

SERVICE-SPECIFIC QUESTIONS

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**PROVIDER OVERVIEW QUESTIONS**

**(Questions 1 – 21)**

In the space provided below please answer the listed questions. The space for your response will expand to the length of your response. When finished please print only the pages that enclose your answers.

Please **do not** attach brochures, newspaper clippings or other materials unless otherwise specified. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **PROVIDER OVERVIEW QUESTIONS**  **(OAA Providers Questions 1 – 16,**  **ADRN Providers Questions 1 – 22)** | |
| --- | --- |
| **Applicant Description** | |
|  | Provide a short provider description indicating the year the provider was established; include a description of the current executive leadership and governance structure; describe any challenges that may prevent the provider from implementing the goals of the proposed service(s). |
|  | Describe the provider’s mission and state how the proposed service(s) fit within the provider’s mission. Include a copy of the mission statement as an attachment *(Checklist Item #15).* |
|  | Describe why the provider is applying for Older Americans Act funding. |
|  | Describe provider’s experience serving people age 60 and older in the proposed service(s): |
|  | Define the geographic area that will be served with the proposed service(s). Include zip codes in the description. |
|  | Describe the needs of the geographic area that will be served through the proposed service(s). If an entire county will be served, indicate which zip codes are underserved and describe strategies that will be used to address the needs in these underserved areas. |
|  | Describe how the provider works collaboratively with other community partners as it relates to the delivery of the proposed service(s). |
|  | If the provider is applying for nutrition service(s), indicate whether service overlaps exist in the defined geographic service area and how the provider is addressing these overlaps. |
|  | Describe the provider’s community outreach efforts to target individuals with the greatest economic and social needs.  Explain how the success of this outreach is measured. |
|  | Describe the provider’s experience in measuring consumer satisfaction with proposed service(s).  Share the results from the most recent measurement. |
|  | Describe the provider’s experience in measuring consumer outcomes with proposed service(s).  Share the results from the most recent measurement. |
|  | Describe the provider’s ability to engage in staff development and staff supervision of the proposed service(s). |
|  | Describe the provider’s system for evaluating the efficiency of service delivery and the cost-effectiveness as it relates to the proposed service(s). |
|  | Please affirmatively state whether the Agency is debarred or listed on the non-procurement portion of the General Services Administration’s “Excluded Parties List System” (EPLS); access to the EPLS is readily available on <https://www.sam.gov> |
|  | Please affirmatively state whether the Agency has the ability to perform and will perform according to the requirements contained in the 2022 Sample Contract.pdf, should the provider receive the grant(s) for which application is made. |
|  | Describe how the applicant shall specify how it intends to satisfy the need for services by consumers with the greatest economic and social needs, with particular attention to consumers who:   * are low-income: * are low-income minorities: * have limited proficiency in the English language: * reside in rural areas: * are at risk for institutional placement: |
| **If you are applying for Aging and Disability Resource Network (ADRN) services, please answer the following questions** | |
|  | Describe protocols for handling crises. Indicate whether written crisis information policies and procedures are in place for specific types of emergencies. Be sure to include any information that may be relevant to the needs of older adults and adults with disabilities. |
|  | Describe weaknesses in the current service support systems which create challenges for providing crisis interventions. |
|  | Describe any experience the provider has delivering the proposed service(s) in a way that utilizes collaborative, interagency consumer data collecting and sharing. |
|  | How would the provider ensure the protection and confidentiality of any consumer data collected during the proposed service(s)? |
|  | How does the provider ensure the proposed service(s) is differentiated from other provider functions? |
|  | Describe how service staff remains objective, reliable, and neutral as sources of information and referral. |

**CONDITIONS OF PARTICIPATION QUESTIONS**

**(Questions 1 - 35)**

Answers to these questions must reflect **current practices** at the provider. The space for your response will expand to the length of your response. When finished please print only the pages that enclose your answers.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **CONDITIONS OF PARTICIPATION QUESTIONS**  **(Questions 1 - 35)** | | | |
| --- | --- | --- | --- |
| **Organizational Structure** | | **Yes** | **No** |
|  | Is Applicant a formally organized:  501c3 service agency providing the services applied for?  or a  Formally organized business, providing the services applied for, and disclosing all entities with five percent or more ownership?  or a  Government entity | | |
|  | Does Applicant have written statements defining the purpose of the business or service provider, and its policies and directives, bylaws, or articles of incorporation? |  |  |
|  | Does Applicant have a written table of organization that clearly identifies lines of administrative, advisory, contractual, and supervisory authority? |  |  |
|  | Does Applicant operate in compliance with all applicable federal, state, and local laws, and have a written statement supporting compliance with: non-discrimination laws, federal wage and hour laws, and workers compensation laws in the recruitment and employment of individuals; non-discrimination laws in the provision of services? |  |  |
|  | Does Applicant have a written affirmative action plan that is used when posting open positions and making hiring decisions? |  |  |
| **Personnel** | | **Yes** | **No** |
|  | Does Applicant have written job descriptions including qualifications for each position involved in the delivery of services? |  |  |
|  | Does Applicant provide performance appraisals or a development plan for all employed, contract workers, and volunteers involved in providing services? |  |  |
|  | Does Applicant have a signed and dated document indicating completion of employee orientation including: employee position description and expectations, personnel policies, reporting procedures and policies, an organizational table, and a code of ethics? |  |  |
| **Policies and Procedures** | | **Yes** | **No** |
|  | Does Applicant have written procedures regarding business operations and provisions of service? |  |  |
|  | Does Applicant have written procedures supporting a system to document services delivered, billed, and reimbursed that complies with service provisions described in these application materials? |  |  |
|  | Does Applicant have a written procedure for reporting and documenting all consumer incidents including significant changes that affect service delivery or imminent health or safety risks? |  |  |
|  | Can Applicant provide evidence detailing financial responsibility in the coverage of consumer loss due to theft, property damage or personal injury? |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Yes** | **No** |
|  | Does Applicant have written procedures which identify the steps a consumer must take to file a liability claim, including a phone number for the Long Term Care Ombudsman? |  |  |
|  | Does Applicant have a written procedure for follow-up and investigation of consumer complaints and grievances? |  |  |
|  | Is Applicant willing to have a separate grievance policy and procedure in place for all consumers regarding Older Americans Act (OAA) services seeking a resolution from their grievance from Western Reserve Area Agency on Aging (WRAAA) and the Long-Term Care Ombudsman (LTCO)? |  |  |
|  | Does Applicant maintain a file for each consumer and caregiver, which includes: name, address, telephone number, DOB, gender, emergency contact person or caregiver information, functional abilities and limitations relevant to authorized services, and demographic data as requested by WRAAA? |  |  |
|  | Does Applicant maintain documentation of each consumer contact and each service delivered? |  |  |
|  | Does Applicant obtain written approval from the consumer to release relevant consumer information to WRAAA? |  |  |
|  | Does Applicant utilize a designated locked storage space for consumer records? |  |  |
|  | Does Applicant have a written policy to ensure that the confidentiality of information about the consumer and/or caregiver is protected? |  |  |
|  | Does Applicant retain all consumer records for at least three years or until an audit is completed? |  |  |
|  | Does Applicant provide the opportunity for consumers to make voluntary contributions for services? |  |  |
|  | Does Applicant have a procedure to administer cost-sharing with consumers? |  |  |
|  | Does Applicant conduct consumer satisfaction surveys? |  |  |
| **Compliance** | | **Yes** | **No** |
|  | Is Applicant willing to deliver services in compliance with the service provisions for providers? |  |  |
|  | Is Applicant willing to maintain documentation demonstrating that all service provisions have been met when delivered either directly or by sub-contract? |  |  |
|  | Is Applicant willing to use A and D (SAMS) to “self-monitor” consumer demographic data on a quarterly basis which includes gender, poverty status, ethnicity, ethnic race, rural, lives alone, disabled, frail and understands English (limited English proficiency)? |  |  |
|  | Does Applicant correct the consumers missing data each quarter? |  |  |
|  | Is Applicant willing to allow access to ODA, AAA, and other representatives with a need to access the provider’s facility, policies, procedures, records, and other documents related to the provision of OAA services? |  |  |
|  | Is Applicant willing to comply with OAC Rule 173-9 regarding background checks and reviewing databases? |  |  |
|  | Is Applicant willing to maintain a Criminal Records Check Employee/Applicant Roster? |  |  |
|  | Is Applicant willing to allow ODA and/or AAA monitors to access the criminal background reports and database reviews? |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Additional Terms** | | **Yes** | **No** |
|  | Is Applicant willing to cooperate with the AAA and ODA to assess the extent of a disaster impact upon persons aged sixty years and over, and to coordinate with public and private resources in the field of aging in order to assist older disaster victims, whenever the President of the United States declares that the service area is a disaster area? |  |  |
|  | Does Applicant immediately notify the appropriate authorities once you have reasonable cause to believe that a consumer is the victim of abuse, neglect or exploitation? |  |  |
| **Applicant Comments** | | | |
|  | Please provide a brief written explanation regarding each question for which a “NO” response was given. Please include the question number with the response: | | |

**Service Specific Questions**

The questions on the following pages are specific to each proposed service. Please fill out and print only those questions that pertain to the service Applicant proposes to serve.

Please indicate a yes or a no, by checking the appropriate boxes.

Questions that require descriptive text will expand as you type, to accommodate your response.

There is a Comments section at the end of each service where you can explain any answers you marked with a No response.

## Aging and Disability Resource Center (ADRN)

## Core Services Questions

### Benefits Assistance Questions

**(Questions 1 - 8)**

**Core Service: Benefits Assistance**

Benefits Assistance is a process of educating and assisting persons with information and applications for public and private benefits such as Supplemental Security Income (SSI), Supplemental Nutrition Assistance Program (SNAP), Medicare Savings Programs (MSP), Medicaid, etc. via a continuum of services from benefit screening, analysis, counseling, and follow-up that may include assistance with renewals. Staff uses multiple modes for consumers to access benefits including in person and by phone. The process of providing Benefits Assistance includes eight steps:

* Establishing Rapport;
* Benefits Education and Outreach
* Discovery (Gathering Information)
* Benefits Screening;
* Benefits Analysis (optional);
* Benefits Counseling; and
* Follow-Up
* Advocacy and System Development

A unit of service is one hour.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **Benefits Assistance Questions**  **(Questions 1 - 8)** | | |
| --- | --- | --- |
| Service Delivery | | |
|  | a | How will Applicant operationalize the goals of the ADRN through Benefits Assistance? Include the number of consumers to be served by the proposed service. |
| b | How has Applicant’s experience providing Benefits Assistance service improved its design and delivery? |
| c | Describe how Benefits Assistance would be integrated with other services the Applicant provides. |
| d | How would Benefits Assistance be differentiated from other Applicant functions? |
| e | Describe Applicant’s experience working in a formal network of other provider agencies in Benefits Assistance. |
| Staff Structure and Qualifications | | |
|  | a | Describe the staffing structure that supports the delivery of Benefits Assistance. Include the number of FTE staff that will be providing the proposed service. |
| b | Describe qualifications/certifications of staff delivering the proposed service. |
| c | Describe staff expertise or capabilities for the proposed service in the areas of Aging, Disability, and/or Dementia. |
| d | Indicate whether the Applicant plans to use volunteers in the delivery of Benefits Assistance. |
| Staff Development | | |
|  | a | How does the Applicant plan to use orientation, trainings, and other opportunities to develop staff skills in the delivery of Benefits Assistance? |
| b | Describe staff supervision in the provision of the proposed service. |
| Quality Assurance | | |
|  | Based on your evaluation activities described in the Provider Overview what specific changes have you made to improve consumer satisfaction with Benefits Assistance services? | |
| Outreach and Community Education | | |
|  | Describe Applicant’s methods and tools for outreach and community education that are specific to Benefits Assistance. | |
| Technology Infrastructure | | |
|  | Describe the capacity of Applicant’s technology infrastructure, which either enhances or creates a barrier to the efficiency of Benefits Assistance service delivery, i.e. telephone system, computer hardware, software, etc. | |
| Facility Infrastructure | | |
|  | Describe how the Applicant’s facilities ensure the effective delivery of Benefits Assistance i.e. office layout, designated space for proposed service, parking, waiting area, etc. | |
| Critical Path Partnerships | | |
|  | Describe any current or future formal linkages with critical path partners that may help consumers more easily and effectively access services. | |

### Specialized Information & Assistance Questions

**(Questions 1 - 8)**

**Core Service: Specialized Information and Assistance (I&A)** is a service which maintains information about health and long-term services and supports that are specific to adults with disabilities, older adults, and caregivers. This service links individuals with appropriate resources and/or provides information about community agencies and organizations that offer specialized services. The specialized information and assistance process involves identifying issues, strengths, and preferences to maintain independence; and opening doors and linking with the array of services that support community living, economic security, and health and wellness.

The components of the Specialized I & A process are:

* Establishing Rapport
* Discovery (Gathering Information)
* Exploring Options (Education and Service Identification)
* Selecting Providers
* Making Seamless Referrals
* Following-up
* Advocacy and System Development

A unit of service is one contact.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **Specialized Information & Assistance (I&A) Questions**  **(Questions 1 - 8)** | | |
| --- | --- | --- |
| Service Delivery | | |
|  | a | How will Applicant operationalize the goals of the ADRN through Specialized I&A? Include the number of consumers to be served by the proposed service. |
| b | How has Applicant’s experience providing the proposed service improved its design and delivery? |
| c | Describe how the proposed service would be integrated with other services the Applicant provides. |
| d | How would the proposed service be differentiated from other Applicant functions? |
| e | Describe Applicant’s experience working in a formal network of other providers in the proposed service. |
| Staff Structure and Qualifications | | |
|  | a | Describe the staffing structure that supports the delivery of Specialized I&A. Include the number of FTE staff that will be providing the proposed service. |
| b | Describe qualifications/certifications of staff delivering the proposed service. |
| c | Describe staff expertise or capabilities for the proposed service in the areas of Aging, Disability, and/or Dementia. |
| d | Indicate whether the Applicant plans to use volunteers in the delivery of the proposed service. |
| Staff Development | | |
|  | a | How does the Applicant plan to use orientation, trainings, and other opportunities to develop staff skills in the delivery of Specialized I&A? |
| b | Describe staff supervision in the provision of the proposed service. |
| Quality Assurance | | |
|  | Based on Applicant’s evaluation activities described in the Provider Overview what specific changes have you made to improve consumer satisfaction with Specialized I&A? | |
| Outreach and Community Education | | |
|  | Describe Applicant’s methods and tools for outreach and community education that are specific to Specialized I&A. | |
| Technology Infrastructure | | |
|  | Describe the capacity of Applicant’s technology infrastructure, which either enhances or creates a barrier to the efficiency of Specialized I&A delivery, i.e. telephone system, computer hardware, software, etc. | |
| Facility Infrastructure | | |
|  | Describe how the Applicant’s facilities ensure the effective delivery of Specialized I&A i.e. office layout, designated space for proposed service, parking, waiting area, etc. | |
| Critical Path Partnerships | | |
|  | Describe any current or future formal linkages with critical path partners that may help consumers more easily and effectively access services. | |

### Information & Referral (I&R) Questions

**(Questions 1 - 8)**

**Core Service: Information & Referral (I&R)** is a service which maintains general information about human service resources in the community. I&R links people who need assistance with appropriate service providers and/or supplies descriptive information about the agencies or organizations which offer services.

