

OMB Approval No. 0985-0018

Expiration 05/31/2010

**The Community Living Program:
Supporting Independence and Choice in the Community**

Program Announcement and Grant Application Instructions

**U.S. Administration on Aging
In Collaboration with
U.S. Department of Veterans Affairs -
Veterans Health Administration**

2009

Department of Health and Human Services (HHS)

Administration on Aging (AoA)

AoA Office for Planning and Policy Development

Funding Opportunity Title: Community Living Program Cooperative Agreements

Announcement Type: Initial

Funding Opportunity Number: HHS-2009-AoA-CD-0919

Catalog of Federal Domestic Assistance (CFDA) Number: 93.048

Key Dates: The deadline for submission of applications is August 3, 2009. The deadline for submission of letter of intent is July 1, 2009. An open information teleconference for applicants of this solicitation will be held June 24, 2009 at 2:00 p.m., EST. The toll-free teleconference phone number will be 888-396-9185, pass code: 2043392.

Applicable Dates:

Open Information Teleconference	June 24, 2009
Voluntary Notice of Intent to Apply	July 1, 2009
Grant Application Due Date	August 3, 2009
Issuance of Notice of Grant Awards	Prior to September 30, 2009
Grant Period Start Date	September 30, 2009

Overview: This Program Announcement provides an opportunity for the Aging Network to modernize its approach to service delivery and to prioritize helping individuals who are at imminent risk of nursing home placement but not eligible for Medicaid to avoid nursing home placement and spend-down to Medicaid, consistent with the long-term care provisions that were included in the 2006 Amendments to the Older Americans Act (OAA).

Under this Announcement, AoA will award Cooperative Agreements to assist State Units on Aging (SUA) to develop Community Living Programs (formerly known as Nursing Home Diversion Programs). A successful SUA applicant will propose to implement projects in partnership with Area Agencies on Aging (AAA), Aging and Disability Resource Centers (ADRC) or ADRC type providers, aging services provider organizations, and other long-term care stakeholders including the Single State Medicaid Agency that strengthen the capacity of the Aging Network to target and serve individuals at highest risk of nursing home placement and spend-down to Medicaid with flexible services, including offering consumer directed options.

Grants under this Announcement are to be used to make changes in the way existing federal and state programs, that are currently being administered by SUAs and AAAs, operate so that these programs will:

- Utilize ADRC or ADRC-type programs to efficiently and effectively identify individuals who are not Medicaid eligible but are at imminent risk of nursing home placement and spend-down;
- Enable the Aging Network to rapidly authorize and provide services and supports to the individuals who are identified by the ADRC or ADRC-type program as being at imminent risk of nursing home placement and spend-down to Medicaid;
- Enhance the Aging Network’s ability to deliver flexible service delivery models that provide a full range of options and allow the Network to tailor services to the unique and changing needs of high-risk individuals, including consumer directed models such as Cash and Counseling that give people the option to control the types of services they receive and the manner in which those services are provided; and,
- Strengthen the Aging Network’s capacity to track client outcomes and document effectiveness of the program and how the Network can help the high-risk individuals targeted under this Announcement to avoid nursing home placement and spend-down and also reduce the rate of growth in Medicaid long-term care expenditures.

The specific requirements and fundable activities for this opportunity are outlined in Section I.5.

Applications will be scored in part based on the degree of progress a state proposes to make toward achieving the types of long-term care program changes called for in this Announcement (see above), in comparison to the status quo statewide and within the geographic areas covered by a proposed Community Living Program.

Special Funding Opportunity to Serve Veterans: While not a specific funding opportunity within this announcement, the Veterans Health Administration is providing an opportunity to SUAs and AAAs to provide Veterans Directed Home and Community-Based Services (VDHCBS) Programs, which are consumer directed and designed to empower veterans of any age at risk of nursing home placement to direct their own home and community based services. VDHCBS payments are used to assess Veterans’ service and support needs for the VDHCBS program, develop a service plan, and assist Veterans in purchasing and directing their home and community-based long-term care services.

