal and state laws, rules and regulations, and policies and procedures governing Older Americans Act programs.

1. Provide insurance as required in the Contract.

Planning/Evaluation Requirements 650-25-61-25-10

(Revised 1/1/14 ML#3396)

View Archives

1. Assess/reassess needs of older individuals in the defined service area through program and service evaluations with provision for client input. Develop and maintain a report of the outcomes. Outcomes should be considered in planning for development of new services, continuation of existing services, and/or discontinuing an existing service.
2. Coordinate services within the community to avoid duplication.
3. Evaluate overall program to determine whether or not services were delivered, at what cost; and to what extent goals/objectives were met.
4. Participate in Department of Human Services/Aging Services Division evaluation activities as requested.

Older Americans Act Title III Monitoring 650-25-65

(Revised 1/1/14 ML#3396)

View Archives

Monitoring activities are conducted to determine the following:

- Compliance with state and federal rules, regulations and policies;
- Compliance with the terms of the contract and any attachments;
- If service provision meets or exceeds service standards and/or contract requirements, as applicable; and
- Factors that may have contributed to the achievement or lack of achievement in meeting service standards and/or contract requirements.

Using the Older Americans Act Title III Monitoring tool, on-site monitoring must be conducted by Department staff according to the schedule set forth by Aging Services Division. Department staff may conduct additional and/or more in-depth reviews based on specific circumstances and the needs of legal and contract entities. Regional Aging Services staff may request assistance from Aging Services Division staff in conducting monitoring activities.

An exit conference will be held at the conclusion of each on-site monitoring activity to summarize monitoring activities and outline non-compliance issues. Legal entities must respond, in writing, to any non-compliance issues identified during the assessment process in the time frame set forth by Department staff. Follow-up will be conducted to assure appropriate action has been taken to address each non-compliance issue.

Monitoring reports and written responses to non-compliance issues are forwarded to Aging Services Division for review and, if necessary, implementation of remedies. Failure to rectify issues of non-compliance may result in non-payment, recapture of funds, or contract termination.

Program Reporting Requirements 650-25-70

(Revised 1/1/12 ML#3303)

View Archives

Contract entities may be required to submit program reports. Content of the report and timeframes will be identified in the specific program service standard, Sections 650-25-70-01, Section 650-25-70-05, and/or the contract..

SAMS Reporting 650-25-70-01

(Revised 1/1/13 ML#3359)

View Archives

SAMS is a web-based data management system used to comply with Administration on Aging reporting requirements as well as integrate data collection with other federal and state funded home and community-based services.

Contract entities providing the following services are required to submit program reports using the SAMS data system: ADRL Services; Health Maintenance Services; Nutrition Services; and Tribal Home Visits.

Instructions for use of the SAMS data system can be accessed at: www.synergysw.com/support/login.php. Each user must create a user ID to access the standard user manuals. A Help button is in place in the database to assist the user and can used any time when logged into the system.

Periodic SAMS trainings and on-going technical assistance are provided by Aging Services Division. Contract entities can request specific trainings on SAMS usage and reporting.

A SAMS Agency Summary Report must be generated in the SAMS data system to complete information for the Monthly Data & Payment Report (SFN 269) (235 kb), also generated in the SAMS data system. The SAMS Agency Summary Report must be attached to the Monthly Data & Payment Report and submitted no later than thirty days after the end of the monthly service period.

In addition, a SAMS Service Progress Report must be generated in the SAMS data system for Health Maintenance Services. The SAMS Service Progress Report must be attached to the Monthly Data & Payment Report, and submitted no later than thirty days after the end of the monthly service period.

Contract entities may be required to develop and submit additional reports upon request.

Service Progress Reports/Other Reports 650-25-70-05

(Revised 1/1/06 ML#2995)

View Archives

Contract entities may be required to submit a monthly service progress report. Content of the report and timeframes for submission will be identified in each specific contract.

Any additional reporting requirements will be identified in each specific contract.

State Program Report 650-25-70-10

(Revised 1/1/14 ML#3396)

View Archives

The Administration on Aging established the National Aging Program Information System (NAPIS), which requires the State to submit an annual performance report. This reporting system includes the State Program Report (SPR). The State Program Report is generated from data elements gathered from the SAMS database.