The Information and Referral process involves

* Establishing contact with the individual;
* Assessing the individual's long and short-term needs;
* Identifying resources to meet those needs;

Providing a referral to identified resources;

A unit of service is one contact.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **Information & Referral (I&R) Questions**  **(Questions 1 - 8)** | | |
| --- | --- | --- |
| Service Delivery | | |
|  | a | How will Applicant operationalize the goals of the ADRN through I&R? Include the number of consumers to be served by the proposed service. |
| b | How has Applicant’s experience providing the proposed service improved its design and delivery? |
| c | Describe how the proposed ADRN service would be integrated with other services the Applicant provides. |
| d | How would the proposed ADRN service be differentiated from other Applicant functions? |
| e | Describe Applicant’s experience working in a formal network of other providers in the proposed service. |
| Staff Structure and Qualifications | | |
|  | a | Describe the staffing structure that supports the delivery of I&R. Include the number of FTE staff that will be providing the proposed service. |
| b | Describe qualifications/certifications of staff delivering the proposed service. |
| c | Describe staff expertise or capabilities for the proposed service in the areas of Aging, Disability, and/or Dementia. |
| d | Indicate whether the Applicant plans to use volunteers in the delivery of the proposed service. |
| Staff Development | | |
|  | a | How does the Applicant plan to use orientation, trainings, and other opportunities to develop staff skills in the delivery of I&R? |
| b | Describe staff supervision in the provision of the proposed service. |
| Quality Assurance | | |
|  | Based on Applicant’s evaluation activities described in the Provider Overview what specific changes have you made to improve consumer satisfaction with I&R? | |
| Outreach and Community Education | | |
|  | Describe Applicant’s methods and tools for outreach and community education that are specific to I&R. | |
| Technology Infrastructure | | |
|  | Describe the capacity of Applicant’s technology infrastructure, which either enhances or creates a barrier to the efficiency of I&R, i.e. telephone system, computer hardware, software, etc. | |
| Facility Infrastructure | | |
|  | Describe how the Applicant’s facilities ensure the effective delivery of I&R i.e. office layout, designated space for proposed service, parking, waiting area, etc. | |
| Critical Path Partnerships | | |
|  | Describe any current or future formal linkages with critical path partners that may help consumers more easily and effectively access services. | |

### Options Counseling Questions

**(Questions 1 - 8)**

**Core Service: Long Term Support Options Counseling**

Options Counseling (OC) is an interactive process where individuals receive guidance in their deliberations to make informed choices about long term supports. The process is directed by the individual and may include others that the person chooses or those that are legally authorized to represent the individual. Options Counseling is for persons of all income levels but is targeted for persons with the most immediate concerns, such as those at greatest risk for institutionalization. Essential components of Options Counseling include:

* Gathering Information (Discovery)
* Exploring Options
* Decision Support
* Collaboration with Individual to Develop Action Plan
* Access to Community Supports
* Follow-up

A unit of service is one hour.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **Options Counseling (OC) Questions**  **(Questions 1 - 8)** | | |
| --- | --- | --- |
| Service Delivery | | |
|  | a | How will Applicant operationalize the goals of the ADRN through the proposed service? Include the number of consumers to be served by the proposed service. |
| b | How has Applicant’s experience providing the proposed service improved its design and delivery? |
| c | Describe how the proposed ADRN service would be integrated with other services Applicant provides. |
| d | How would the proposed ADRN service be differentiated from other functions of Applicant? |
| e | Describe Applicant’s experience working in a formal network of other providers in the proposed service. |
| Staff Structure and Qualifications | | |
|  | a | Describe the staffing structure that supports the delivery of the proposed service. Include the number of FTE staff that will be providing the proposed service. |
| b | Describe qualifications/certifications of staff delivering the proposed service. |
| c | Describe staff expertise or capabilities for the proposed service in the areas of Aging, Disability, and/or Dementia. |
| d | Indicate whether Applicant plans to use volunteers in the delivery of the proposed service. |
| Staff Development | | |
|  | a | How does Applicant plan to use orientation, trainings, and other opportunities to develop staff skills in the delivery of the proposed service? |
| b | Describe staff supervision in the provision of the proposed service. |
| Quality Assurance | | |
|  | Based on your evaluation activities described in the Overview what specific changes have you made to improve consumer satisfaction with the services provided? | |
| Outreach and Community Education | | |
|  | Describe Applicant’s methods and tools for outreach and community education that are specific to the proposed service. | |
| Technology Infrastructure | | |
|  | Describe the capacity of Applicant’s technology infrastructure, which either enhances or creates a barrier to the efficiency of the proposed service delivery, i.e. telephone system, computer hardware, software, etc. | |
| Facility Infrastructure | | |
|  | Describe how Applicant’s facilities ensure the effective delivery of the proposed service i.e. office layout, designated space for proposed service, parking, waiting area, etc. | |
| Critical Path Partnerships | | |
|  | Describe any current or future formal linkages with critical path partners that may help consumers more easily and effectively access services. | |

### Specialized Care Coordination: Economic Security Questions

**(Questions 1 - 8)**

**Core Service: Economic Casework and Service Coordination**

Economic Casework and Service Coordination is specialized care coordination that provides a holistic approach to addressing the various issues that impact the economic security of older adults through case management. The goals of this core service are to:

* Streamline the process of seniors accessing services and benefits through one-on-one case management assistance.
* Move economically vulnerable seniors closer to financial stability and/or to improve their quality of life.
* Help develop stronger partnerships with non-profit financial services organizations.

Specialized care coordination (Economic Casework and Service Coordination) is defined as having a minimum of the following four components:

1. Screening
2. Assessment and reassessment
3. Planning
4. Follow-up

A unit of service is one hour.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **Specialized Care Coordination: Economic Security Questions**  **(Questions 1 - 8)** | | |
| --- | --- | --- |
| Service Delivery | | |
|  | a | How will Applicant operationalize the goals of the ADRN through the proposed service? Include the number of consumers to be served by the proposed service. |
| b | How has Applicant’s experience providing the proposed service improved its design and delivery? |
| c | Describe how the proposed ADRN service would be integrated with other services Applicant provides. |
| d | How would the proposed ADRN service be differentiated from other functions of Applicant? |
| e | Describe Applicant’s experience working in a formal network of other provider agencies in the proposed service. |
| Staff Structure and Qualifications | | |
|  | a | Describe the staffing structure that supports the delivery of the proposed service. Include the number of FTE staff that will be providing the proposed service. |
| b | Describe qualifications/certifications of staff delivering the proposed service. |
| c | Describe staff expertise or capabilities for the proposed service in the areas of Aging, Disability, and/or Dementia. |
| d | Indicate whether Applicant plans to use volunteers in the delivery of the proposed service. |
| Staff Development | | |
|  | a | How does Applicant plan to use orientation, trainings, and other opportunities to develop staff skills in the delivery of the proposed service? |
| b | Describe staff supervision in the provision of the proposed service. |
| Quality Assurance | | |
|  | Based on your evaluation activities described in the Overview what specific changes have you made to improve consumer satisfaction with the services provided? | |
| Outreach and Community Education | | |
|  | Describe Applicant’s methods and tools for outreach and community education that are specific to the proposed service. | |
| Technology Infrastructure | | |
|  | Describe the capacity of Applicant’s technology infrastructure, which either enhances or creates a barrier to the efficiency of the proposed service delivery, i.e. telephone system, computer hardware, software, etc. | |
| Facility Infrastructure | | |
|  | Describe how Applicant’s facilities ensure the effective delivery of the proposed service i.e. office layout, designated space for proposed service, parking, waiting area, etc. | |
| Critical Path Partnerships | | |
|  | Describe any current or future formal linkages with critical path partners that may help consumers more easily and effectively access services. | |

**ADULT DAY SERVICE QUESTIONS**

**(Questions 1 - 43)**

The following questions are required only for those Providers applying for OAA ***Adult Day******Services***.

Adult Day Service is a service within Family Caregiver Support Title III E funding, in that it provides respite for caregivers. If Applicant is applying for the provision of respite services under Title III E, the following definitions apply:

*Respite Care* means services that enable caregivers to be temporarily relieved from their care giving responsibilities which may include homemaker, personal care, adult institutional, and emergency respite.

*Family Caregiver Involvement*

Respite providers must assess the Family Caregiver’s needs and obtain his/her involvement and acceptance of the care plan. In planning respite, the provider will confer with the Family Caregiver on the implementation of the service plan. The Family Caregiver evaluation of his/her own needs will be the driving force in determining which of the available services he/she receives.

*For respite, the FCSP eligibility criteria are:*

* Family Caregivers age 18 or over, who are caring for an individual who is 60 years old or older and frail; or, family caregivers of a person with Alzheimer’ disease or a related disorder with neurological and organic brain dysfunction may be served regardless of the age of the person with dementia.
* For Caregiver Respite services the Family Caregiver must be relieved from providing care; i.e. he/she must provide care to the Care Recipient to be eligible. The assessment should include the type and frequency of care provided.
* For the purpose of respite, the term frail means a person who is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. In this context, ‘Frail’ has the same meaning as ‘At Risk of Institutionalization’.

*Adult Day Service (ADS)* means a regularly-scheduled service delivered at an ADS center, which is a non-institutional, community-based setting. ADS includes recreational and educational programming to support an individual’s health and independence goals; at least one meal, but no more than two meals per day; and, sometimes, health status monitoring, skilled therapy services, and transportation to and from the ADS center. .

Please review Rule 173-3-06.1 for Adult Day Service Requirements, which is incorporated herein by reference.

A unit of ADS is a four to eight hour day. A unit of ADS does not include the transportation service, even if the consumer is transported to or from the ADS facility by the ADS provider.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **ADULT DAY SERVICE QUESTIONS**  **(Questions 1-43)** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Level of Adult Day Services (Rule 173-3-06.1)** | | | | | **Yes** | | **No** | |
| Is Applicant applying to provide: | | | | |  | |  | |
| Basic ADS only? | | | | |  | |  | |
| Enhanced and Basic ADS only? | | | | |  | |  | |
| Intensive, Enhanced and Basic ADS? | | | | |  | |  | |
| **Purpose of OAA Adult Day Services (ADS)** | | | | | **Yes** | | | **No** | |
| 1. Is the Adult Day Program provided by Applicant designed to meet the needs of consumers with functional or cognitive impairments? | | | | |  | | |  | |
| 1a. If yes, describe how: | | | | | | | | | |
| 2. Does your Adult Day Program encourage optimal capacity for self-care or maximize the functional abilities of consumers? | | | | |  | | |  | |
| 2a. If yes, describe how: | | | | | | | | | |
| 3. Is your Adult Day Program designed to provide respite for the consumer’s Caregiver? | | | | |  | | |  | |
| 3a. If yes, describe how, and what activities the caregivers are able to participate in as a result: | | | | | | | | | |
| 4. Does Applicant track outcomes of the Adult Day Program, and the satisfaction of each consumer and his/her family caregiver? | | | | |  | | |  | |
| 4a. If yes, describe the outcomes you measure: | | | | | | | | | |
| 5. Describe how effective your outreach for your Adult Day Program has been in the past (for example, how many new consumers were enrolled in the past 12 months? If you have a waiting list, how many individuals are on it?) | | | | | | | | | |
| **ADS Facility** | | | | | | | | | |
| 6. What is/are the address(es) of the Adult Day Site(s)? | | | | | | | | | |
| A: | B: | C: | | | | | | | |
| 6a: What is the maximum number of consumers to be present at one time at this Adult Day site: | | | | | | | | | |
| A: | B: | C: | | | | | | | |
|  | | | | **Yes** | | | | **No** | |
| 7. Does your facility maintain a staff to consumer ratio of at least one staff member to every 6 consumers at all times? | | | |  | | | |  | |
| 8. Does your facility have a separate, identifiable space available for ADS activities, with at least sixty square feet (excluding hallways, offices, rest rooms and storage areas) per consumer? | | | |  | | | |  | |
| 8a. What is the total square footage available for Adult Day programming at the site? | | | | | | | | | |
| 9. Does your facility comply with the American with Disabilities Act (ADA) Accessibility Guidelines for Buildings and Facilities? | | | |  | | | |  | |
| 10. Does your facility have at least one working toilet for every ten consumers present that it serves, and at least one wheelchair-accessible toilet? | | | |  | | | |  | |
| 10a. What is the number of working toilets? | | | | | | | | | |
| 10b. What is the number of wheel-chair accessible toilets? | | | | | | | | | |
| 11. Does your facility have a locked area in which consumers’ medications are kept at a temperature that meets the storage requirements of the medications? | | | |  | | | |  | |
| 12. Are toxic substances stored in an area that is inaccessible to the consumers? | | | |  | | | |  | |
| 13. If requesting funding for intensive ADS: Does your facility have bathing facilities suitable to the needs of individual consumers? N/A | | | |  | | | |  | |
| 14. Does Applicant develop and annually review a fire inspection and emergency safety plan? | | | |  | | | |  | |
| 15. Does Applicant post evacuation procedures in prominent locations throughout the facility? | | | |  | | | |  | |
| 16. Does Applicant conduct evacuation drills at least quarterly when consumers are present and retain records on the date and time it was completed? | | | |  | | | |  | |
| 16a. What were the dates of your last 3 evacuation drills? | | | | | | | | | |
| 17. Does your facility have fire extinguishers and smoke alarms, which receive routine maintenance, and annual inspections with documentation of completion? | | | |  | | | |  | |
| 17a. Who provides maintenance? | | | | | | | | | |
| 17b. Who performs the inspections? | | | | | | | | | |
| 17c. What was the date of the last inspection? | | | | | | | | | |
| **Adult Day Service Consumer Management** | | | | **Yes** | | | | **No** | |
| 18. Does Applicant conduct an initial assessment of each consumer which includes the functional and cognitive profiles that identify the ADL’s and IADL’s that require attention or assistance of the ADS center staff and the social profile (Major life events, caregiver data, behavior patterns, etc.)? | | | |  | | | |  | |
| 18a. If yes, when is the initial assessment completed? | | | | | | | | | |
| 19. Does Applicant perform a health assessment which identifies the psychosocial needs, risk factors, diet and medications? | | | |  | | | |  | |
| 19a. If yes, when is the health assessment completed? | | | | | | | | | |
| 19b. Describe the qualifications of the individual who performs these assessments in Applicant. | | | | | | | | | |
| 20. Does Applicant create an Activity Plan that addresses the consumer’s strengths, needs, problems or difficulties, goals, objectives, and a plan to achieve them? | | | |  | | | |  | |
| 20a. If yes, when is the activity plan completed? | | | | | | | | | |
| 20b. If yes, what are the title and qualifications of the individual who develops Applicant’s activity plans: | | | | | | | | | |
| 21. Does Applicant conduct interdisciplinary care conferences for each consumer at least once every six months, and create a plan as a result of the conference? | | | |  | | | |  | |
| 21a. If yes, are the consumer and his/her caregiver invited to attend the care conference? Please estimate the percentage of the care conferences in which the caregiver attended or phoned in during the past year. | | | | | | | | | |
| 21b. If yes, describe the titles and credentials of the individuals who routinely participate in the interdisciplinary care conferences: | | | | | | | | | |
| 22. Does Applicant maintain documentation of authorization from a licensed healthcare professional whose scope of practice includes making plans of treatment prior to administering medications or meals with a therapeutic diet, nursing services, nutrition counseling, physical therapy or speech therapy? | | | |  | | | |  | |
| **Adult Day Service Programming** | | | | **Yes** | | | | **No** | |
| 23. If Applicant provides the transportation service, does it comply with Rule 173-3-06.6? | | | |  | | | |  | |
| 23a. Describe the means of transportation that consumers use to travel to and from your facility: | | | | | | | | | |
| 24. Are consumer activities planned and supervised by an Activity Director who is employed by Applicant? | | | |  | | | |  | |
| 25. Does Applicant post the daily and monthly planned activities in prominent locations throughout the facility? | | | |  | | | |  | |
| 26. Does Applicant ensure that at least two staff members are present in the ADS activity area whenever more than one consumer is present? | | | |  | | | |  | |
| 26a. If yes, does Applicant ensure that at least one of the two staff members is a paid personal care staff member? | | | |  | | | |  | |
| 26b. If yes, does Applicant ensure that at least one of the two staff members present is certified in CPR? | | | |  | | | |  | |
| 27. Does Applicant provide lunch and snacks to each consumer who is present during serving time, and comply with Rule 173-4-05 of the Administrative Code? | | | |  | | | |  | |
| 28. Does Applicant maintain a daily sign-in sheet that documents the date of service, the consumer’s name, arrival and departure times, mode of transportation, and the consumer’s signature? | | | |  | | | |  | |
| 29. Is Applicant able to provide structured activity programming, health assessments, and supervision of one or more ADL? | | | |  | | | |  | |
| 30. **If applying for Enhanced ADS**: Is Applicant able to provide the components of Basic ADS plus provide hands-on assistance with one or more ADL (excluding bathing), supervision of medication administration, assistance with medication administration, comprehensive therapeutic activities, intermittent monitoring of health status, and hands-on assistance with personal hygiene activities (excluding bathing)? | | | |  | | | |  | |
| 31. **If applying for Intensive ADS:** Is Applicant able to provide the components of Enhanced ADS plus provide hands-on assistance with two or more ADLs, regular monitoring of health status, hands-on assistance with personal hygiene activities (including bathing, if needed), social work services, skilled nursing services(i.e. dressing changes), and rehabilitative services, including physical therapy, speech therapy, and occupational therapy? | | | |  | | | |  | |
| **Adult Day Services Staff Qualifications** | | | | **Yes** | | | | **No** | |
| 32. Does Applicant ensure that an RN or LPN (under RN supervision) is on-site whenever a consumer who receives enhanced ADS or intensive ADS requires services within the nurse’s scope of practice? | | | |  | | | |  | |
| 33. Do all members of Applicant’s ADS staff possess a current and valid license to practice their profession? | | | |  | | | |  | |
| 33a. Name the licensed individuals on the ADS staff, the type of license that they hold and the expiration date of their current license to practice in their profession: | | | | | | | | | |
| 34. Does the activity staff person who directs consumer activities meet the requirements of 173-3-06.1 B (5)(b)(ii)? | | | |  | | | |  | |
| 34a. Name the activity staff person who directs consumer activities, and describe their qualifications: | | | | | | | | | |
| 35. Does the activity staff person(s) who leads or assists consumer activities meet the requirements of 173-3-06.1 B (5)(b)(ii)? | | | |  | | | |  | |
| 35a. Name all the activity staff persons who lead or assist consumer activities, and describe their qualifications: | | | | | | | | | |
| 36. Do all other personal care staff meet the requirements of 173-3-06.1 B (5)(b)(iv)? | | | |  | | | |  | |
| 36a. Name other personal care staff persons and describe their qualifications: | | | | | | | | | |
| **Adult Day Services Staff Training** | | | | **Yes** | | | | **No** | |
| 37. Before each new personal care staff member provides ADS, does Applicant provide the following training and document the staff member’s completion of:  a. Orientation training including expectation of employees, Applicant’s ethical standards, an overview of personnel policies, incident reporting procedures, universal precautions for infection control, description of organization and lines of communication?  b. Task-based instruction, which includes the instructor’s title, qualifications, and signature; the date and time of instruction; the content of the instruction, and the name and signature of the personal care staff member completing the instruction? | | | |  | | | |  | |
| 38. Does Applicant provide and document at least eight hours of in-service or continuing education on appropriate topics each calendar year? | | | |  | | | |  | |
| 38a. Briefly describe your in-service or continuing education program: | | | | | | | | | |
| 39. Does Applicant ensure that the caregiver meets the definition of Family Caregiver? | | |  | | |  | | | |
| 40. Does Applicant have a standard for assessing the caregiver’s needs? | | |  | | |  | | | |
| 40a. Does this assessment include the caregiver’s involvement and acceptance of the care plan? | | |  | | |  | | | |
| 41. Does Applicant offer any specific programs for the caregiver? | | |  | | |  | | | |
| 41a. How often are these programs offered to the caregiver? | | | | | | | | | |
| 41b. Describe the programs offered: | | | | | | | | | |
| 42. If the caregiver was not involved, would the consumer be “At Risk of Institutionalization”? | | |  | | |  | | | |
| **Comments** | | | | | | | | | |
| 1. Comments and explanations of any ‘No’ answers: *Please indicate question number with response* | | | | | | | | | |