In conjunction with last year’s Community Living Program (formerly known as Nursing Home Diversion) Announcement, the Veterans Health Administration has committed \$11 million to date to implement the Veterans Directed Home and Community Based Services (VDHCBS) Program within 10 Community Living Program grantee states through their Veterans Integrated Service Network and VA Medical Center partners. As part of this year’s Program Announcement, the Veterans Health Administration plans to commit additional funds to expand the VDHCBS program through SUAs and/or AAAs. State Units on Aging must complete and submit an application for the VDHCBS program along with their AoA CLPM grant application. States seeking to apply for this option should see Attachment I for information about the program and application instructions.

SECTION I. FUNDING OPPORTUNITY DESCRIPTION

1. Statutory Authority

The statutory authority for grants under this program announcement is contained in Title IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365 (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

2. Purpose

The Administration on Aging (AoA) is providing this competitive grants opportunity to assist State Units on Aging (SUA) to make changes in the way existing federal and state programs are administered so those programs will strengthen the Aging Network's role in helping at-risk individuals who are not Medicaid eligible to avoid unnecessary nursing home placement and spend-down, and to have access to flexible and consumer directed services consistent with the long-term care provisions that were included in the 2006 Amendments to the Older Americans Act. The proposed projects are to be carried out in partnership with Area Agencies on Aging (AAAs), Aging and Disability Resource Centers (ADRCs) or ADRC-type programs, community-based aging service providers, and other key long-term care stakeholders including the Single State Medicaid Agency.

Since the primary objective of this Program Announcement is to demonstrate how the Aging Network can use existing federal and/or state programs to serve individuals who are at imminent risk of nursing home placement and spend-down to Medicaid, AoA expects that over the course of the 24-month project period, funding for the home and community-based services provided by the Community Living Projects under this Announcement will come from one or more of a variety of sources (e.g., the Older Americans Act, the Alzheimer's Disease Supportive Services Program (ADSSP) program, other public programs, and other sources that can be used to cover the cost of services for individuals who are not eligible for Medicaid. Accordingly, not more than 20% of the total grant funds made available under this Announcement may be used to cover the cost of the home and community-based services and supports provided under the Community Living Programs. If the ADSSP funds will be used, successful applicants should consult with AoA to assure that funds will be used for their statutory purpose. The Community Living Program (CLP) funding opportunity seeks system change that prioritizes home and community based services funded under these programs that are successfully targeted to the at risk population, and these individuals have the ability to use OAA and other funds in a consumer directed model.

This is the third CLP (formerly NHD) funding opportunity. In 2007, twelve (12) states were awarded approximately \$500,000 each to develop Community Living Programs. In 2008, 14 states were awarded approximately \$750,000 each. In both years, grantees were required to target those at greatest risk of institutionalization and spend-down to Medicaid through ADRCs or ADRC-type providers, and using existing non-Medicaid funding, to provide targeted individuals with flexible services to assist them in remaining at home and in the community. AoA saw these CLP grants as an opportunity to learn about how SUAs and AAAs, with their

community partners, could most effectively approach Community Living Program activities that met AoA standards. This 2009 CLP Program Announcement draws from the experiences and lessons learned by these grantees. This includes identification of Aging and Disability Resource Centers or ADRC-type providers and Financial Management Service providers as key components of an effectively managed, consumer-driven system of long-term care.