Contract entities not using the SAMS data system will be required to report data for the State Program Report on the form titled "State Program Report for Older Americans Act Contract Entities not using SAMS." Data for the State Program Report is based on the Federal Fiscal Year (October 1 through September 30).

Inventory Listing of Federal Equipment 650-25-70-15

(Revised 1/1/06 ML#2995)

View Archives

Upon request, the contract entity must submit to Aging Services Division an inventory listing of federal equipment as outlined in this manual, Section 25-25-55. Equipment.

Contracting 650-25-75

Procurement of Services 650-25-75-01

(Revised 1/1/14 ML#3996)

View Archives

The Department of Human Services, Aging Services Division, will contract for services in accordance with the following:

- NDAC Article 4-12 State Procurement Practices
- Department of Human Services Manual Chapter 240-03 Contracting for Services
- Department of Human Services Manual Chapter 120-01 Request for Proposal

Contract 650-25-75-05

(Revised 1/1/12 ML#3303)

View Archives

Funds are awarded through the issuance of a contract document depending upon the service requirements.

A contract entity must provide the service(s) throughout the contract period.

A contract may be terminated with or without cause upon thirty (30) days written notice by either party.

Failure to perform the work or comply with the terms of the contract may result in non-payment, recapture of funds, or contract termination.

Subcontract 650-25-75-05-01

(Revised 1/1/14 ML#3396)

View Archives

A contract entity may subcontract with qualified entities provided that any such subcontract shall acknowledge the binding nature of the contract, and incorporates the contract, together with its attachments, as appropriate. The contract entity is solely responsible for the performance of any subcontractor.

The Department of Human Services, Aging Services Division, requires the completion and submission of a Subcontracting Form that identifies each subcontractor and the percentage of work being performed by each.

The Subcontracting Forms will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the forms, including any updated attachments to the forms. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Service Provision Form 650-25-75-05-05

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Service Provision Form. The form(s) outlines location and frequency of a specific funded service.

The Service Provision Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Service Provision Form. The legal entity must submit changes using the Notification of Proposal change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity. The legal entity must submit changes using the Notification of Proposal Change Form.

The new form(s) will become a part of the contract.

Identifying Data Form 650-25-75-05-10

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of an Identifying Data Form. This form provides identification of legal entity information necessary for development of a contract. The form also provides identification of a contact individual who has been delegated authority to represent the legal entity as it relates to the contract.

The Identifying Data Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Notification of Proposal Change Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Program Requirements Form 650-25-75-05-15

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Program Requirements Form. The form provides acknowledgment of review and understanding of program requirements, as well as acknowledgment that monitoring activities will be conducted to assure that services are being provided according to requirements.

The Program Requirements Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Program Requirements Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Principal Officer & Board Members Form 650-25-75-05-20

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Principal Officers & Board Members Form.

The Principal Officers & Board Members Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contined on the Principal Officers & Board Members Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Administration Form 650-25-75-05-25

(Revised 10/1/15 ML#3454)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of an Administration Form. The form identifies staff involved in providing a specific service.

Upon request, an organization chart (diagram form) that shows the structure of the organization, illustrating staff by title, lines of authority, and a current review date must be submitted.

The Administration Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Administration Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Nutrition Dietitian Services Form 650-25-75-05-30

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Dietitian Services Form for legal entities providing nutrition services. The form identifies the individual(s) providing dietitian services.

The Dietitian Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Dietitian Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Health Maintenance Professional Services Form 650-25-75-05-35

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Health Maintenance Professional Services Form for legal entities providing health maintenance services. The form identifies the individual(s) providing health maintenance services.

The Health Maintenance Professional Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Health Maintenance Professional Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Options Counselor Services Form 650-25-75-05-40

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of an Options Counselor Services Form for legal entities providing options counseling services. The form identifies the individual(s) providing options counseling.

The Options Counseling Services Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the Options Counseling Services Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

SAMS User License Form 650-25-75-05-45

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a SAMS User License Form. The form identifies licensed SAMS users.

The SAMS User License Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any information contained on the SAMS User License Form. The legal entity must submit changes using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Notification of Proposal Change Form 650-25-75-05-50

(Revised 1/1/14 ML#3396)

View Archives

The Department of Human Services, Aging Services Division, requires the completion and submission of a Notification of Proposal Change with the applicable proposal form(s) that outlines a change(s) or update(s) to the proposal document.