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**ESCORT-ASSISTED TRANSPORTATION QUESTIONS**

**(Questions 1 - 17)**

The following questions are required only for those providers applying for OAA ***Escort Assisted Transportation Service.*** Please review Rule 173-3-06 for Transportation Service Provisions.

*Transportation Service* means a service that transports a consumer from one place to another through the use of a provider's vehicle and driver, and which may, or may not, include providing the consumer with assistance to safely enter and exit the vehicle. Examples of places to which the service may transport a consumer are a medical office, congregate dining project site, grocery store, senior center, or government office.

*Escort-Assisted Transportation Service* means a service that transports a consumer from one place to another through the use of a paid driver and/or volunteer’s vehicle. It also incorporates assistance to the consumer during the errand, such as, taking notes from the doctor after a medical appointment, or accompanying the consumer into the grocery store to assist with the shopping process.

A *one-way trip constitutes one unit of escort-assisted transportation service*. The unit rate in a provider agreement shall reflect the provider’s fully allocated costs, including administrative costs, training costs, and documentation costs.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **ESCORT-ASSISTED TRANSPORTATION QUESTIONS**  **(Questions 1 - 17)** | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Purpose of OAA Transportation Service** | | | | | | | |
| 1. What is the primary purpose of Applicant’s escort-assisted transportation service? Describe the typical destinations, and the activities the consumers are able to participate in as a result: | | | | | | | |
| 2. Describe Applicant’s scheduling system. How do Applicant’s consumers reserve Applicant’s transportation service? Which staff members do the consumers interact with when they need to schedule the transportation service? How much lead time is required to make a reservation for a ride? | | | | | | | |
| 1. Describe Applicant’s back-up plan for times when a driver or vehicle is unavailable. | | | | | | | | |
| 4. Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers utilized Applicant’s assisted transportation service in the past 12 month? If Applicant has a waiting list, how many individuals are on it?) | | | | | | | | |
| 5. Describe Applicant’s program. | | | | | | | | |
| 5a: What are Applicant’s common trip destinations and percentages annually: | | | | | | | | |
| **Escort-Assisted Transportation Drivers** | | | | | **Yes** | **No** | | |
| 6. Does Applicant plan to subcontract the transportation service? | | | | |  |  | | |
| 6a. If yes, please indicate the name of the subcontractor and the reason why you plan to subcontract with them: | | | | | | | | |
| 7. Does Applicant or its WRAAA-authorized subcontractor own the vehicles used to provide transportation? | | | | |  |  | | |
| 7a. If yes, please indicate the current number of owned vehicles that are used to transport OAA consumers, the type and year of the vehicle(s): | | | | | | | | |
| 8. Are the drivers employed by Applicant or are they volunteers? | | | | |  |  | | |
| 8a. If yes, please indicate the number of employed drivers: | | | | | | | | |
| 8b. If yes, please indicate the number of volunteer drivers: | | | | | | | | |
| 1. Will transportation be directly provided by an urban or a rural transit system? | | | | |  |  | | |
| **Escort-Assisted Transportation Services Driver Qualifications** | | | | | **Yes** | **No** | | |
| 10. Are drivers required to complete an introductory course approved by EMFTS (<http://www.ems.ohio.gov/medical-transportation-faq.aspx>) on passenger-assistance training (i.e. DRIVE or PASS) no later than 6 months post-hire? | | | | |  |  | | |
| 11.Does Applicant maintain documentation of compliance of each driver with the passenger-assistance training course requirements described above? | | | | |  |  | | |
|  | | | | | | | | |
| **Driver Qualifications for Escort-Assisted Transportation Services** | | | | **Yes** | **No** | **N/A** | | |
| ***If the direct provider is a rural or urban transit system, these questions may be answered as N/A.*** | | | | | | | | |
| 12. Does Applicant document the following requirements before hiring a paid driver or assigning a volunteer driver?: | 1. Hold a current valid driver’s license for at least 2 years, with the endorsement necessary for the type of vehicle used for the service? | | |  |  |  | | |
| 1. Have fewer than six points issued under Chapter 4506 and 4507 of the revised code? | | |  |  |  | | |
| 1. Have a signed statement from a licensed physician acting within the scope of the physician’s practice that states that the driver has no medical or physical condition, including an incurable vision impairment that may impair safe driving, passenger assistance, emergency treatment, or the health and welfare of a consumer or the general public? | | |  |  |  | | |
| 1. Pass drug and alcohol tests? The drug tests check for the use or abuse of amphetamines, cannabinoids, cocaine, opiates, and phencyclidine. The alcohol tests check blood-alcohol content. Tests shall be obtained from a hospital or another entity that the Ohio Department of Health permits to conduct the tests? | | |  |  |  | | |
| 1. Pass a training course in first aid and CPR offered by the American Red Cross, the American Heart Association, the National Safety Council, Medic First Aid International, American safety and Health Institute, or an equivalent organization approved by ODA? | | |  |  |  | | |
| 1. Possess the ability to understand written and oral instructions? | | |  |  |  | | |
| 1. Possess the ability to assist passengers into and out of the vehicle? | | |  |  |  | | |
| 1. Possess the ability to comply with the documentation requirement the “Pre-Trip Vehicle Inspection”? | | |  |  |  | | |
| 13. Are drivers required to maintain the validity of the above certifications? | | | |  |  |  | | |
| 13a. Please indicate the frequency of re-certification or testing of: | | | 1. BMV points: | | | | | |
| 1. Physician statement: | | | | | |
| 1. Drug and alcohol testing: | | | | | |
| 1. First Aid training: | | | | | |
| 1. CPR Certification: | | | | | |
| **Transportation Records / Documentation** | | | | | **Yes** | **No** |
| 14. Does Applicant maintain a policy for drivers indicating that the driver shall help the consumer to safely enter and exit the vehicle, and with any additional responsibilities assigned to the driver by the provider agreement? | | | | |  |  |
| 14a. Does Applicant inform every consumer of this policy before providing the service to the consumer? | | | | |  |  |
| 15. Does the driver maintain a trip log that contains the consumer’s name; service date’ pick-up point (address) and time of the pick up; destination point (address) and time of the drop off; service units; driver’s name and driver’s signature? | | | | |  |  |
| 16. Does Applicant maintain a written plan for preventative maintenance and inspection of each vehicle and wheelchair lift used for this service which shall include the recommended preventative-maintenance schedule of the vehicle or wheelchair lift and the: | | 1. “Annual Vehicle Inspection” on form ODA0004. The provider shall only use the vehicle for the service if a mechanic who is certified by the national institute for automotive service excellent (ie, ASE-certified) or another mechanic approved by the AAA, inspected it no more than twelve months beforehand and the answers to all questions on the form were “yes”, | | |  |  |
| 1. “Pre-Trip Vehicle Inspection” on form ODA0008. The provider shall only use a vehicle if, before providing the first service of the day, the driver inspected it and the answers to all questions required by the form was “yes”. | | |  |  |
| **Comments** | | | | | | |
| 1. Comments and Explanations of any ‘No’ answers: *Please indicate question number with response* | | | | | | |

## CAREGIVER EDUCATION AND TRAINING QUESTIONS

**(Questions 1-12)**

The following questions are required only for those providers applying for OAA ***Caregiver Education and Training.***

Caregiver Education and Training are classroom sessions, community workshops, lectures and forums for family, informal and unpaid caregivers. The focus of this service is educating and training caregivers in the areas of health, nutrition, financial literacy, decision making, and problem solving related to their roles.

Eligible Caregivers are age 18 or over, who are caring for an individual who is 60 years old or older and frail; family caregivers of an individual of any age with Alzheimer’ disease or a related disorder, or older relatives, including parents, age 55 and older providing care to adults ages 18-59 with a disability.

A unit of service is one (1) hour of education.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **CAREGIVER EDUCATION AND TRAINING QUESTIONS**  **(Questions 1-12)** | | |
| --- | --- | --- |
| **OAA Caregiver Education and Training: Description of Program** | | |
| 1. Briefly describe Applicant’s Caregiver Education and Training program. Provide the following information: topics, frequency of sessions, length of sessions, and typical number of caregivers attending per session. | | |
| 2. Where and when will the Caregiver Education classes be held? Provide location(s), including address(es). | | |
| 3. What methods of outreach are used to target this service to priority populations? | | |
| 4. Describe the methods a caregiver would use to access the agency’s Caregiver Education and Training program. | | |
| 5. Describe the Applicant’s service delivery model. Are the sessions led by staff, volunteers, or professionals from the community? Describe, if any, the materials provided to the caregivers? | | |
| 6. List staff directly involved in the program, their role(s), qualifications / certification, and years of experience working with caregivers of older adults. | | |
| 7. How will Applicant’s program help caregivers to better understand their role, access assistance and services, and care for themselves? | | |
| **Caregiver Education and Training - Provider Requirements** | **Yes** | **No** |
| 8. Does Applicant have the capacity to provide effective caregiver education and training? |  |  |
| 8a. Please indicate the number of years Applicant has been providing caregiver education and training: | | |
| 9. Are caregivers, volunteers, and staff, informed of their rights to confidentiality, protected health information, and privacy? |  |  |
| 10. Do participating caregivers sign an agreement not to share information about others outside the group setting? |  |  |
| 11. Does Applicant have a written procedure that assures an effective and meaningful assessment of caregiver satisfaction and outcome measurement? |  |  |
| 11a. Please indicate the outcomes that you measure: | | |
| **Comments** | | |
| 12. Comments and Explanations of any “No” answers. *Please indicate question number with response.* | | |

**CAREGIVER SUPPORT GROUPS QUESTIONS**

**(Question 1 - 12)**

The following questions are required only for those providers applying for OAA ***Caregiver Support Groups.***

**Caregiver Support Groups** are organized groups of persons who meet regularly to discuss topics of common interest share community resources and receive emotional support. These activities occur in a peer to peer environment with attendees sharing information and offering support to one another. A qualified facilitator convenes the group and keeps the meetings on track so that they are productive and meaningful. Support groups are required to meet on a regular scheduled day and time, once per month, for a minimum of 10 months each year.

Eligible Caregivers are age 18 or over, who are caring for an individual who is 60 years old or older and frail; family caregivers of an individual of any age with Alzheimer’ disease or a related disorder, or older relatives, including parents, age 55 and older providing care to adults ages 18-59 with a disability.

A support group is defined as two or more caregivers in attendance, excluding the facilitator.

A unit of service is one (1) hour of a support group session.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **CAREGIVER SUPPORT GROUPS QUESTIONS**  **(Question 1 - 12)** | | |
| --- | --- | --- |
| **OAA Caregiver Support Group: Description of Program** | | |
| 1. Briefly describe Applicant’s Caregiver Support Group. Provide the following information: frequency of group meetings, average number of caregivers per session, date and time meetings are held, and the meeting location(s), including address(es): | | |
| 2. What methods of outreach are used to target this service to priority populations? | | |
| 3. Describe the methods a caregiver would use to access the agency’s Caregiver Support Group program. | | |
| 4. Describe the Applicant’s service delivery model. Are the sessions led by staff or volunteers? What training do the leaders receive to facilitate the group? What materials, if any, are provided to the caregivers? | | |
| 5. List staff directly involved in this service, their role(s), qualifications / certification, and years of experience working with caregivers of older adults. | | |
| 6. How will the Applicant’s Caregiver Support Group help caregivers to better understand their role, to access assistance and services, and to decrease stress? | | |
| **Caregiver Support Group - Provider Requirements** | **Yes** | **No** | |
| 7. Does Applicant have the capacity to provide effective Caregiver Support *Groups* to caregivers of older adults? |  |  | |
| 7a. Indicate the number of years that Applicant has been providing Caregiver Support Groups: | | | |
| 8. Are caregivers, volunteers, any other attendees, and staff, informed of their rights to confidentiality, protected health information, and privacy? |  |  | |
| 9. Do participating caregivers attending the group sign an agreement not to share information about others outside the group setting? |  |  | |
| 10 Does Applicant have a written procedure that assures an effective and meaningful assessment of caregiver satisfaction and outcome measurement? |  |  | |
| 10a. Please indicate the outcomes that you measure: | | | |
| **Comments** | | | |
| 11. Comments and Explanations of any “No” answers. *Please indicate question number with response.* | | | |

**CHORE SERVICE QUESTIONS**

**(Questions 1-11)**

The following questions are required only for those providers applying for OAA ***Chore Services***. Please review Rule 173-3-06.2 for Chore Service Specifications.