These competitive grants offer SUAs the opportunity to partner with their AAAs, ADRC or ACRC-type entity (if different than the AAA) , the State Medicaid Agency, a Financial Management Service (FMS) provider, and community-based aging services provider organizations to modernize the way existing state and federal programs are being used to deliver home and community-based services. This includes developing models to identify individuals who are at imminent risk of nursing home placement and spend-down. It also includes methods for delivering flexible services and using per capita budgeting techniques that allow programs to manage their resources in a way that enables them to better respond to the unique and changing needs of individual consumers while simultaneously tracking service dollars to statutory funding streams. The project will also allow aging services providers, generally in concert with financial services providers, to participate in consumer-directed programs that give consumers greater control over the types of services they receive and the manner in which those services are provided. As a result of their involvement in this project, aging services provider organizations should be better positioned in the changing long-term care environment, and have greater capacity to serve the growing number of individuals who will be at risk of nursing home placement and spend-down to Medicaid.

3. Background on the Policy Context for this Program Announcement

The Older Americans Act has always authorized the Aging Network at all levels to promote the development of comprehensive and coordinated systems of services and supports that enable seniors to remain in their own homes and communities for as long as possible. Consistent with the flexibility provided under the Act, the Network has carried out this statutory responsibility in a variety of ways, using different strategies and approaches that reflect varying state and local conditions, policies and practices. Additionally, the state-of-the-art in helping seniors to remain at home has evolved over time, with the development of new approaches and techniques for identifying and serving people who are at risk of nursing home placement, including the use of nursing home preadmission screening programs. Most diversion and systems change strategies and programs have focused on Medicaid-eligible individuals, but some states have supplemented their OAA programs with state revenue funds to establish such programs specifically targeted at helping individuals who are not Medicaid eligible.

The new long-term care provisions that were incorporated into the Older Americans Act in 2006 create an opportunity for the Aging Network to modernize its approach to providing services to at-risk individuals and to strengthen its overall role in long-term care. The new OAA provisions complement the changes occurring in Medicaid, in particular the “Money Follows the Person Initiative” by strengthening the Network’s capacity to help states reach people before they enter a nursing home and spend-down to Medicaid. The 2006 Amendments authorize all levels of the Network to actively promote and participate in the development of consumer-centered systems of long-term care. The Amendments also emphasize the Network’s use of a three-pronged

strategy for advancing needed changes in our long-term care programs at the Federal, state and local level that will make them more responsive to the needs and preferences of consumers. These three strategies include:

- Empowering individuals to make informed decisions about their care options through ADRCs;
- Enabling older people to live healthier lives through the use of Evidence-Based Disease and Disability Prevention Programs; and,
- Helping seniors who are not Medicaid eligible to avoid unnecessary nursing home placement and spend-down through targeted home and community based services and supports and the use of flexible, consumer-directed models of care.

AOA, in collaboration with a variety of Federal partners and several private foundations, has been rolling out programs since 2003 to support the first two components of the strategy (ADRCs and Evidence-Based Prevention Programs). This funding opportunity, like the 2007 and 2008 Community Living Program funding opportunities, is designed to support the implementation of the third component of the long-term care strategy that is now embedded in the OAA, and also supports the growth of ADRCs as an integral part of CLP programs and overall long-term care system reform.

4. Relevant Sections of the Older Americans Act

As a result of the 2006 Amendments, Title II Section 202b of the Older Americans Act authorizes the Assistant Secretary for Aging to “promote the development and implementation of comprehensive, coordinated systems at the Federal, state, and local levels that enable older individuals to receive long-term care in home and community-based settings, in a manner responsive to the needs and preferences of older individuals.”

Title II Section 202 b(4) goes on to authorize the Assistant Secretary to: “facilitate, in coordination with the Administrator of the Centers for Medicare and Medicaid Services, and other heads of Federal entities as appropriate, the provision of long-term care in home and community-based settings, including the provision of such care through self-directed models that:

(A) provide for the assessment of the needs and preferences of an individual at risk for institutional placement to help such individual avoid unnecessary institutional placement and depletion of income and assets to qualify for benefits under the Medicaid program under title XIX of the Social Security Act (42 U.S.C et seq.);

(B) respond to the needs and preference of such individual and provide the option-

- (i) for the individual to direct and control the receipt of support services provided; or
- (ii) as appropriate, for a person who was appointed by an individual, or is legally acting on the individual’s behalf, in order to represent or advise the individual in financial or service coordination matters (referred to in this paragraph as a ‘representative’ of the individual), to direct and control the receipt of those services; and

(C) assist an older individual (or, as appropriate, a representative of the individual) to develop a plan for long-term support, including selecting, budgeting for, and purchasing home and community-based long-term care and supportive services.”