The Notification of Proposal Change Form will be forwarded to the legal entity through the procurement process. Throughout the contract term, the legal entity is responsible for updating and resubmission of any changes or updates to the proposal using the Notification of Proposal Change Form.

Upon receipt of the resubmitted forms, the documents will be reviewed; acknowledgment of receipt and/or approval will be indicated by signature of the Director of Aging Services Division on the Notification of Proposal Change Form. A copy of the signed Notification of Proposal Change Form will be forwarded to the legal entity.

The new form(s) will become a part of the contract.

Fiscal Administration 650-25-80

Older Americans Act Budget 650-25-80-01

(Revised 10/20/08 ML#3160)

View Archives

The Older Americans Act Budget is developed each Federal Fiscal Year based on availability of Federal and State funds. Funding levels for State Funds to match Older Americans Act programs are set on a biennial basis by the North Dakota State Legislature. Funds are distributed using an allocation plan developed by Aging Services Division.

Aging Services Division retains the authority for final decision-making regarding the distribution of any additional funds as well as reductions due to a shortfall in funds.

Nutrition Services Incentive Program (NSIP)
650-25-80-05

(Revised 1/1/06 ML#2995)

View Archives

The Nutrition Services Incentive Program (NSIP) is funded through an appropriation to the United States Department of Agriculture. Funding levels are based on the total number of eligible meals served during the preceding federal fiscal year and the amount of funds authorized by Congress.

NSIP funds for each nutrition contract entity will be determined by the contract entity's share (percentage) of the total eligible meals served in the preceding federal fiscal year and the amount of funds allocated to the State of North Dakota. Funds will be disbursed upon receipt from the federal government.

Contract entities will request payment by reporting the number of eligible meals served on the Monthly Data & Payment Form.

North Dakota will continue to request cash-in-lieu of commodities. NSIP funds must be used to purchase food grown in the United States of America for meals provided during the federal fiscal year for which the funds were authorized.

Cost Sharing 650-25-80-10

(Revised 1/1/06 ML#2995)

View Archives

The 2000 amendments to the Older Americans Act allow states to implement cost sharing by clients for certain services funded under the Act. Cost sharing is prohibited for the following services: Information and Assistance, Outreach, Benefits Counseling, Case Management, Ombudsman, Elder Abuse Prevention, Legal Assistance, other Consumer Protection Services, Congregate Meals, Home-Delivered Meals, and any services delivered through a Tribal Organization. In addition, a state may not permit cost sharing by a low-income individual if the income is at or below the federal poverty line. The state may also exclude low-income individuals whose incomes are above the federal poverty line.

Cost sharing is not permitted for the majority of services currently funded with Older Americans Act funds. Since development and implementation of a system to address cost sharing would result in an unreasonable administrative and fiscal burden for both Aging Services Division and the contract entities, services are provided through tribal organizations, and a significant portion of clients receiving OAA services are low-income, cost sharing will not be implemented.

Program Income 650-25-80-15

(Revised 10/1/15 ML#3454)

View Archives

Program income is that income which is received as service contributions from eligible clients.

All collected contributions must be used to expand the service for which the contributions were given and supplement (not supplant) funds received under the Older Americans Act.

Program income is used within each service period towards meeting the expenses of the service provided, therefore allowing for the provision of additional service units. Program income cannot be used to meet non-federal cash match requirements.

Required Match 650-25-80-20

(Revised 1/1/14 ML #3396)

View Archives

The required non-federal cash match amount is identified in the Contract.

To meet the Administration on Aging's match requirement as well as the match requirement in the Contract, contract entities must use the following to calculate the match requirement for each service period: service period expenditure amount divided by .85 (85%); multiply that amount by .15 (15%) = required match.

Match is only required up to the amount that is identified in the Contract. Supporting documentation identifying the source of the required match must be submitted on a monthly basis in the form and manner prescribed by the Department. Additional funds may be required to meet the actual cost of the provided service.

Funds received to provide Older Americans Act Family Caregiver Support Services must be matched with 25% non-federal cash match (federal award divided by 75% multiplied by 25%).

Additional Local Funds 650-25-80-21

(Revised 1/1/14 ML#3396)

View Archives

Additional local funds may be needed to meet the cost of providing services throughout the contract term.