*Chore Service* means a service that improves, restores, or maintains a clean, sanitary, and safe living environment through the performance of tasks on the property where the consumer resides that are beyond the consumer’s capability, and the removal of hazards posing a threat to the consumer’s health and welfare. This includes heavy household cleaning, simple household maintenance, pest control, disposal of garbage or recyclable materials, and seasonal maintenance.

Eligibility: A consumer is only eligible if no other person (e.g., a landlord) has a legal or contractual responsibility to perform the service..

A unit of Chore Service is 1 completed job order.

Please **do not** attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **CHORE SERVICE QUESTIONS**  **(Questions 1-11)** | | | |
| --- | --- | --- | --- |
| **Purpose of OAA Chore Service** | | | |
| 1. Describe Applicant’s Chore Service program. What types of chores are performed? | | | |
| 2. Describe how these services improve, restore or maintain a clean, sanitary and safe living environment for the consumer: | | | |
| 3. Describe how Applicant determines consumer eligibility to receive the Chore Service. How does Applicant determine that no other person has a legal or contractual responsibility to perform the job? | | | |
| 4. Describe how Applicant prioritizes which consumers will receive Chore service? | | | |
| 5. Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers received Chore Service in the past 12 month?) If you have a waiting list, how many individuals are on it? | | | |
| **Delivery of Chore Service and Specifications** | | **Yes** | **No** |
| 6. Does Applicant retain a record of the chemicals or substances used for each job order? | |  |  |
| 6a. Is Applicant willing to furnish this list to WRAAA upon request? | |  |  |
| 6b. Briefly describe Applicant’s safety program. Describe how the staff is trained in the safe use of cleaning chemicals and/or pesticides, and in the safe performance of chores involving lifting and/or ladders: | | | |
| 1. Does Applicant:   a. Inform the consumer of any specific health or safety risks expected during the job and;  b. Coordinate times and date of service to ensure minimal risk of hazard to the consumer and any other resident residing with the consumer? | |  |  |
| 8. Does Applicant comply with all applicable local codes or ordinances in the performance of each job order? | |  |  |
| 8a. Briefly summarize any applicable local codes or ordinances that apply to the performance of chores Applicant provides: | | | |
| 9. For each service performed, Does Applicant retain a record of: | a. The consumer’s name |  |  |
| b. Service date |  |  |
| c. Service description, including a comparison between tasks in the service plan and task(s) provided |  |  |
| d. Whether the consumer or family caregiver consented to the service before it was provided |  |  |
| e. Number of service units |  |  |
| f. Name of each person in contact with the consumer |  |  |
| g. Provider’s signature |  |  |
| h. Consumer’s signature |  |  |
| 10. Are the chores performed by staff, volunteers or contractors? | | | |
| 10a Describe the qualifications and training of those who perform the chores. | | | |
| 10b. If the chores are subcontracted, provide the name(s) of the firm(s). | | | |
| **Comments** | | | |
| 11. Comments and Explanations of any ‘No’ answers, *Please indicate question number with response*. | | | |

**CONGREGATE DINING PROJECT QUESTIONS**

**(Questions 1 - 43)**

The following questions are required only for those providers applying for OAA ***Congregate nutrition program.*** Please review the following Administrative Rules 173-4-01, 173-4-02, 173-4-03, 173-4-04, 173-4-05, 173-4-07 and 173-4-08 for the applicable service specifications.

***Congregate Dining Project*** means a program that consists of administrative functions; meal production; the provision of nutritious, safe, and appealing meals for eligible consumers in a group setting; and the provision of the nutrition-related services described in rules 173-4-05, 173-4-08 and 173-4-09 of the Administrative Code.

The purpose of a congregate meal nutrition program is to promote health, to reduce risk of malnutrition, to improve nutritional status, to reduce social isolation, and to link older adults to community services.

Unit of service for the Congregate nutrition program: One (1) congregate meal = a unit of (1) Nutrition Services Incentive Program (NSIP) eligible meal.

Please do not attach brochures, newspaper clippings or other materials. Answer all questions related to the programs and services you are proposing to provide. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **CONGREGATE DINING PROJECT QUESTIONS**  **(Questions 1 - 43)**  ***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION*** | | |
| --- | --- | --- |
| **Purpose and Outcomes of OAA Nutrition Program(s)** | | |
| 1. Briefly describe Applicant’s proposed congregate nutrition program. As applicable, include the location of congregate meal sites. | | |
| 1. List the geographic area to be served by the proposed congregate nutrition program(s). | | |
| 1. Describe the methods used for outreach and to target WRAAA priority populations for the proposed congregate meal program. | | |
| 1. Describe the outcomes/goals of the proposed congregate program, and how Applicant measures and tracks them. | | |
| 1. Describe how Applicant will develop and implement an annual evaluation plan to improve the effectiveness of the program’s operation and services to ensure continuous improvement. It should include a review of the existing program, satisfaction survey results from consumers, staff and program volunteers; program modifications made that responded to changing needs or interests of consumers, staff or volunteers; proposed program and administrative improvements; and the results of program monitoring. | | |
| 1. Describe your reservation system and the measures taken to monitor the number of left-over and offered second meals. | | |
| **Eligibility, Enrollment, and Nutrition Screening** | **Yes** | **No** |
| 1. Before enrolling a person into a congregate meal nutrition program, does Applicant follow the eligibility criteria and meet the requirements of Rule 173-4-02?   Congregate nutrition program:  At least sixty years of age, or;  Is the spouse of an eligible person, *or;*  Is a volunteer providing service during meal preparation/service hours, *or*;  Is a guest who is otherwise ineligible to participate in a Congregate Dining Project and who pays the provider for the providers actual contracted unit cost of the meal,  Is a staff member who is otherwise ineligible to participate and pays the providers suggested donation or pays a rate mutually agreed upon by the provider and the WRAAA.  Is a person who is less than sixty years of age and is a person with a disability who resides in a facility that is primarily occupied by residents who are at least sixty years of age at which a congregate dining project is provided? |  |  |
| 1. Does Applicant use the “Determine Your Own Nutritional Health” (ODA form ODA0010) check list to screen consumers for nutritional risk? |  |  |
| 1. Does Applicant enter the results of the nutrition risk screening into A & D? |  |  |
| 10. Does Applicant have a prioritization system that distributes meals equitably by prioritizing persons who are determined to have high nutritional risk status (as determined by a health screening service conducted under rule 173-4-03) and the nutritional risk status of the spouse (if any), if the spouse is determined to have a higher nutritional risk than the consumer (173-4-03 (C)(1)-(2)? |  |  |
| 10 a. Does Applicant have a referral system for potential interventions for consumers with high nutrition risk (score of 6 or above) to community based services such as United Way 211, Benefits Enrollment Center, SNAP, Food Banks, Nutritionist (as described in Rule 173-4-09)? |  |  |
| 10 b. Does Applicant use the referral system to refer any consumer who is determined to have a high nutritional risk? |  |  |
| 11. Does Applicant conduct a nutrition risk screening no later than one month after the consumer’s enrollment into the Congregate Meal program? |  |  |
| 12. Does Applicant update the nutrition risk screening at least annually thereafter? |  |  |
| **Food Safety, Sanitation and Emergency Procedures** | **Yes** | **No** |
| 13. Does Applicant maintain appropriate licenses and can demonstrate compliance with local health department inspections? |  |  |
| 14. Does Applicant have a process of informing the WRAAA Program Nutrition Coordinator within five (5) calendar days of receipt of a *critical* citation by the local health department? |  |  |
| 15. Does Applicant have a process to provide the corrective action plan to the WRAAA Program Nutrition Coordinator within five (5) calendar days after receipt of a critical citation issued by the local health department? |  |  |
| 16. Does Applicant have a process to promptly notify the local health department when any person complains of a food-borne illness? |  |  |
| 17. Does Applicant have a process to inform the WRAAA Program Nutrition Coordinator no more than two (2) calendar days after the occurrence or receipt of a complaint regarding an outbreak of a *food-borne illness?* |  |  |
| 18. Does Applicant have written contingency procedures for emergency closings due to short-term weather-related emergencies, loss of power, kitchen malfunctions, natural disaster, etc. |  |  |
| 18a. If so, does the written contingency plan include procedures for timely notification of emergency situations to consumers? |  |  |
| 18b. If so, does the written contingency plan include distribution of information to consumers on how to stock an emergency food shelf? |  |  |
| **Program Income** | **Yes** | **No** |
| 1. Does Applicant provide each eligible consumer with the opportunity to voluntarily contribute to a meal’s cost? |  |  |
| 20. Does Applicant clearly inform each consumer that he/she has no obligation to contribute in order to receive a meal and it is the consumer who determines how much to contribute toward the cost? |  |  |
| 21. Does Applicant protect each consumer’s privacy and confidentiality with respect to the consumer’s contribution or lack of contribution? |  |  |
| 22. Does Applicant have procedures to safeguard and account for all contributions and fees? |  |  |
| 22a. If so, briefly describe your system for collecting and accounting for contributions: | | |
| 1. Does Applicant use all collected contributions and fees to supplement (not supplant) and/or expand the service for which the fees were given? |  |  |
| **Training Requirements for Food Handlers** | **Yes** | **No** |
| 24. Does Applicant provide and document the orientation and training to perform assigned responsibilities for each paid staff member and volunteer(s)? |  |  |
| 25. Does Applicant utilize volunteers in your Congregate Nutrition Program? |  |  |
| 25a. If so, please estimate the number of volunteers in your Congregate Nutrition Program: | | |
| 25b. If so, list the roles that the volunteers perform: | | |
| 26. Who is the “Person in Charge” (PIC) who is employed by the Applicant for the Congregate Nutrition Program? | | |
| 26a. Is that person in possession of a Level I certification in food protection from the local Board of Health? |  |  |
| 1. Does Applicant ensure that at least one staff member with PIC certification is working in the kitchen while food is being handled? |  |  |
| 27a. How many staff members have PIC training? | | |
| 28. Does Applicant provide and document continuing education to each staff member, whether the staff member works as a paid employee or a volunteer? |  |  |
| **Food Temperatures and Safety** | **Yes** | **No** |
| 29. Does Applicant ensure that the temperature of bulk food is measured as soon as it arrives from the caterer? |  |  |
| 30. To protect the integrity of package food (e.g. milk carton, sealed sandwiches, box lunches) does Applicant use an infrared thermometer that measures the food’s surface temperature? |  |  |
| 31. If the infrared thermometer indicates that the packaged food’s temperature does not meet 41 degrees Fahrenheit or less, does Applicant use a probe thermometer to measure the food’s internal temperature? |  |  |
| 31a. If so, before inserting a probe thermometer into the food, does your staff clean and sanitize the probe thermometer and practice proper hand-washing techniques? |  |  |
| 32. Does Applicant reject the food delivery if it does not meet the temperature standard? |  |  |
| 33. Does Applicant ensure that it does not reuse a food item that has been served to a consumer that is time/temperature controlled for safety food? |  |  |
| 34. Does the provider agree regardless of whether the food items are purchased or donated, agree to only use food items from a source approved by the AAA? |  |  |
| 34a. Does the provider agree to follow the AAA written procedures for allowing a consumer to remove items from the congregate dining project after the consumer finished eating? |  |  |
| **Documentation of Service Delivery** | **Yes** | **No** |
| 35. Does Applicant develop and utilize a system for documenting the total number of meals: all eligible meals served, plus the number of ineligible meals served, and the number of left-over meals? |  |  |
| 36. Does Applicant document congregate meals by obtaining the signature of the consumer who received each meal (document seconds) on a daily basis? |  |  |
| 37. Does Applicant input the daily number of meals served to each consumer of all eligible meals (including OAA, and community funded meals catered through WRAAA i.e. meals ordered by WRAAA and the provider with funds other than OAA funds.) into SAMS? |  |  |
| 38. Does Applicant report the monthly number of ineligible meals (separating ineligible OAA and ineligible community meals) served as SAMS consumer groups? |  |  |
| **Program Requirements** | **Yes** | **No** |
| 39. Does Applicant have a written procedure for allowing a consumer to remove items from the Congregate Dining Project after the consumer finishes eating? |  |  |
| 40. Does Applicant obtain comments from consumers on the dining environment, type of food, portion size, food temperatures and report via the weekly meal evaluation? |  |  |
| 41. Does Applicant obtain comments from consumers on their nutrition program schedule, and staff professionalism via the yearly evaluation? |  |  |
| 42. How does Applicant distribute menus to consumers in advance of service ? | | |
| **Comments** | | | |
| 1. Comments and Explanations of any “No” answers. *Please indicate question number with response*. | | | |

***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION***

## Evidence Based Disease prevention & Health Promotion PROGRAM (EBHPP)

**(Questions 1-8)**

The following questions are required only for those providers applying for OAA ***Evidence Based Health Promotion.***

**EVIDENCE BASED HEALTH PROMOTIONS**

***Chronic Disease Self-Management Program (CDSMP)***

***Better Choices Better Health Chronic Disease Self-Management Program (CDSMP) (online)***

***Tomando Control de su Salud (Spanish CDSMP)***

The Chronic Disease Self-Management Program is a workshop held for two and a half hours, once a week for six weeks, in community settings such as senior centers, churches, libraries and hospitals. People with different chronic health problems attend together. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic diseases themselves.

Subjects covered in the CDSMP workshop include: 1) techniques to deal with problems such as frustration, fatigue, pain and isolation 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance 3) appropriate use of medications 4) communicating effectively with family, friends, and health professionals 5) nutrition 6) decision making and7) how to evaluate new treatments.

A unit of service is one completed six (6) week session.

***Chronic Pain Self-Management Program (CPSMP)***

The Chronic Pain Self-Management Program is a workshop held for two and a half hours, once a week for six weeks, in community settings such as senior centers, churches, libraries and hospitals. Workshops are facilitated by two trained leaders, one or both of whom are non-health professionals with chronic pain themselves.

Subjects covered in the CPSMP workshop include: 1) techniques to deal with problems such as frustration, fatigue, isolation, and poor sleep 2) appropriate exercise for maintaining and improving strength, flexibility, and endurance 3) appropriate use of medications 4) communicating effectively with family, friends, and health professionals 5) nutrition 6) pacing activity and rest and 7) how to evaluate new treatments.

A unit of service is one completed six (6) week session.

***Diabetes Empowerment Education Program (DEEP)***

The Diabetes Empowerment Education Program is a workshop held for two hours, once a week for six weeks, in a community setting such as senior centers, churches, libraries, and hospitals. Individuals with pre-diabetes, diabetes, and relatives or caregivers attend to gain a better understanding of diabetes self-care, how to take control of the disease, and how to reduce the risk of complications.

Learning objectives of the DEEP workshop include 1) improving and maintaining the quality of life of persons with diabetes 2) preventing complications and incapacities 3) improving eating habits and maintaining adequate nutrition 4) increasing physical activity 5) developing self-care skills 6) improving the relationship between patients and health care providers and 7) utilizing available resources.

A unit of service is one completed six (6) week session.

***Diabetes Self-Management Program (DSMP)***

***Better Choices Better Health Diabetes Self-Management Program (CDSMP) (online)***

***Tomando Control de su Salud (Spanish DSMP)***

The Diabetes Self-Management workshop is held for two and a half hours, once a week for six weeks, in community settings such as senior centers, churches, libraries, and hospitals. The program is designed for individuals with Type 2 Diabetes. Workshops are facilitated by two trained leaders, one or both of whom are non-health professions with diabetes themselves.