To complement this new authority, the 2006 Amendments also included a new definition in Title I Section 102(a) (46) to support the use of consumer-directed models:

“The term ‘**self-directed care**’ means an approach to providing services (including programs, benefits, supports, and technology) under this Act intended to assist an individual with activities of daily living, in which:

(A) such services (including the amount, duration, scope, provider, and location of such services) are planned, budgeted, and purchased under the direction and control of such individual;

(B) such individual is provided with such information and assistance as are necessary and appropriate to enable such individual to make informed decisions about the individual’s care options;

(C) the needs, capabilities, and preferences of such individual with respect to such services, and such individual’s ability to direct and control the individual’s receipt of such services, are assessed by the area agency on aging (or other agency designated by the area a agency on aging) involved;

(D) based on the assessment made under subparagraph (C), the area agency on aging (or other agency designated by the area agency on aging) develops together with such individual and the individual’s family caregiver (as defined in paragraph (18)(B)), or legal representative:

(i) a plan of services for such individual that specifies which services such individual will be responsible for directing;

(ii) a determination of the role of family members (and others whose participation is sought by such individual) in providing services under such plan; and

(iii) a budget for such services; and

(E) the area agency on aging or State agency provides for oversight of such individual’s self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under this Act.”

5. Description of FY 2009 CLP Funding Opportunity

Under this Announcement, AoA will award Cooperative Agreements to assist State Units on Aging (SUA) to strengthen the capacity of the Aging Network to help individuals who are not eligible for Medicaid but at imminent risk of nursing home placement and spend-down to remain at home and in the community and have access to flexible, consumer-directed services.

States are expected to use existing federal and state program funds to cover the cost of the home and community-based services provided under the proposed projects. Not more than 20% of the total amount of grant funds made available under this Announcement may be used to cover the cost of the home and community-based services provided under the proposed projects.

Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being rapidly authorized and initiated, that client and family needs are being met, and that necessary adjustments in services

are rapidly being made as the needs of the client and/or family caregiver change, as well as insuring that all payment, payroll and tax functions are completed accurately and in a timely manner.

Projects must also be able to track individual clients and be able to document and report on the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down.

Projects will be funded for a 24-month project period. A SUA may propose a project within one or more Planning and Service Areas (PSA). States with a single PSA may propose a project targeted to one or more counties or regions of the state. Other than States where there is a single PSA, the SUA is encouraged to look to the AAA (in coordination with the local ADRC or ADRC-type entity if the AAA is not such an entity) to lead the local implementation of any project within its PSA that is supported under this Announcement.

No later than the end of the 12th month after receiving the grant award, projects funded under this Announcement must have at least one local project up and be delivering services to the high-risk individuals targeted under this Announcement in a way that:

- A. Uses an ADRC or ADRC-type program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,
- B. Has formal protocols and other tools in place for use by key stakeholder organizations (e.g., AAAs, ADRCs, aging services providers, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that local projects can rapidly provide home and community-based services and supports to the high-risk individuals who are identified by the ADRC program, and that the services for these individuals can be quickly adjusted as necessary as their needs change, and
- C. Is able to provide Financial Management Services (FMS) to facilitate delivery of consumer directed services by providing necessary supports including payment for goods and services, payroll functions and reports.