Additional local funds should include only costs that are directly related to providing a specific service after federal, state, required match, program income, and for nutrition contract entities, Nutrition Services Incentive Program (NSIP) funds that have been expended. Reporting costs not related to the provision of the service results in an inflated unit cost.

Additional local funds must be recorded on the Monthly Data & Payment Report as outlined in Section 650-25-85-01 of this manual. Supporting documentation identifying the source of the expended additional local funds must be submitted on a monthly basis in the form and manner prescribed by the Department.

Compensation 650-25-80-25

(Revised 1/1/14 ML#3396)

View Archives

Compensation for an identified unit of service is based on a contracted unit rate. The contract outlines the service to be provided, the award per service, and the contracted unit rate, as applicable.

Compensation for other services is based on approved line items as outlined in the specific contract.

Availability of an advance payment prior to performance for a contracted service will be addressed in the Request for Proposal or through separate correspondence.

The Nutrition Services legal entity will receive NSIP compensation as outlined in Section 650-25-80-05, Nutrition Services Incentive Program.

The State will make payment within 30 days after the receipt of the request for reimbursement and required reporting, except that no payment will be made until the reimbursement and required reporting have been approved by the State.

Non-payment or recapture of payment may result if the legal entity fails to meet terms identified in the Contract.

Mileage, Lodging and Meal Rates 650-25-80-30

(Revised 8/1/09 ML#3186)

View Archives

Under current Older Americans Act contracts, contract entities are reimbursed per unit of service or per approved budget. Therefore, contract entities are not required to follow State reimbursement rates but may choose to use the State reimbursement rates as a guideline.

As directed by the North Dakota Legislative Assembly, the reimbursement rates for mileage and lodging are established by policy by the director of the Office of Management and Budget. Rates are amended periodically. Meal rates are established by legislative action.

Audit Responsibility 650-25-80-35

(Revised 1/1/06 ML#2995)

View Archives

Audit responsibility will be outlined in the Contract, as applicable.

Fiscal Reporting Requirements 650-25-85

(Revised 1/1/13 ML#3359)

View Archives

As applicable to each contract, the Monthly Data & Payment Report (SFN 269) or the Request for Reimbursement – Direct Services (SFN 1763) must be submitted to Aging Services Division to receive reimbursement.

Availability of an advance payment prior to performance for a contracted service will be addressed in the Request for Proposal or through separate correspondence.

The State will make payment within 30 days after the receipt of the request for reimbursement and required reporting, except that no payment will be made until the reimbursement and required reporting have been approved by the State.

Monthly Data & Payment Report (SFN 269) 650-25-85-01

(Revised 10/1/15 ML#3454)

View Archives

The Monthly Data & Payment Report (SFN 269) is available in the SAMS report section and as a PDF fillable form on-line at www.nd.gov/eforms. The report is due at Aging Services Division no later than 30 days after the end of the identified service period.

Required program reports must be submitted with the Monthly Data & Payment Report (SFN 269).

The State will make payment within 30 days after the receipt of the Monthly Data & Payment Report and required reporting, except that no payment will be made until the reimbursement and required reporting have been approved by the State.

Instructions for Completion of the Monthly Data & Payment Report (SFN 269).

Legal Entity Name, Address, City, State, Zip Code: Complete as included in the contract.

Service Period From/Service Period To: Record the service period for which the payment is requested. Recording must include the month, days, and a four-digit year.

Contract Number: Record the contract number as it appears on the contract.

Vendor Number: Record the Office of Management and Budget (OMB) approved Vendor Number.

ASD File Number: Aging Services Division will record the ASD File Number for the first payment request. The contract entity must record the number on subsequent requests for payment.

Row A - Nutrition Education: Record the number of units provided during the service period and the dollar value associated with the service.

Row B - Nutrition Counseling: Record the number of units provided during the service period and the dollar value associated with the service.

Next Row: Record the type of service provided using the Report Service Delivery section in SAMS; select the filter for the provided service.

Row C - Unduplicated Individuals Served: Represents the unduplicated number of persons served for the service period. This number is generated automatically in SAMS and will auto-fill into the SAMS report form; the number must be manually entered in the PDF fillable on-line form.