Subjects covered in the DSMP workshop include: 1) techniques to deal with the symptoms of diabetes, fatigue, pain, hyper/hypoglycemia, stress, and emotional problems such as depression, anger, fear and frustration 2) appropriate exercise for maintaining and improving strength and endurance 3) healthy eating 4) appropriate use of medication and 5) working more effectively with health care providers. Participants will make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

A unit of service is one completed six (6) week session.

***Matter of Balance (MOB)***

Matter of Balance workshop is held for one to two hours, once or twice weekly for eight weeks. Meetings are led by volunteer lay leaders called coaches. The goal of MOB is to reduce the fear of falling, stop the fear of falling cycle, and increase activity levels among community-dwelling older adults.

A Matter of Balance (MOB) acknowledges the risk of falling but emphasizes practical coping strategies to reduce this fear. These include:

* Promoting a view of falls and fear of falling as controllable
* Setting realistic goals for increasing activity
* Changing the environment to reduce fall risk factors
* Promoting exercise to increase strength and balance

A unit of service is one completed eight (8) week session.

***Tai Ji Quan: Moving for Better Balance (TJQMBB) formally known as Tai Chi: Moving for Better Balance***

Tai Ji Quan: Moving for Better Balance workshop is held for one hour, twice weekly for twenty-four consecutive weeks. TJQMBB is a research-based balance training regimen designed for older adults at risk of falling and people with balance disorders. Its origin can be traced to the contemporary simplified 24-form Tai Ji Quan routine. TJQMBB represents a significant paradigm shift in the application of Tai Ji Quan, moving the focus from its historical use as a martial art or recreational activity to propagating health by addressing common, but potentially debilitating, functional impairments and/or deficits.

Learning objectives of TJQMBB workshop include 1) improving strength, balance, mobility and daily functioning and 2) preventing falls in older adults and individuals with balance disorders.

A unit of service is one completed twenty-four (24) week session.

| **Evidence Based Disease prevention & Health Promotion PROGRAM**  **(Questions 1-8)** | | |
| --- | --- | --- |
| **Program Summary** | | |
|  | Provide a Program Summary that indicates which evidence based program(s) Applicant proposes to implement. Outline project goals, objectives and overall approach including target populations, significant partnerships, anticipated outcomes, and phases of development. | |
| **Reach** | | |
|  | a | Describe the population most in need and at highest risk that will be targeted with the implementation of the EBHPP. |
| b | Describe the geographic reach of Applicant’s proposed program. |
| c | Describe outreach and marketing strategies. |
| d | What are the barriers that may limit Applicant’s ability to successfully reach Applicant’s intended target population? |
| e | How will Applicant overcome these barriers? |
| **Effectiveness** | | |
|  | a | Describe program outcomes for a regional implementation of EBHPP. |
| b | Identify key partners and describe roles in implementing the regional plan. |
| **Adoption** | | |
|  | Describe the types of community organizations you will work with to offer EBHPPs and explain the rationale for choosing selected settings. | |
| **Implementation** | | |
|  | a | Describe challenges in maintaining program fidelity and how Applicant anticipates overcoming those challenges. |
| b | Describe anticipated challenges to program fidelity as the program expands. |
| **Maintenance** | | |
|  | a | Describe the greatest challenges Applicant will experience in continuing the program over time. |
| b | What strategies may help to overcome these challenges? |
| **Staffing and Volunteers** | | |
|  | a | Describe anticipated staffing and volunteer needs for the provision of a coordinated regional approach to EBHHP. Include the number of FTE staff and volunteers as well as a description of staff/volunteer experience and qualifications. |
| b | Describe volunteer recruiting and retention strategies and if you plan to work with any community partners related to volunteer needs. |
| **Program Outputs** | | |
|  | a | Describe program outputs. This includes the number of program participants completing each program and the number of volunteers trained. |
| b | Also describe outputs in terms of partnerships and settings in which the program will be offered. |

## HOME-DELIVERED MEALS PROJECT QUESTIONS

**(Questions 1 – 50)**

The following questions are required only for those providers applying for OAA ***Home-delivered meals project.*** Please review the following Administrative Rules 173-4-01, 173-4-02, 173-4-03, 173-4-04, 173-4-05.2, ~~173-4-04.2~~, 173-4-06, 173-4-07 and 173-4-08 for the applicable service specifications.

***Home-delivered meals project*** means a program that consists of administrative functions; meal production; the delivery of nutritious and safe meals to eligible consumers in a home setting; and the provision of the nutrition-related services described in rules 173-4-05.2, 173-4-08 and 173-4-09 of the Administrative Code.

The purpose of a home-delivered meals project is to sustain or improve a consumer’s health through safe and nutritious meals served in a home setting.

Unit of service for the Home-delivered meals project: One (1) home-delivered meal = a unit of (1) Nutrition Services Incentive Program (NSIP) eligible meal.

Please do not attach brochures, newspaper clippings or other materials. Answer all questions related to the programs and services you are proposing to provide. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **HOME-DELIVERED MEALS PROJECT QUESTIONS**  **(Questions 1 – 50)**  ***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION*** | | | | |
| --- | --- | --- | --- | --- |
| **Purpose and Outcomes of OAA Nutrition Program(s)** | | | | |
| 1. Briefly describe Applicant’s proposed home-delivered meals project. As applicable, include the location of kitchen(s). | | | | |
| 2. List the geographic area served by the proposed home-delivered meals project(s). | | | | |
| 3. Describe the methods used for outreach and to target WRAAA priority populations for the proposed home-delivered meals project(s). | | | | |
| 4. Describe the outcomes/goals of the proposed home-delivered meals project, and how Applicant measures and tracks them. | | | | |
| 5. Describe how Applicant will develop and implement an annual evaluation plan to improve the effectiveness of the program’s operation and services to ensure continuous improvement. It should include a review of the existing program, satisfaction survey results from consumers, staff and program volunteers; program modifications made that responded to changing needs or interests of consumers, staff or volunteers; proposed program and administrative improvements; and the results of program monitoring. | | | | |
| 6. Describe Applicant’s reservation system and the measures taken to monitor and decrease the number of left-over meals and meals offered second. | | | | |
| **Eligibility, Enrollment, and Nutrition Screening** | | | **Yes** | **No** |
| 1. Before enrolling a person into a nutrition program, does Applicant follow the eligibility criteria and meet the requirements of Rule 173-4-02 of the Administrative Code?   Home-delivered meals:  At least sixty years of age, and:  Is unable to prepare his/her own meals, *and;*  Is unable to participate in a congregate dining project because of  physical or emotional difficulties, *and;*  Lacks another meal support service in the home or the community    Or, is less than sixty years of age and:  Is the spouse of an eligible person regardless of age or abilities who lives in the home of the eligible person, *or;*  Is a volunteer providing service during meal preparation/service hours, *or;*  Is a person with a disability residing in a home or facility at which a  home-delivered meals project is provided | | |  |  |
| 1. Does Applicant use the “Determine Your Own Nutritional Health” (ODA form ODA0010) check list as a health screening instrument to determine nutritional risk? | | |  |  |
| 1. Does Applicant enter the results of the nutrition risk screening into SAMS? | | |  |  |
| 10. Does Applicant have a prioritization system that distributes meals equitably by prioritizing persons who are determined to have high nutritional risk status (as determined by a health screening service conducted under rule 173-4-03) and the nutritional risk of the spouse (if any), if the spouse is determined to have a higher nutritional risk than the consumer as described in Rule 173-4-03(C)(1) – (2))? | | |  |  |
| 11. Has Applicant established a procedure for conducting: | a. Initial eligibility assessments by telephone with the consumer or a consumer’s family caregiver, prior to the in home, face-to-face assessment? | |  |  |
| b. An in-home functional assessment of ADL’s activities of daily living) and IADL’s (instrumental activities of daily living) to confirm eligibility? | |  |  |
| c. Enter the results of the ADL’s and IADL’s into SAMS? | |  |  |
| 12. Does Applicant conduct a nutrition risk screening no later than one month *after the first meal is delivered* to a consumer’s home? | | |  |  |
| 1. Does Applicant update the nutrition risk screening at least every 12 months thereafter? | | |  |  |
| **Food Safety, Sanitation and Emergency Procedures** | | | **Yes** | **No** |
| 14. Does Applicant maintain appropriate licenses and can demonstrate compliance with local health department inspections? | | |  |  |
| 15. Does Applicant have a process to inform the WRAAA Nutrition Program Coordinator within five (5) calendar days of receipt of a *critical* citation by the local health department? | | |  |  |
| 16 Does Applicant have a process to provide the corrective action plan to the WRAAA Nutrition Program Coordinator within five (5) calendar days after receipt of a critical citation issued by the local health department? | | |  |  |
| 17. Does Applicant have a process to promptly notify the local health department when any person complains of a food-borne illness? | | |  |  |
| 18. Does Applicant have a process to inform the WRAAA Nutrition Program Coordinator no more than two (2) calendar days after the occurrence or receipt of a complaint regarding an outbreak of a *food-borne illness?* | | |  |  |
| 19. Does Applicant have written contingency procedures for emergency closings due to short-term weather-related emergencies, loss of power, kitchen malfunctions, natural disaster, etc. | | |  |  |
| 19a. Does the written contingency plan include procedure for timely notification of emergency situations to consumers? | | |  |  |
| 19b. Does the written contingency plan include distribution of information to consumers on how to stock an emergency food shelf, or provision of shelf-stable meals for emergency situations? | | |  |  |
| **Program Income** | | | **Yes** | **No** |
| 20. Does Applicant provide each eligible consumer with the opportunity to voluntarily contribute to a meal’s cost? | | |  |  |
| 21. Does Applicant clearly inform each consumer that he/she has no obligation to contribute in order to receive a meal and it is the consumer who determines how much to contribute toward the cost? | | |  |  |
| 22. Does Applicant protect each consumer’s privacy and confidentiality with respect to the consumer’s contribution or lack of contribution? | | |  |  |
| 23. Does Applicant have procedures to safeguard and account for all contributions and fees? | | |  |  |
| 23a. Briefly describe Applicant’s system for collecting and accounting for contributions: | | | | |
| 24. Does Applicant use all collected contributions and fees to supplement (not supplant) and/or expand the service for which the fees were given? | | |  |  |
| **Training Requirements for Food Handlers** | | | **Yes** | **No** |
| 25. Does Applicant provide and document the orientation and training to perform assigned responsibilities for each paid staff member and volunteer(s)? | | |  |  |
| 26. Does Applicant utilize volunteers in your Home-Delivered Meal Nutrition Program? | | |  |  |
| 26a. If so, please estimate the number of volunteers in your Home-Delivered Meal Nutrition Program: | | | | |
| 26b. If so, list the roles that the volunteers perform: | | | | |
| 27. Who is the “Person in Charge” (PIC) who is employed by the Applicant for the Home Delivered Nutrition Program? | | | | |
| 27a. Is that person in possession of a Level I certification in food protection from the local Board of Health? | |  | |  |
| 28. Does Applicant ensure that at least one staff member with PIC certification is working in the kitchen while food is being handled? | |  | |  |
| 28a. How many staff members have Person-In-Charge training? | | | | |
| 29. Does Applicant provide and document continuing education to each staff member, whether the staff member works as a paid employee or a volunteer? | |  | |  |
| **Food Temperatures and Safety** | | **Yes** | | **No** |
| 30. Does Applicant agree to not serve food obtained from food banks or other food sources that surpass its use by date or expiration date? | |  | |  |
| 31. Does Applicant ensure that the temperature of bulk food is measured as soon as it arrives from the caterer? | |  | |  |
| 32. To protect the integrity of package food (e.g. milk carton, sealed sandwiches, box lunches) does Applicant use an infrared thermometer that measures the food’s surface temperature? | |  | |  |
| 33. If the infrared thermometer indicates that the packaged food’s temperature does not meet 41 degrees Fahrenheit or less, does Applicant use a probe thermometer to measure the food’s internal temperature? | |  | |  |
| 33a. If so, before inserting a probe thermometer into the food, does your staff clean and sanitize the probe thermometer and practice proper hand-washing techniques? | |  | |  |
| 34. Does Applicant reject the food delivery if it does not meet the temperature standard? | |  | |  |
| 35. Does Applicant ensure that it does not reuse a food item that has been served to a consumer that is time/temperature controlled for safety food? | |  | |  |
| **Documentation** | | **Yes** | | **No** |
| 36. Does Applicant develop and utilize a system for documenting the total number of meals: all eligible meals served, plus the number of ineligible meals served, and the number of left-over meals? | |  | |  |
| 37. Does Applicant utilize a route sheet that includes the name of each consumer, the date, and number of meals provided to the consumer in each delivery, and the funding source associated with the meal(s) (examples include OAA, PASSPORT, local levy)? | |  | |  |
| 38. Does Applicant document the delivery of home-delivered meals to consumers by obtaining the signature of the consumer, consumer’s caregiver or driver who delivered the meals on the route sheet? | |  | |  |
| 39. Does Applicant input the daily number of meals served to each consumer of all eligible meals (including OAA, and community funded meals catered through WRAAA i.e. meals ordered by WRAAA and the provider with funds other than OAA funds.) into SAMS? | |  | |  |
| 40. Does Applicant report the monthly number of *ineligible* meals (separating ineligible OAA and ineligible community meals) served as SAMS consumer groups? | |  | |  |
| 41. Does Applicant obtain comments from consumers on the type of food, portion size, food temperatures and report via the weekly meal evaluation? | |  | |  |
| 42. Does Applicant obtain comments from consumers on their nutrition program schedule, and staff professionalism via the yearly evaluation? | |  | |  |
| 43. How does Applicant distribute menus to consumers in advance of service ? | | | | |
| **Meal Delivery and Temperature Monitoring:** | | **Yes** | | **No** |
| 44. Has Applicant developed and implemented procedures for assuring the safe delivery of meals? | |  | |  |
| 45. Does Applicant’s driver only leave the meal after a *face-to-face* contact with the consumer or the family caregiver? | |  | |  |
| 46. How often does Applicant clean & sanitize the insulated food carriers? | | | | |
| 47. What is the frequency that the insulated food carriers are evaluated for replacement; indicate the frequency in months? | | | | |
| 48. Describe Applicant’s policies and procedures for handling situations when a home-delivered meal consumer is not home at the scheduled meal delivery time. | | | | |
| 49. Describe Applicant training policies for staff who deliver meals to consumer homes. Include a list of orientation topics covered with new staff and ongoing training provided to staff annually. | | | | |
| **Comments** | | | | |
| 50. Comments and Explanations of any “No” answers. *Please indicate question number with response*. | | | | |

***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION***

## HOMEMAKER QUESTIONS

**(QUESTIONS 1-16)**

The following questions are required only for those providers applying for OAA Homemaker service

Homemaker Services are services funded by Title III B and within Family Caregiver Support Title III E funding, in that it provides respite for caregivers. For the provision of respite services, the following definitions must be considered:

*Respite Care* means services that enable caregivers to be temporarily relieved from their care giving responsibilities which may include in-home, adult institutional and emergency respite.

*Family Caregiver Involvement*

Respite providers must assess the Family Caregiver’s needs and obtain their involvement and acceptance of the care plan. In planning respite, the provider will confer with the Family Caregiver on the implementation of the service plan. The Family Caregiver evaluation of his/her own needs will be the driving force in determining which of the available services he/she receives.

*For respite, the FCSP eligibility criteria are:*

* Family Caregivers age 18 or over, who are caring for an individual who is 60 years old or older and frail; or, family caregivers of a person with Alzheimer’ disease or a related disorder with neurological and organic brain dysfunction may be served regardless of the age of the person with dementia.
* For Caregiver Respite services the Family Caregiver must be relieved from providing care; i.e. he/she must provide care to the Care Recipient to be eligible. The assessment should include the type and frequency of care provided.
* For the purpose of respite, the term frail means a person who is unable to perform at least two activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. In this context, ‘Frail’ has the same meaning as ‘At Risk of Institutionalization’.