Definition of Terms:

For purposes of this Announcement, an “Aging and Disability Resource Center” (ADRC) or ADRC-type program must have the operational capacity to:

- A. effectively and efficiently identify individuals who are at imminent risk of nursing home placement but not eligible for Medicaid and who, without some type of intervention, will in fact go into – or stay in – a nursing home facility and spend-down to Medicaid (consistent with Standards I.B and I.D in Appendix G);
- B. assesses the needs of such individuals; provide them with options counseling; and, as needed, work with them to develop care plans and arrange for services, including linking them to services provided by aging network provider organizations (consistent with Standard II. A in Attachment G);

- C. provide streamlined processes for determining an individual’s eligibility for publicly supported long-term care services and supports. This means the ADRC programs used for projects under this Announcement need to be integrated, in some manner, with the process that is used by the state to determine a person’s eligibility for Medicaid long-term care (both their programmatic eligibility and their financial eligibility for Medicaid). To the extent feasible it would be beneficial that individuals who are deemed by Medicaid to be ineligible for Medicaid long-term care and who are at imminent risk of nursing home placement have the opportunity to be referred to the diversion program supported under this Announcement (consistent with Standard II.A. in Attachment G).

For purposes of this Announcement, an “aging services provider organization” is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

For purposes of this Announcement, “Financial Management Services” (FMS) are services that provide fiscal accountability for state and local government agencies and safeguards for individuals enrolled in self-direction programs and their workers by ensuring that payroll, worker’s compensation insurance policy management, and vendor payment tasks are performed accurately and in accordance with federal, state, and local rules and regulations, and in a timely manner. There are various FMS provider models including government and vendor fiscal employer agent models with which a project can contract. (See Standards in Attachment F and FMS Providers in Attachment G and Attachment L)

For purposes of this Announcement, “models to deliver flexible services” includes service authorization and service delivery. The service authorization process should include the authority to utilize funds that are not tied to any one provider and can support a wide variety of service options so that services can be tailored to the unique and changing needs of individual clients. Models should enable many provider organizations to provide and coordinate a complete array of services for elderly individuals and foster greater utilization of these types of providers. This approach to flexible services will foster greater efficiency and reduce per capita costs of services. “Consumer-directed models” are methods of delivering services that give the individuals being served the option to determine the specific types of services they receive, the manner in which those services are provided, and the ability to directly manage those services. (See Standards I.A and I.C in Attachment G)

Two examples of tools and protocols that a SUA and/or AAA might want to promote in their policies include:

Contracting – States or Area Agencies that have fixed contracts (e.g. \$25,000 to a specific homemaker agency) may consider implementing fee for service contracting or other variations. Based on an established unit rate, the total amount of funds and service hours can then be controlled by the consumer. When money follows the consumer, a choice of service providers can be made and a greater focus on quality service provision can result.

Prioritization – The specific aim of the Community Living Program Grants is to identify and serve individuals at imminent risk of going into a nursing home and spending down to Medicaid. States and Area Agencies that have served consumers on a “first come, first served” basis may consider implementing assessment and screening tools, as well as care planning and case coordination processes, that have been proven to identify and serve those individuals in priority order.

Priority will be given to states with project proposals that demonstrate real potential to:

- Identify the amount and source(s) of funding from existing federal and state programs to be used for home and community-based services and supports that will be provided to clients under their proposed project no later than the end of the 12th month, as well as during the rest of the grant’s 24 month project period.
- Effectively identify individuals who are at imminent risk of nursing home placement and spend-down to Medicaid.
- Rapidly provide home and community-based services and supports to individuals who are identified by an ADRC or ADRC-type program as being at imminent risk of nursing home placement and spend-down to Medicaid.
- Provide a full range of service options to the individuals who are targeted under this Announcement as well as giving them the option to use consumer-directed/self-directed models that give people control over the types of services they receive, the manner in which they are provided, and the ability to directly manage those services.
- Provide home and community-based services, and access to consumer directed models, to significant numbers of clients in the target population in one or more geographic areas of the state over the 24 months of the grant period. Applications must indicate the anticipated number of targeted individuals that will be diverted from nursing home placement and spend-down to Medicaid during the 24 month grant period. (Attachment K includes a chart that estimates the total number of people within each state that may be at risk of nursing home placement and spend down to Medicaid. Applicants should project the percentage of the estimated population they anticipate to divert from nursing home placement and spend down to Medicaid.)
- Implement the types of system changes described in this Announcement (see Page 1), in comparison to the status quo statewide and within the geographic areas covered by the grant project, and the likelihood that such changes will be sustained beyond the project period.