Row D- Number of Eligible Units Provided: Represents the number of eligible service units provided for the service period. This number is generated automatically in SAMS and will auto-fill into the SAMS report form; the number must be manually entered in the PDF fillable on-line form.

Row E1 – Required Match Balance: Represents the beginning amount of required match that has not been met for the contract term. For the first payment request, the contract entity must record the amount as stated in the contract. For subsequent payment requests, the contract entity must record the amount from Row E3-Balance After Expenditure from the previous service period.

Row E2- Required Match Expended: The contract entity must record the amount of required match that will be expended for each of the contracted services for the service period until the match requirement is met for the contract term. To calculate the amount of required match for each service, divide Row I-Service Period Expenditure by .85 (85%) and multiply by .15 (15%).

Row E3 – Balance After Expenditure: Represents the balance of required match that has not been met for the contract term. The amount is automatically calculated and will auto-fill into the SAMS report form and the PDF fillable on-line form (Row E1-Required Match Balance minus Row E2-Required Match Expended).

Row F1 - Program Income Received: Record the amount of program income received for each service for the service period.

Row F2 - Program Income Expended: Record the amount of program income expended for each service for the service period. Program income can only be expended for the service from which it was generated except for congregate and home-delivered meals where it can be applied to either service.

Row G - Contracted Unit Rate: Record the contracted unit rate per unit of service as identified in the contract.

Row H - Contract Balance: Represents the available balance for the contracted service. This amount will decrease as payments are made. The calculated amount from Row J - Balance After Payment must be recorded by the contract entity in Row H Contract Balance for each subsequent payment request until the contract funds are depleted.

Row I - Service Period Expenditure: Represents the amount of payment requested by the contract entity. The Service Period Expenditure must be calculated by the contract entity by multiplying Row D-Number of Eligible Units Provided by Row G-Contracted Unit Rate.

Row J - Balance After Payment: Represents the amount of contract funds that have not been expended. This amount is automatically calculated and will auto-fill into the SAMS report form and the PDF fillable on-line form (Row H-Contract Balance minus Row I-Service Period Expenditure equals Row J-Balance After Payment).

Row K - NSIP Payment: Represents the amount of NSIP payment based on the number of meals served during the preceding federal fiscal year and the amount of the State's NSIP award. NSIP payments will be disbursed upon receipt from the Federal government.

Coded Sections: The coded sections are for internal use by the Department of Human Services.

Signature Box: Sign and complete title and date fields. By signing, the contract entity certifies compliance with the match requirement as stated in the contract. The completed form must be printed and submitted to Aging Services Division for payment.

Other signature lines are for internal use by the Department of Human Services.

Request for Reimbursement - Direct Services (SFN 1763) 650-25-85-05

(Revised 1/1/07 ML#3061)

View Archives

The Request for Reimbursement – Direct Services (SFN 1763) is available as a fillable form. The report is due at Aging Services Division no later than thirty days after the end of the monthly service period. The State will make payment within thirty days after receipt of the request for reimbursement and required reporting, except that no payment will be made until the reimbursement and reporting have been approved by the State. The State will not make any advanced payments before performance by the contractor.

The form must be completed on-line, printed, signed, and submitted to Aging Services Division for payment.

Senior Centers 650-25-90

(Revised 1/1/06 ML#2995)

View Archives

Senior clubs and centers will be notified through the Department's procurement of services process of the availability of funding for senior center acquisition, renovation, or construction.

If, within ten years after acquisition, or within twenty years after the completion of construction, the owner of the facility ceases to be a public or non-profit agency or organization; or the facility ceases to be used for the purposes for which it was acquired (unless the Assistant Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or owner from the obligation to do so), recapture of payment shall occur as outlined in the Older Americans Act, Section 312.

A senior club that is considering disbanding should contact their respective Regional Aging Services Program Administrator to determine if the club received Older American's Act funds for acquisition or construction of the center as the club may be required to repay a portion of those funds. Equipment acquired with Older American's Act funds may be subject to re-distribution or recapture of payment.

Dissolution of a Non-Profit 650-25-95

(Revised 1/1/06 ML#2995)

View Archives

If a senior club or other non-profit corporation was formally incorporated in the State of North Dakota, a formal dissolution process is required under the Non-Profit Corporations Act (North Dakota Century Code Chapter 10-33). Contact should be made with the Secretary of State's Office to complete the process.