*Homemaker Service (HMK)* means a service that provides routine tasks to help a consumer to achieve and maintain a clean, safe and healthy environment. This includes: routine meal-related, household and transportation tasks (errands). Please review Rule 173-3-06.4 for Homemaker Service Specifications.

A unit of HMK service is 1 hour of service in the consumer’s home (with the exception of routine transportation tasks).

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **HOMEMAKER QUESTIONS**  **(Questions 1-16)** | | |
| --- | --- | --- |
| **Purpose of OAA In-home Services** | **Yes** | **No** |
| 1. Is the Homemaker Service designed to provide respite for the consumer’s Caregiver? |  |  |
| 2. Does Applicant track outcomes of the Homemaker Service, and the satisfaction of each consumer and his/her family caregiver? |  |  |
| 2a. **If so,** describe your outcome measures: | | |
| **Outreach** | | |
| 3.Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers were enrolled in the past 12 month? If you have a waiting list, how many individuals are on it?) | | |
| **Delivery of In-Home Services** | **Yes** | **No** |
| 4. Does Applicant have the capacity to deliver services five days a week? |  |  |
| 5. Does Applicant possess a back-up plan for providing the service when an aide is not available? |  |  |
| 5a.If so,describe Applicant’s back-up plan: | | |
| 6. Does Applicant maintain a consumer record of each service visit? |  |  |
| 7. If so, does this record document the consumer’s name; service date, arrival and departure time; service description; service units; name of each aide in contact with the consumer; aide’s signature and consumer’s signature? |  |  |
| **In-Home Consumer Service Management** | **Yes** | **No** |
| 8. Before allowing an aide to provide service, does the aide’s supervisor visit the consumer’s home to define the expected activities of the aide and prepare a written care plan for the consumer? |  |  |
| 8a. What are the title and qualifications of the HMK aides’ supervisor? | | |
| 8b. Describe the factors the supervisor considers when specifying the visit pattern and length of visit: | | |
| 9. After the aide provides In-Home Services, does the aide supervisor evaluate compliance with the care plan, the consumer’s satisfaction, and the aide’s performance by conducting a visit to the consumer? |  |  |
| 9a. Are all supervisory visits documented, including the date of the visit, supervisor’s name, the consumer’s name, the consumer’s signature, and the supervisor’s signature? |  |  |
| 9b. Provide the average number of days between supervisory visits for HMK service in the past 6 months. | | |
| **In-Home Services Aide Qualifications and Training** | **Yes** | **No** |
| 10. Does Applicant document that prior to providing HMK service, the HMK aide has successfully completed at least 20 hours of training on the following topics, including successful passage of written testing and skill testing by return demonstration of  Communication skills;  Universal precautions for infection control;  A homemaker service;  Recognition of emergencies, knowledge of emergency  procedures, and basic home safety; and,  Documentation skills. |  |  |
| 11. Does Applicant provide and document at least eight hours of in-service or continuing education on appropriate topics each calendar year, excluding WRAAA and program-specific orientation? |  |  |
| 11a. Briefly describe Applicant’s in-service or continuing education program: | | |
| **Additional Questions** | **Yes** | **No** |
| 12. Does Applicant ensure that the caregiver meets the definition of Family Caregiver? |  |  |
| 13. Does Applicant have a standard for assessing the caregiver’s needs? |  |  |
| 13a. If so, does this assessment include the caregiver’s involvement and acceptance of the service plan? |  |  |
| 14. Does Applicant offer any specific programs for the caregiver? |  |  |
| 14a. If so, describe the programs offered: | | |
| 14b. If so, how often are these programs offered to the caregiver? | | |
| 14c. If so, what activities are the caregivers able to do while respite care is being provided? | | |
| 15. If the caregiver was not involved, would the consumer be “At Risk of Institutionalization”? |  |  |
| **Comments** | | |
| 16. Comments and explanations of any ‘No’ answers: *Please indicate question number with response* | | |

## 

## KINSHIP CAREGIVER EDUCATION AND TRAINING

**(Questions 1 - 12)**

The following questions are required only for those providers applying for OAA ***Kinship Caregiver Education and Training.***

***Kinship Caregiver Education and Training*** is a continuing process of aiding the kinship caregiver to better understand his/her role, when and how to access assistance, how to utilize services/information to be able to decrease stress, better care for their loved one, understand the needs of caregivers, and access services for themselves and their loved one.

A **Kinship Caregiver** is a grandparent, step-grandparent, or a relative (other than the parent) of a child by blood, marriage, or adoption who is 55 years of age or older and lives with the child; 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 has a legal relationship to the child, such as legal custody, adoption, guardianship, or is raising the child informally. The term ‘‘child’’ means an individual who is not more than 18 years of age or who is an individual with a disability between the ages of 18-59. A Kinship Caregiver is not a caregiver who cares for a child during the day or on occasion and does not mean a multi-generational household.

A unit of service is one (1) hour of education.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **KINSHIP CAREGIVER EDUCATION AND TRAINING**  **(Questions 1 - 12)** | | |
| --- | --- | --- |
| **OAA Kinship Caregiver Education and Training: Description of Program** | | |
| 1. Briefly describe Applicant’s Kinship Caregiver and Training Education program. Provide the following information: topics, frequency of sessions, length of sessions, and typical number of caregivers attending per session. | | |
| 2. Where and when will the Kinship Caregiver Education and Training sessions be held? Provide location(s), including address(es). | | |
| 3. What methods of outreach are used to target this service to priority populations? | | |
| 4. Describe the methods a caregiver would use to access the agency’s Kinship Caregiver Education and Training program. | | |
| 5. Describe the agency’s service delivery model. Are the classes led by staff, volunteers, or professionals from the community? What materials, if any, are provided to kinship caregivers? | | |
| 6. List staff directly involved in the program, their role(s), qualifications / certification, and years of experience working with kinship caregivers. | | |
| 1. How will the Applicant’s program help kinship caregivers better understand their role, access assistance and services, and decrease stress? | | |
| **Kinship Caregiver Education and Training - Provider Requirements** | **Yes** | **No** |
| 8. Does Applicant have the capacity to provide effective kinship caregiver education and training to older adults? |  |  |
| 8a. Please indicate the number of years that Applicant has been providing kinship caregiver education and training: | | |
| 9. Are caregivers,, volunteers and staff, informed of their rights to confidentiality, protected health information, and privacy? |  |  |
| 10. Do participating kinship caregivers sign an agreement not to share information about others outside the group setting? |  |  |
| 11. Does Applicant have a written procedure that assures an effective and meaningful assessment of the kinship caregiver satisfaction and outcome measurement? |  |  |
| 11a.Please indicate the outcomes that you measure: | | |
| **Comments** | | |
| 12. Comments and Explanations of any “No” answers. *Please indicate question number with response.* | | |

## 

## KINSHIP CAREGIVER SUPPORT GROUPS QUESTIONS

**(Questions 1 - 12)**

The following questions are required only for those providers applying for OAA ***Kinship Caregiver Support Groups.***

**Kinship Caregiver Support Groups** are organized groups of persons who meet regularly to discuss topics of common interest, share community resources, and receive emotional support. These activities occur in a peer-to-peer environment with attendees sharing information and offering support to one another. A qualified facilitator convenes the group and keeps the meetings on track so that they are productive and meaningful. Support group must meet on a regularly scheduled day and time, once per month, for a minimum of 10 months each year.

A **Kinship Caregiver** is a grandparent, step-grandparent, or a relative (other than the parent) of a child by blood, marriage, or adoption who is 55 years of age or older and lives with the child; 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 has a legal relationship to the child, such as legal custody, adoption, guardianship, or is raising the child informally. The term ‘‘child’’ means an individual who is not more than 18 years of age or who is an individual with a disability between the ages of 18-59. A Kinship Caregiver is not a caregiver who cares for a child during the day or on occasion and does not mean a multi-generational household.

A support group is defined as two or more caregivers in attendance, excluding the facilitator.

A unit of service is one (1) hour of support group session.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **KINSHIP CAREGIVER SUPPORT GROUPS QUESTIONS**  **(Questions 1 - 12)** | | |
| --- | --- | --- |
| **OAA Kinship Caregiver Support Group: Description of Program** | | |
| 1. Briefly describe Applicant’s Kinship Caregiver Support Group program. Provide the following information: : frequency of group meetings, average number of caregivers per session, , date and time meetings are held, and the meeting location(s), including address(es): | | |
| 2. What methods of outreach are used to target this service to priority populations? | | |
| 3. Describe the methods a kinship caregiver would use to access the agency’s Kinship Caregiver Support Group program. | | |
| 4. Describe the agency’s service delivery model. Are the sessions led by staff or volunteers? What training do the leaders receive to facilitate the group? What materials, if any, are provided to the kinship caregivers? | | |
| 5. List staff directly involved in the service, their role(s), qualifications / certification, and years of experience working with older adults providing care to a “child.” | | |
| 6. How will the agency’s program help kinship caregivers better understand their role, access assistance and services, and decrease stress? | | |
| **Caregiver Education and Training - Provider Requirements** | **Yes** | **No** |
| 7. Does Applicant have the capacity to provide effective Kinship Caregiver Support Groups to older adults? |  |  |
| 7a. If so, please indicate the number of years that Applicant has been providing Kinship Caregiver Support Groups: | | |
| 8. Are Kinship Caregivers, volunteers, other attendees, and staff, informed of their rights to confidentiality, protected health information, and privacy? |  |  |
| 9 Do participating Kinship Caregivers attending the group sign an agreement not to share information about others outside the group setting? |  |  |
| 10. Does Applicant have a written procedure that assures an effective and meaningful assessment of kinship caregiver satisfaction and outcome measurement? |  |  |
| 10a. If so, please indicate the outcomes that you measure: | | |
| **Comments** | | |
| 11. Comments and Explanations of any “No” answers. *Please indicate question number with response.* | | |

**LEGAL ASSISTANCE SERVICE QUESTIONS**

**(Questions 1-12)**

The following questions are required only for those providers applying for OAA ***Legal Assistance.***

***Legal Assistance Service*** means a one-to-one meeting between a senior seeking legal service and an attorney or paralegal; *or* the presentation of legal information by an attorney or paralegal to a group of seniors. The purpose is to resolve legal matters for older persons in such areas as domestic (divorce, guardianship, kinship custody, etc.), compensation claims (Small Claims, personal injury, Worker’s Compensation, etc.), creditor-debtor, Civil Rights, estate matters, real estate and tenant-landlord. Services may include determining the need for more in-depth legal help.

A unit of service is one (1) hour of legal services, including all time spent in providing legal counseling, research, preparation, representation and education.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **LEGAL ASSISTANCE SERVICE QUESTIONS**  **(Questions 1-12)** | | | | | | |
| --- | --- | --- | --- | --- | --- | --- |
| **Purpose of OAA Legal Assistance** | | | **Yes** | | | **No** |
| 1. Briefly describe Applicant’s legal assistance program. | | | | | | |
| 1. Describe the methods a consumer would use to access your legal assistance service. | | | | | | |
| 1. Describe how outreach is conducted to identify consumers in priority populations of those sixty and older, who are eligible for assistance. | | | | | | |
| 3a. Is Applicant’s service communicated to secondary referral sources? | |  | | |  | |
| 1. Do the attorneys work from offices and/or outreach sites that are convenient and accessible to older persons in the community? | | | | | | |
| 4a. Please provide the address(es) of the locations and describe “senior-friendly” features. | | | | | | |
| 1. Do the attorneys demonstrate the capacity to deliver services to consumers who are institutionalized, homebound, isolated, or in receipt of community-based care programs? |  | | |  | | |
| 5a. Briefly describe Applicant’s practices. | | | | | | |
| **Legal Assistance - Provider Requirements** | | **Yes** | | | **No** | |
| 1. Does Applicant demonstrate the capacity to provide effective administrative and judicial representation in the areas of law affecting older persons with social or economic need? | |  | | |  | |
| 6a. Please indicate the number of years that Applicant has been practicing elder law, | | | | | | |
| 1. Does Applicant have attorneys with expertise in specific areas of law affecting older persons in economic or social need? For example: public benefits, institutionalization, and alternatives to institutionalization. | |  | | |  | |
| 7a. Are the attorneys authorized to practice law in the State of Ohio? | |  | | |  | |
| 7b. Please indicate names of attorneys who would provide the service, and their years of experience in the practice of elder law. | | | | | | |
| 1. Do these attorneys have access to the relevant sections of the Code of Federal Regulations and relevant state and federal statutes? | |  | | |  | |
| 8a. Are these attorneys aware of and able to abide by the Older Americans Act and the Code of Federal Regulations governing Title III legal assistance? | |  | | |  | |
| 1. Do these attorneys maintain malpractice insurance and have proof of coverage available for WRAAA review? | |  | | |  | |
| 1. Are the paralegals and other non-attorney personnel directly and regularly supervised by a qualified attorney? | |  | | |  | |
| 1. Are the paralegals and other non-attorney personnel provided skills training in confidentiality and HIPPA and priority areas of law? | |  | | |  | |
| 1. Does Applicant have a written procedure that assures an effective and meaningful assessment of consumer satisfaction? | |  | | |  | |
| 1. Does Applicant have a written procedure that assures an effective and meaningful communication and resolution of consumers’ grievances? | |  | | |  | |
| **Comments** | | | | | | |
| 14. Comments and Explanations of any “No” answers: *Please indicate question number with response*. | | | | | | |

**LEGAL COUNSELING (KINSHIP) QUESTIONS**

**(Questions 1-15)**

The following questions are required only for those providers applying for OAA ***Legal Counseling (Kinship).***

***Legal Assistance Service*** means a one-to-one meeting between a senior seeking legal service and an attorney or paralegal, or the presentation of legal information by an attorney or paralegal to a group of seniors. The purpose is to resolve legal matters for older persons in such areas as domestic (divorce, guardianship, kinship custody, etc.), compensation claims (Small Claims, personal injury, Worker’s Compensation, etc.), creditor-debtor, Civil Rights, estate matters, real estate and tenant-landlord. Services may include determining the need for more in-depth legal help.

A **Kinship Caregiver** is a grandparent, step-grandparent, or a relative (other than the parent) of a child by blood, marriage, or adoption who is 55 years of age or older and lives with the child; 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 has a legal relationship to the child, such as legal custody, adoption, guardianship, or is raising the child informally. The term ‘‘child’’ means an individual who is not more than 18 years of age or who is an individual with a disability between the ages of 18-59. A Kinship Caregiver is not a caregiver who cares for a child during the day or on occasion and does not mean a multi-generational household.