Grant funds under this announcement can be used for the following activities:

- Not more than 20% of the total grant funds can be used for the provision of home and community-based services and supports to individuals. These services can include, but

are not limited to, personal care, homemaker/chore services, transportation, meal preparation, home-delivered meals, home modifications, respite, assistive devices, and other good and services that support the individual's ability to remain at home or the families ability to continue to provide support.

- Supporting Community Living Program operations of an ADRC to help ensure it is capable of effectively performing, directly or through a seamless system, the functions of client screening, assessment, options counseling, care planning, and streamlined access to all publicly supported long-term care services and supports, including Medicaid HCBS and nursing home care, for the population targeted under this Announcement. Among other things, this can include: developing or refining a program's targeting criteria and tools to ensure that those at-risk of imminent nursing home placement and spend-down to Medicaid are effectively and efficiently targeted.
- Case management/support brokerage services that provide supports to individuals to understand and manage their consumer directed services including developing and controlling a budget and spending plan, hiring and supervising workers, and other activities related to self directing services.
- Costs related to developing or contracting with a Financial Management Services provider to supply the necessary supports for consumer directed services that include payment of goods and services and tax and payroll functions.
- Training and technical assistance activities designed to assist the state and its partners in understanding and achieving project goals and objectives. AoA is funding a Community Living Program Technical Assistance Center that will provide technical assistance to successful grantees
- Designing and implementing evaluation and quality assurance systems and protocols.
- Costs related to development and implementation of VDHCBS including funds needed to cover service costs for Veterans between when AAA submits and bill and is reimbursed by the local VAMC.
- Project administration, but not costs for hiring state or AAA staff without a direct role in the project.

As part of its diversion program, states may propose to direct a portion of its diversion activities on transitioning individuals who are not eligible for Medicaid out of acute care and other facility settings, including hospitals and nursing homes, into the community if such individuals otherwise would have remained in, or have been sent to, a nursing facility for a long-term stay and spent down to Medicaid.

Applicants should note in their Project Narrative if activities developed under this funding opportunity are supported with other funding and if so, how the multiple funding sources will support, and not duplicate, efforts (e.g. CMS Real Choice Systems Change grants for ADRC and

Hospital Discharge Planning activities, previous CLP (NHD) grants, etc.). In addition, applicants for this opportunity should indicate if they are currently applying for:

- The 2009 Aging and Disability Resource Center grant and how activities proposed under that opportunity support and do not duplicate efforts proposed in the CLP application.
- The Veterans Health Administration Option (Veteran Directed Home and Community Based Service Program) described in Attachment I of this announcement. The Veteran Directed Home and Community Based Service ((VDHCBS) Program is designed to serve Veterans of any age at risk of nursing home placement with consumer directed services. **The AoA application shall include a statement regarding how the VDHCBS program will be implemented in conjunction with the Community Living Program Grant, including how much of the proposal's funds will be needed for VDHCBS start-up costs. States interested in applying for this option must complete a separate application as described in Attachment I and submit it with their AoA grant application. States can find more information on the VDHCBS Option in Attachment M: VDHCBS Program Standards. The States where the Veterans Health Administration has already committed funding for VDHCBS need not reapply through this process.**

NOTE: Additional information important in the development of proposals for this grant opportunity can be found in Section IV.2.C Project Narrative and in Section V.1. Application Review Criteria.