A unit of service is one (1) hour of legal services, including all time spent in providing legal counseling, research, preparation, representation and education. \*Note: Legal Counseling (Kinship) services does not include presentations of legal information to groups of seniors.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **LEGAL COUNSELING (KINSHIP)QUESTIONS**  **(Questions 1-15)** | | | | |
| --- | --- | --- | --- | --- |
| **Purpose of OAA Legal Assistance** | | **Yes** | | **No** |
| 1. Briefly describe Applicant’s legal counseling program. | | | | |
| 1. Describe the methods a consumer would use to access Applicant’s legal counseling service. | | | | |
| 1. Describe how outreach is conducted to identify consumers in priority populations of those sixty and older, who are eligible for assistance. | | | | |
| 3a. Is Applicant’s service communicated to secondary referral sources? |  | |  | |
| 1. Do the attorneys work from offices and/or outreach sites that are convenient and accessible to older persons in the community? |  | |  | |
| 4a. Please provide the address(es) of the locations and describe ‘senior-friendly’ features. | | | | |
| 1. Do the attorneys demonstrate the capacity to deliver services to consumers in receipt of community-based care programs? |  | |  | |
| 5a. Briefly describe your practices, | | | | |
| **Legal Counseling - Provider Requirements** | | **Yes** | | **No** |
| 1. Does Applicant demonstrate the capacity to provide effective administrative and judicial representation in the areas of law affecting older persons with social or economic need? | |  | |  |
| 6a. Please indicate the number of years that Applicant has been practicing elder law. | | | | |
| 1. Does Applicant have attorneys with expertise in specific areas of law affecting older persons in economic or social need? For example: public benefits, institutionalization, and alternatives to institutionalization. | |  | |  |
| 7a. Are the attorneys authorized to practice law in the State of Ohio? | |  | |  |
| 7b. Please indicate names of attorneys who would provide the service, and their years of experience in the practice of elder law. | | | | |
| 1. Do these attorneys have access to the relevant sections of the Code of Federal Regulations and relevant state and federal statutes? | |  | |  |
| 8a. Are these attorneys aware of and able to abide by the Older Americans Act and the Code of Federal Regulations governing Title III legal counseling? | |  | |  |
| 1. Do these attorneys maintain malpractice insurance, and have proof of coverage available for WRAAA review? | |  | |  |
| 1. Are the paralegals and other non-attorney personnel directly and regularly supervised by a qualified attorney? | |  | |  |
| 1. Are the paralegals and other non-attorney personnel provided skills training in confidentiality and HIPAA and priority areas of law? | |  | |  |
| 1. Does Applicant have a written procedure that assures an effective and meaningful assessment of consumer satisfaction? | |  | |  |
| 1. Does Applicant have a written procedure that assures an effective and meaningful communication and resolution of consumer grievances? | |  | |  |
| **Additional Questions** | | | | |
| 14. Does the caregiver meet the definition of kinship caregiver? | |  | |  |
| 15. Does Applicant offer any specific programs for the kinship caregiver? | |  | |  |
| 15a. If so, describe the programs offered. | | | | |
| 15b. If so, how often are these programs offered to the kinship caregiver? | | | | |
| 16. If the kinship caregiver was not involved, would the consumer be “At Risk of Institutionalization”? | |  | |  |
| **Comments** | | | | |
| 17. Comments and Explanations of any “No” answers: *Please indicate question number with response*. | | | | |

**NUTRITION EDUCATION QUESTIONS**

**(QUESTIONS 1- 5)**

The following questions are required for those providers applying for OAA ***Congregate nutrition program,*** OAA ***Home-delivered meal nutrition program.*** Please review the following Administrative Rules 173-4-01, 173-4-02, 173-4-03, 173-4-04, 173-4-05, 173-4-05.1, 173-4-05.2, 143-05.3, 173-4-07 and 173-4-08 for the applicable service specifications.

***Nutrition Education Service*** means a service that promotes better health by providing accurate and culturally-sensitive information and instruction to consumers or family caregivers on nutrition, physical activity, or disease prevention, whether provided in a group or an individual setting.

Unit of service is one (1) nutrition education session.

Please do not attach brochures, newspaper clippings or other materials. Answer all questions related to the programs and services you are proposing to provide. Points will be deducted for unanswered questions and/or failure to answer questions directly.

|  |  |  |
| --- | --- | --- |
| **NUTRITION EDUCATION QUESTIONS**  **(QUESTIONS 1- 5)** | | |
| **Nutrition Education Service Requirements** | **Yes** | **No** |
| 1. Does Applicant conduct Nutrition Education using WRAAA-supplied materials two times each year? |  |  |
| 1. WRAAA will provide approved Nutrition Education materials. Describe how Applicant presents and/or distributes this information: | | |
| 1. Explain Applicant’s plan to ensure that nutrition education is conducted twice each year. | | |
| **For a congregate nutrition program:** | | |
| 1. Does Applicant document the consumers who attended or received Nutrition Education? |  |  |
| 1. Are the materials presented in a group setting? |  |  |
| 1. Is attendance documented, including the consumer’s name, date and duration of the nutrition educational topic, service units, instructor’s name and instructor’s signature? |  |  |
| **For a home-delivered or restaurant voucher program:** | | |
| 1. Are the materials provided to each consumer? |  |  |
| 1. Is a record kept of the number of consumers who received the education materials, service date, the educational topic, provider’s signature? |  |  |
| **Comments** | | |
| 1. Comments and explanations of any ‘No’ answers: *Please indicate question number with response*. | | |

**PERSONAL CARE QUESTIONS**

**(QUESTIONS 1- 18)**

The following questions are required only for those providers applying for OAA Personal Care.

Personal Care Services are services within the National Family Caregiver Support Program (NFCSP) Title III E funding, in that they provide respite for caregivers. For the provision of respite services, the following definitions must be considered:

*Respite Care* means services that enable caregivers to be temporarily relieved from their care giving responsibilities, which may include in-home, institutional and emergency respite.

*Family Caregiver Involvement*

Agencies must assess the family caregiver’s needs and obtain his/her involvement and acceptance of the care plan. In planning respite services, Applicant will confer with the family caregiver on the implementation of the care plan. The family caregiver’s evaluation of his/her own needs will be the driving force in determining which of the available services he/she receives.

*For respite, the NFCSP eligibility criteria are:*

* A family caregiver age 18 or over, who is caring for an individual 60 years old or older and frail; or, a family caregiver of an individual with Alzheimer’ disease or a related disorder with neurological and organic brain dysfunction regardless of the age of the individual with dementia.
* The term “frail” means a person who is unable to perform at least two (2) activities of daily living without substantial human assistance, including verbal reminding, physical cueing, or supervision; or due to a cognitive or other mental impairment, requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or to another individual. In this context, “frail” has the same meaning as “at risk of institutionalization.”
* For Caregiver Respite services, the family caregiver must be relieved from providing care; i.e. he/she must provide care to the Care Recipient to be eligible. The assessment should include the type and frequency of care provided.

*Personal Care Service (PC)* means a service comprised of tasks that help a consumer achieve optimal functioning with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). This includes the following:

* Homemaker service under rule 173-3-06.4 of the Administrative Code, if the tasks of the homemaker service are specified in the consumer’s service plan and are incidental to the services furnished or are essential to the health and welfare of the consumer rather than the consumer’s family. These tasks include routine meal-related tasks, routine household tasks, and routine transportation tasks.
* Tasks that assist a consumer with managing the household, handling personal affairs, and providing assistance with self-administration of medications.
* Tasks that assist the consumer with ADLs and IADLs.
* , Respite Services.

A unit of PC service is one (1) hour of service, which includes personal care in the home and transportation services that are components of personal care.

**Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.**

| **PERSONAL CARE QUESTIONS**  **(Questions 1- 18)** | | |
| --- | --- | --- |
| **Purpose of OAA In-home Services** | **Yes** | **No** |
| 1. Is the Personal Care Service provided by Applicant designed to meet the needs of consumers who require assistance with IADL’s and ADL’s? |  |  |
| 1a. If so, describe how: | | |
| 2. Is the Personal Care Service designed to provide respite for the consumer’s caregiver? |  |  |
| 3. . Does Applicant have a written procedure that assures an effective and meaningful assessment of caregiver satisfaction and outcome measurement? |  |  |
| 3a.If so, describe your outcome measures. | | |
| **Outreach** | | |
| 4.Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers were enrolled in the past 12 months? If you have a waiting list, how many individuals are on it?). | | |
| **Delivery of In-Home Services** | **Yes** | **No** |
| 5. Does Applicant have the capacity to deliver services five days a week? |  |  |
| 6. Does Applicant possess a back-up plan for providing the service when an aide is not available? |  |  |
| 6a.If so, describe Applicant’s back-up plan: | | |
| 7. Does Applicant maintain a consumer record of each service visit? |  |  |
| 7a. If so, does this record document the consumer’s name; service date; arrival and departure time; service description; service units; name of each aide in contact with the consumer; aide’s signature and consumer’s signature? |  |  |
| **In-Home Consumer Service Management** | **Yes** | **No** |
| 8. Before allowing an aide to provide service, does the aide’s supervisor visit the consumer’s home to define the expected activities of the aide and prepare a written care plan for the consumer? |  |  |
| 8a. What are the title and qualifications of the PC aides’ supervisor? | | |
| 8b. Describe the factors the supervisor considers when specifying the visit pattern and length of visit. | | |
| 9. After the aide provides In-Home Services, does the aide supervisor evaluate compliance with the care plan, the consumer’s satisfaction, and the aide’s performance by conducting a visit to the consumer? |  |  |
| 9a. Are all supervisory visits documented including the date of the visit, supervisor’s name, the consumer’s name, the consumer’s signature, and the supervisor’s signature? |  |  |
| 9b. Provide the average number of days between supervisory visits for PC service in the past 6 months. | | |
| 10. Is the supervisor available to respond to emergencies when the aides are scheduled to work? |  |  |
| 11. Does Applicant have a monitoring system to verify that services are provided according to the care plan? In this system, Applicant shall include a protocol for scheduling a substitute employee when the system identifies an employee has failed to provide the personal care service; a procedure for maintaining records of the information obtained through the monitoring system; and procedures for conducting random checks of the accuracy of the monitoring system (no more than 5% of the visits). |  |  |
| 11a. Describe Applicant’s monitoring system. | | |
| **In-Home Services Aide Qualifications and Training** | **Yes** | **No** |
| 11 Does Applicant document and verify that prior to providing PC service, an aide has:   * Completed the training and passed the evaluations in a nurse aide training and competency evaluation program (NATCEP) that addresses the nine (9) subject areas outlined in 42 C.F.R. 484.36 (October 1, 2012 Edition). * Completed the training and passed the evaluations in one or more of the following five (5) categories of NATCEP: STNA, COALA, Medicare, Vocational School, or Applicant’s NATCEP. * Verify the aides competency of the subject matter as follows: * STNA: Aide is listed as “active” on the state-tested nurse aid registry. * Not- in house NATCEP: Applicant’s RN or LPN (under the direction of an RN) conducts written and skill testing of the aide by return demonstration upon the person. For each person, Applicant tests, Applicant documents the testing site, date, and results; name and credentials of the aide; and the tester’s name, credentials, and signature. * In house NATCEP: If the aide completed the training and passed the competency evaluations, additional testing is not needed. |  |  |
| 12. Does Applicant conduct written testing and skill testing by return demonstration of aides who are expected to complete tasks that are not included in the subject area outlined in 173-3-06.5 (B)(2)(a)?? |  |  |
| 13. Does Applicant provide and document at least eight hours of in-service or continuing education on appropriate topics each calendar year, excluding WRAAA and program-specific orientation? |  |  |
| 13a. Briefly describe your in-service or continuing education program. | | |
| **Additional Questions** | **Yes** | **No** |
| 14. Does the caregiver meet the definition of family caregiver? |  |  |
| 15. Does Applicant have a standard for assessing the caregiver’s needs? |  |  |
| 15a. Does this assessment include the caregiver’s involvement and acceptance of the service plan? |  |  |
| 16. Does Applicant offer any specific programs for caregivers? |  |  |
| 16a. If so, describe the programs offered. | | |
| 16b. If so, how often are these programs offered to caregivers? | | |
| 16c. If so, what activities are the caregivers able to do while respite care is being provided? | | |
| 17. If the caregiver was not involved, would the consumer be “At Risk of Institutionalization”? |  |  |
| **Comments** | | |
| 18. Comments and explanations of any ‘No’ answers: *Please indicate question number with response*. | | |

**RESTAURANT VOUCHER MEAL SERVICE QUESTIONS**

**(Questions 1 - 32)**

The following questions are required only for those providers applying for OAA ***Restaurant voucher meal service.*** Please review the following Administrative Rules 173-4-01, 173-4-02, 173-4-03, 173-4-04, 173-4-05, 173-4-05.1, 173-4-05.2, 173-4-05.3, 173-4-07 and 173-4-08 for the applicable service specifications.

***Restaurant voucher meal service*** means a service that consists of administrative functions; meal production; and the provision of nutritious, safe, and appealing meals for eligible consumers who are at least sixty years of age; and the provision of the nutrition-related services described in rules 173-4-05.2, 173-4-08 and 173-4-09 of the Administrative Code.

The purpose of the restaurant voucher meal service is to promote health; to reduce risk of malnutrition, to improve nutritional status, to reduce social isolation, and to link older adults to community services

Unit of service for Restaurant voucher meal service: One (1) Voucher Unit = One (1) restaurant (congregate) meal.

Please do not attach brochures, newspaper clippings or other materials. Answer all questions related to the programs and services you are proposing to provide. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **RESTAURANT VOUCHER MEAL SERVICE QUESTIONS**  **(Questions 1 - 32)**  ***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION*** | | |
| --- | --- | --- |
| **Purpose and Outcomes of OAA Nutrition Program(s)** | | |
| 1. Describe how Applicant determined the need for a restaurant voucher program in your service area; include where the nearest congregate meal program is located in your service area: | | |
| 2. Provide a detailed description of the proposed restaurant voucher program.  Include the location of the restaurant(s) where vouchers would be redeemed. | | |
| 3. List the geographic area served by the proposed Restaurant Voucher nutrition program(s). | | |
| 4. Describe the methods used for outreach to WRAAA priority populations for the proposed Restaurant Voucher program(s). | | |
| 5. Describe the outcomes/goals of the proposed Restaurant Voucher program, and how Applicant measures and tracks them. | | |
| 6. Describe how Applicant will develop and implement an annual evaluation plan to improve the effectiveness of the program’s operation and services to ensure continuous improvement. It should include a review of the existing program, satisfaction survey results from consumers, staff and program volunteers; program modifications made that responded to changing needs or interests of consumers, staff or volunteers; proposed program and administrative improvements; and the results of program monitoring. | | |
| 1. Describe Applicant’s consumer enrollment process. | | |
| 1. What measures are taken to monitor the usage of vouchers? | | |
| 1. Are all of the fixed menu items preapproved by WRAAA Registered and Licensed Dietitian? | | |
| **Eligibility, Enrollment, and Nutrition Screening** | **Yes** | **No** |
| 1. Before enrolling a person into a nutrition program, does Applicant follow the eligibility criteria and meet the requirements of Rule 173-4-02?     Restaurant vouchers:  At least sixty years of age, and:  Lives in a rural county, without access to an existing congregate meal site |  |  |
| 1. Is Applicant using the “Determine Your Own Nutritional Health” (ODA form ODA0010) check list as a health screening instrument to determine nutritional risk? |  |  |
| 1. Does Applicant enter the results of the nutrition risk screening into SAMS? |  |  |
| 13. Does Applicant have a prioritization system that distributes meals equitably by prioritizing persons who are determined to have high nutritional risk status (as determined by a health screening service conducted under rule 173-4-03) and lowest income level (as described in Rule 173-4-03(C)(1)- (2))? |  |  |
| 14. Does Applicant conduct a nutrition risk screening no later than one month after the consumer’s enrollment into the restaurant (voucher) nutrition program and at least every 12 months thereafter? |  |  |
| **Food Safety, Sanitation and Emergency Procedures** | **Yes** | **No** |
| 15. Does Applicant ensure that the contracted restaurant maintain appropriate licenses and demonstrate compliance with local health department inspections? |  |  |
| 16. Does Applicant have a process for the contracted restaurant to promptly notify the local health department when any person complains of a food-borne illness? |  |  |
| 17. Does Applicant have a process to inform the WRAAA Nutrition Program Coordinator no more than two (2) calendar days after the occurrence or receipt of a complaint regarding an outbreak of a *food-borne illness* at the restaurant*?* |  |  |
| 18. Does Applicant have written contingency procedures for emergency closings due to short-term weather-related emergencies, loss of power, kitchen malfunctions, natural disaster, etc. |  |  |
| 18a. Does the written contingency plan include procedures for timely notification of emergency situations to consumers? |  |  |
| 18b. Does the written contingency plan include distribution of information to consumers on how to stock an emergency food shelf? |  |  |
| **Program Income** | **Yes** | **No** |
| 19. At the time the vouchers are received, does Applicant give the consumer the opportunity to voluntarily contribute to the cost of the meal(s)? |  |  |
| 20. Does Applicant clearly inform each consumer that he/she has no obligation to contribute in order to receive the voucher and it is the consumer who determines how much to contribute toward the cost? |  |  |
| 21. Does Applicant have procedures to safeguard and account for all contributions and fees? |  |  |
| 21a. Briefly describe Applicant’s system for collecting and accounting for contributions: | | |
| 21b. Does Applicant keep the consumer’s level of the voluntary contribution in confidence? |  |  |
| 21. Does Applicant use all collected contributions and fees to supplement (not supplant) and/or expand the service for which the fees were given? |  |  |
| **Training Requirements for Food Handlers** | **Yes** | **No** |
| 22. Does Applicant ensure that the restaurant provides and documents training provided to each staff member? |  |  |
| **Documentation** | **Yes** | **No** |
| 23. Does Applicant have a written agreement with a restaurant to provide a meal service to consumers who is geographically isolated or to consumers who are currently participating in an existing restaurant meal service program? |  |  |
| 24. Does Applicant have a written agreement with a restaurant to provide meal service to consumers with religious or ethnic dietary needs, or to a consumer who needs meals at a time when the usual congregate dining project is not open such as during mornings, evenings, or weekends? |  |  |
| 25. Does Applicant have a policy and procedure that requires a consumer to register to obtain meal vouchers which are then presented to a designated staff person at the restaurant in order to receive or select from a prepared menu of meals? |  |  |
| 26. Does Applicant ensure that the restaurant maintains documentation that all meals comply with sections 918.01 to 918.31 of the Revised Code and Chapter 3717-1 of the Administrative Code, which is also known as “The State of Ohio Uniform Food Safety Code”? |  |  |
| 27. If the restaurant receives a *critical* citation by the local health department, does the restaurant notify Applicant and will Applicant then submit the citation and the corrective action plan to the WRAAA Nutrition Program Coordinator no later than 5 calendar days? |  |  |
| 28. Does Applicant develop and utilize a system for maintaining receipt of the meal vouchers? |  |  |
| 29. Does Applicant document receipt of a meal by obtaining the date the meal was received and signature of the consumer who received the meal on the redeemed voucher? |  |  |
| 30. Does Applicant document and input the number of meals served to each consumer into SAMS? |  |  |
| 31. Does Applicant obtain comments from consumers on: the dining environment, food appearance, type of food, food temperatures, and staff professionalism? |  |  |
| **Comments** | | |
| 32. Comments and explanations of any ‘No’ answers: *Please indicate question number with response*. | | |