SECTION II. AWARD INFORMATION

Award Type: Cooperative Agreements to Eligible State Units on Aging

Estimated Federal Funds Available: up to \$6 million AoA funds

Estimated Number of Awards: Up to 20

Project Start Date: September 30, 2009

Estimated Project Length: 24 Months

The total amount of AoA funds available for this new funding opportunity for the first year is up to \$6,000,000. AoA plans to fund up to 12 - 20 states for a period of 24 months. The average grant amount per state over the 24 month period is anticipated to be approximately \$600,000 with the maximum award up to \$1,000,000. Because the nature and scope of the proposed projects will vary from application to application, it is anticipated that the size of each award will also vary. AoA reserves the right to offer a funding level that differs from the requested amount. Funding for the first 12 months will be provided at the time of the award. AoA may supplement grants at a later date based on availability of funding.

Grantees will be required to provide a 25% cash or in kind match for this CLP award. If a state concludes it is unable to meet the match requirement and has demonstrated it has exhausted all existing options to pursue the match (including both cash and in-kind options), states will be

allowed to submit a written request with their application to AoA to waive the match requirement. Waiver requests will be reviewed on a case-by-case basis.

These grants will be issued as Cooperative Agreements (see Attachment H) because AoA anticipates having substantial involvement with the recipients during performance of funded activities. AoA's involvement may include:

- Assisting the project leadership in understanding the strategic goals and objectives, policy perspectives, and priorities of the AoA by sharing such information on an ongoing basis via e-mail, conference calls, briefings, and other consultations;
- Providing technical assistance and support on Community Living Program methodologies and long term care systems change strategies, grant management and implementation issues, including execution of the cooperative agreement;
- Identifying specific data that will need to be collected;
- Defining project performance criteria and expectations; and,
- Monitoring, evaluating and supporting the projects' efforts in achieving performance goals.
- Training and contact with the State agency, Area Agency on Aging, and the aging services provider organizations that receive and administer service funds through the grant, and other partners that are participating substantially in the Community Living Program.

Grantees will be expected to maintain regular contact with their Federal project officer and to cooperate with the AoA Resource Center that will be providing technical assistance. Grantees will also be expected to share with AoA all significant products from their CLP program.

Special Opportunity to Serve Veterans -VDHCBS Option:

In conjunction with last year's Community Living Program Announcement, the Veterans Health Administration has committed \$11 million to date to implement the Veterans Directed Home and Community Based Services (VDHCBS) Program within 10 Community Living Program grantee states through their Veterans Integrated Service Network and VA Medical Center partners. As part of this year's Program Announcement, the Veterans Health Administration plans to expand the VDHCBS program through SUAs and/or AAAs in additional states via their Veterans Integrated Service Networks and VA Medical Centers.

The Veterans Health Administration (VHA) will directly purchase services from SUAs and/or local AAAs for the VDHCBS program. Service funding will be provided by the local VA Medical Centers to SUAs and/or their selected AAA pilot sites based on the number of veterans that will be enrolled in the VDHCBS and the monthly budget for services for each enrolled veteran. Reimbursement for services will be made retroactively after receipt by the VAMC of a bill for these services.

States interested in applying for this option must complete a separate application as described in Attachment I and submit it with their AoA grant application. States can find

more information on the VDHCBS Option in Attachment M: VDHCBS Program Standards. States where the Veterans Health Administration has already committed funding for VDHCBS need not apply through this process.

An applicant's eligibility and receipt of funding from the Veterans Health Administration for this option is dependent upon the submission of the required application per the instruction in Attachment I in conjunction with a 2009 CLP application, as well as the proven capacity of the applicant to provide the VDHCBS program through successfully completing a readiness review. The VDHCBS Option selection of participating states will be made no later than September 30, 2009 by the VHA. At the time a Notice of Award is made by AoA to CLP grantees, the VHA in partnership with AoA will make contact with all accepted VDHCBS awardees and all committed parties as demonstrated by the letters of support, to discuss and negotiate the details of their proposal for partnership, and to enable them to finalize the arrangement between the local VA Medical Center(s) and the State Unit on Aging or local AAA pilot site(s).