***YOU MUST ALSO COMPLETE THE QUESTIONS FOR NUTRITION EDUCATION***

**SUPPORTIVE SERVICE QUESTIONS**

**(Questions 1-12)**

The following questions are required only for those providers applying for OAA ***Supportive Service***.

**Supportive Service** is the process of providing short-term assistance in obtaining needed benefits or services. The contacts need not be at the same time. Activities include: (1) Provision of information about benefits or services through identification, prioritization, and discussion of consumer s’ needs. (2) Provision of assistance in obtaining benefits or services through completion of necessary forms, language translation and/or interpretation following screening. (3) Provision of assistance through initial referral and linkage of consumers to appropriate resources. Linkage includes notifying WRAAA of forthcoming contact, scheduling initial appointment assisting/participating with consumer in scheduled appointment. (4) Follow-up by contacting consumer and/or WRAAA to determine outcome of referral/linkage.

Staff providing the service must document **8 hours of continuing education** annually in benefits assistance and community service topics that are relevant to the needs of older adults.

A unit of service is one (1) hour with or on behalf of a consumer.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **SUPPORTIVE SERVICE QUESTIONS**  **(Questions 1-12)** | | | |
| --- | --- | --- | --- |
| **Purpose of OAA Supportive Services** | | **Yes** | **No** |
| 1. Does the service include: | a. Provision of information about benefits |  |  |
| b. Benefits eligibility screening |  |  |
| c. Assistance in applying for benefits, including completion of forms |  |  |
| d. Provision of information about available services |  |  |
| e. Referrals to appropriate resources and other service providers |  |  |
| f. Assistance in contacting resources and other service providers |  |  |
| g. Follow-up to referrals |  |  |
| h. Language translation/interpretation |  |  |
| i. Coordination with other professional contacts |  |  |
| 1. Describe other types of activities provided that are not listed in Question 1: | | | |
| 3. Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers received Supportive Service in the past 12 months?) | | | |
| **Supportive Service Delivery and Outcomes** | | | |
| 4. Describe how referrals/linkages to appropriate resources are identified and provided. | | | |
| 5. Describe the process used to follow-up on referrals, once they are made. | | | |
| 6. Does Applicant’s staff make in home visits? What percentage of total consumers served in the past 12 months received an in home visit? | | | |
| 7. What are the most frequent topics Applicant’s staff addresses with consumers? Please describe outcomes that Applicant measures and recent changes Applicant has made to its program to better meet consumer needs. | | | |
| 8. Provide a brief example of how Applicant’s Supportive Service has assisted a consumer who was at risk of nursing home placement, and enabled him/her to remain in the community. | | | |
| **Supportive Service Staff Credentials** | | | |
| 9. Who provides the supportive service, and what are their credentials? | | | |
| 10. Please describe training Applicant’s staff attended in the last 12 months that enhanced their ability to provide supportive services. Include the title of the continuing education session and dates. | | | |
| 11. Who supervises the supportive service, and what are his/her credentials? | | | |
| **Comments** | | | |
| 12. Comments and Explanations of any ‘No’ answers. *Please indicate question number with response*. | | | |

**TRANSPORTATION QUESTIONS**

**(Questions 1 - 17)**

The following questions are required only for those providers applying for OAA ***Transportation Service.*** Please review Rule 173-3-06.6 for Transportation Service Specifications.

*Transportation Service* means a service that transports a consumer from one place to another through the use of a provider's vehicle and driver, and which may, or may not, include providing the consumer with assistance to safely enter and exit the vehicle. Examples of places to which the service may transport a consumer are a medical office, congregate dining project site, grocery store, senior center, or government office.

*Coordinated Transportation* is characterized by a centralized call center which dispatches vehicles by phone requests from seniors and their caregivers. It is a demand–response system that does follow a fixed route or fixed destination. Demand response services carry more than one passenger picked up from different points of entry and dropped off at separate destinations.

A *one-way trip constitutes one unit of transportation service*. The unit rate in a provider agreement shall reflect the provider’s fully–allocated costs, including administrative costs, training costs, and documentation costs.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| **TRANSPORTATION QUESTIONS**  **(Questions 1 - 17)** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Type of Transportation Services** | | | | | | **Yes** | **No** | |
| Is Applicant applying to provide: | | | | | |  |  | |
| Coordinated Transportation Service? | | | | | |  |  | |
| Fixed Destination Transportation Service? | | | | | |  |  | |
| **Purpose of OAA Transportation Service** | | | | | | | | |
| 1. What is the primary purpose of Applicant’s transportation service? Describe the typical destinations, and the activities the consumers are able to participate in as a result: | | | | | | | | |
| 2. Describe Applicant’s scheduling system. How does Applicant’s consumers reserve Applicant’s transportation service? Which staff members do the consumers interact with when they need to schedule the transportation service? How much lead time is required to make a reservation for a ride? | | | | | | | | |
| 1. Describe Applicant’s back-up plan for times when a driver or vehicle is unavailable. | | | | | | | | | |
| 4. Describe how effective Applicant’s outreach has been in the past (for example, how many new consumers utilized Applicant’s transportation service in the past 12 month? If Applicant has a waiting list, how many individuals are on it?) | | | | | | | | | |
| 5. Describe Applicant’s program. | | | | | | | | | |
| 5a: What are Applicant’s common trip destinations and percentages annually: | | | | | | | | | |
| **Transportation Service Direct Provider** | | | | | | **Yes** | **No** | | |
| 6. Does Applicant plan to subcontract the transportation service? | | | | | |  |  | | |
| 6a. If yes, please indicate the name of the subcontractor and the reason why you plan to subcontract with them: | | | | | | | | | |
| 7. Does Applicant or its WRAAA-authorized subcontractor own the vehicles used to provide transportation? | | | | | |  |  | | |
| 7a. If yes, please indicate the current number of owned vehicles that are used to transport OAA consumers, the type and year of the vehicle(s): | | | | | | | | | |
| 8. Are the drivers employed by Applicant or the subcontractor? | | | | | |  |  | | |
| 8a. If yes, please indicate the number of trained Regular drivers: | | | | 8b. If yes, please indicate the number of trained Back up drivers: | | | | | |
| 9. Will transportation be directly provided by an urban or a rural transit system? | | | | | |  |  | | |
| **Transportation Services Driver Qualifications** | | | | | | **Yes** | **No** | | |
| 10. Are drivers required to complete an introductory course approved by EMFTS (<http://www.ems.ohio.gov/medical-transportation-faq.aspx>) on passenger-assistance training (i.e. DRIVE or PASS) no later than 6 months post-hire? | | | | | |  |  | | |
| 1. Does Applicant maintain documentation of compliance of each driver with the passenger –assistance training course requirements described above? | | | | | |  |  | | |
| **Driver Qualifications for Transportation Services** | | | | | **Yes** | **No** | **N/A** | | |
| ***If the direct provider is a rural or urban transit system, these questions may be answered as N/A.*** | | | | | | | | | |
| 12. Before providing transportation service, does Applicant document that the drivers meet these qualifications: | 1. Hold a current valid driver’s license for at least 2 years, with the endorsement necessary for the type of vehicle used for the service? | | | |  |  |  | | |
| 1. Have fewer than six points issued under 4766.09 or 4510.036 of the Ohio Revised Code? | | | |  |  |  | | |
| 1. Have a signed statement from a licensed physician acting within the scope of the physician’s practice that states that the driver has no medical or physical condition, including an incurable vision impairment that may impair safe driving, passenger assistance, emergency treatment, or the health and welfare of a consumer or the general public? | | | |  |  |  | | |
| 1. Pass drug and alcohol tests? The drug tests check for the use or abuse of amphetamines, cannabinoids, cocaine, opiates, and phencyclidine. The alcohol tests check blood-alcohol content. Tests shall be obtained from a CLIA-certified laboratory to conduct the tests? | | | |  |  |  | | |
| 1. Pass a training course in first aid and CPR offered by a training organization approved by the board of EMFTS (<http://www.ems.ohio.gov/medical-transportation-faq.aspx>)? | | | |  |  |  | | |
| 1. Possess the ability to understand written and oral instructions? | | | |  |  |  | | |
| 1. Possess the ability to assist passengers into and out of the vehicle? | | | |  |  |  | | |
| 1. Possess the ability to comply with trip-verification requirements? | | | |  |  |  | | |
| 13. Are drivers required to maintain the validity of the above certifications? | | | | |  |  |  | | |
| 13a-e. Please indicate the frequency of re-certification or testing of: | | 1. BMV points: | | | | | | | |
| 1. Physician statement: | | | | | | | |
| 1. Drug and alcohol testing: | | | | | | | |
| 1. First Aid training: | | | | | | | |
| 1. CPR Certification: | | | | | | | |
| **Transportation Records / Documentation** | | | | | | **Yes** | **No** |
| 14. Does Applicant maintain a policy for drivers indicating that the driver shall help the consumer to safely enter and exit the vehicle, and any additional responsibilities assigned to the driver by the provider agreement? | | | | | |  |  |
| 14a. Does Applicant inform every consumer of this policy before providing the service to the consumer? | | | | | |  |  |
| 15. Does the driver Trip Verification contain: consumer’ name, type of trip (transportation or assisted transportation), date of trip, pick-up point (address) and time of the pick-up, destination point (address) and time of the drop off, service units, driver’s name, and consumer’s signature? | | | | | |  |  |
| 16. Does Applicant maintain vehicles according to the manufacturer’s maintenance schedule for each vehicle used to transport consumers? If the vehicle includes a wheelchair lift, the provider shall maintain the wheelchair lift according to the manufacturer’s maintenance schedule. | | | 1. “Annual Vehicle Inspection” on form ODA0004. The provider shall only use the vehicle for transporting consumers if a mechanic who is certified by the national institute for automotive service excellence (ie, ASE-certified), or another mechanic approved by the AAA, inspected it no more than twelve months beforehand and the answers to all questions on the form were “yes”, 2. Or does the vehicle display a valid safety inspection decal issued by the state highway patrol? | | |  |  |
| 1. “Daily Vehicle Inspection” on form ODA0008. The provider shall only use a vehicle if, before providing the first trip of the day, the provider inspected it and the answers to all questions required by the form were “yes”. | | |  |  |
| **Comments** | | | | | | | |
| 17. Comments and Explanations of any ‘No’ answers. *Please indicate question number with response*. | | | | | | | |

VOLUNTEER Guardianship SERVICE QUESTIONS

(Questions 1 - 12)

The following questions are required only for those providers applying for ***Volunteer******Guardianship Services.***

***Volunteer Guardianship Services*** are services provided to a person who has been determined by evaluation to require them for the prevention, correction or discontinuance of an act as well as conditions resulting from abuse, neglect or exploitation.***Guardianship***is the legal process by which a court determines that a person is incapable of making decisions about some or all areas of life. Because of certain medical conditions, a developmental disability, dementia, mental illness, inability to communicate, a person may not be able to take care of his or her own finances, make medical decisions, or understand the need for assistance with the activities of daily living. ***Guardianship services*** may include but are not limited to case work, medical care, mental health services, fiscal management, home health care, homemaker, housing services, and placement services. They may also include the provision of food, clothing and shelter.

Unit of service is one (1)hour, including caseworker or lawyer’s time.

Please do not attach brochures, newspaper clippings or other materials. All questions must be answered. Points will be deducted for unanswered questions and/or failure to answer questions directly.

| VOLUNTEER Guardianship SERVICE QUESTIONS  **(Questions 1 - 12)** | | | | |
| --- | --- | --- | --- | --- |
| **Purpose of OAA Volunteer Guardianship Services** | | | | |
| 1. Describe Applicant’s *Volunteer* *Guardianship* program. List the types of assistance provided to the consumer: | | | | |
| 2. Describe the methods by which a consumer may be referred to Applicant for *Volunteer Guardianship.* | | | | |
| 3. Describe Applicant’s collaboration with other providers. | | | | |
| **Guardianship Service Requirements** | | | **Yes** | **No** |
| 4. Is each consumer evaluated and assessed to determine eligibility for volunteer guardianship services prior to delivery of service? | | |  |  |
| 5. Does Applicant ensure that qualified staff (RN, Social Worker or Counselor) evaluates consumers, initiates care plans, and updates care plan annually and as needed? | | |  |  |
| 5a. Indicate the number of staff members who perform this role, and their credentials / qualifications: | | | | |
| 6. Are all of Applicant’s staff registered guardians? | | |  |  |
| 6a. Indicate the total number of staff: | 6b. Indicate the number of staff that are registered guardians: | | | |
| 7. Are all of Applicant’s volunteers registered guardians? | | |  |  |
| 7a. Indicate the total number of volunteers: | | 7b. Indicate the number of volunteers that are registered guardians: | | |
| 8. Does Applicant ensure that services are appropriate to individual consumers? | | |  |  |
| 9. Does Applicant receive informed consent on all consumers? | | |  |  |
| 10. Do Applicant’s Staff and volunteers receive annual training? | | |  |  |
| 10a. Describe Applicant’s training program, including the training topics: | | | | |
| 11. Does Applicant have a well-defined system of tracking and monitoring the well-being of consumers? | | |  |  |
| 11a. Describe the system: | | | | |
| **Comments** | | | | |
| 12. Comments and Explanations of any “No” answers. *Please indicate question number with response*. | | | | |

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