SECTION III. ELIGIBILITY INFORMATION

1. Eligible Applicants

Only a State Unit on Aging (SUA) may apply for a Community Living Program Grant.

2. Cost Sharing or Matching

Under this Older Americans Act (OAA) opportunity, a 25% cash or in kind match will be required. If a state concludes it is unable to meet the match requirement and has demonstrated it has exhausted all existing options to pursue the match (including both cash and in-kind options), states will be allowed to submit a written request, with their application, to waive the match requirement. Requests will be reviewed on a case-by-case basis.

3. Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the three screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

- A.** Applications must be submitted electronically via www.grants.gov by 11:59 pm of **August 3, 2009**
- B.** The Project Narrative section of the Application must be double-spaced, on "8 ½ x 11" plain white paper, with 1" margins on both sides, and a font size of not less than 11.
- C.** The Project Narrative must not exceed 15 pages. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel and Attachment I - the application

for the Veterans Directed Home and Community Based Service Program - **are not counted** as part of the Project Narrative for purposes of the 15-page limit.

4. Responsiveness Criteria

All applications will be screened to assure they meet two (2) basic responsiveness criteria. Applications that fail to meet the criteria described below will **not** be reviewed or receive further consideration.

The successful applicant will be an organization that meets the following criteria:

1. Provides letters of commitment from the Area Agency(ies) on Aging that will play an operational role in the proposed project, and.
2. The application must include **all** components of the project narrative, including:
 - Summary/Abstract
 - Current Status of State's Community Living Program Efforts
 - Goal(s) and Objective(s)
 - Proposed Approach
 - Project Outcomes
 - Project Management
 - Organizational Capability

SECTION IV. APPLICATION AND SUBMISSION INFORMATION

1. Address to Request Application Package

Application materials can be obtained from <http://www.grants.gov> or <http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx>.

Application materials are also available by writing to:

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development
Fax: 202-357-3469

Or by calling: 202-357-3417

Or e-mailing: joseph.lugo@aoa.hhs.gov

Please note, AoA is requiring applications for all announcements to be submitted electronically through www.grants.gov. The Grants.gov registration process can take several days. If your organization is not currently registered with www.grants.gov, please begin this process immediately. **For assistance with www.grants.gov, please contact them at**

support@grants.gov or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time. At www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website.

Applications submitted via www.grants.gov :

- You may access the electronic application for this program on www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2009-AoA-CD-0919) or CFDA number (93.048).
- At the www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through www.grants.gov because of the time delay.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the Grants.gov compatibility information and submission instructions provided at www.grants.gov (click on “**Vista and Microsoft Office 2007 Compatibility Information**”).
- Your application must comply with any page limitation requirements described in this Program Announcement.
- After you electronically submit your application, you will receive an automatic acknowledgement from www.grants.gov that contains a Grants.gov tracking number. The Administration on Aging will retrieve your application form from Grants.gov.
- After the Administration on Aging retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov
- Each year organizations registered to apply for Federal grants through www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (<http://www.ccr.gov>).

2. Content and Form of Application Submission

A. Letter of Intent

AoA strongly recommends that applicants submit a “letter of intent” via fax, email or phone to apply for this funding opportunity to assist AoA in planning for the application review process. The deadline for submission of the “letter” is July 1, 2009.

U.S. Department of Health and Human Services
Administration on Aging
Joseph Lugo
Office of Planning and Policy Development

Fax: 202-357-3469

Or by calling: 202-357-3417

Or e-mailing: joseph.lugo@aoa.hhs.gov

B. DUNS Number

The Office of Management and Budget requires applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements on or after October 1, 2003. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.

Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide:

https://www.whitehouse.gov/omb/grants/duns_num_guide.pdf.

C. Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. AoA will not accept applications with a Project Narrative that exceeds 15 pages. The Project Work Plan, Letters of Commitment, Vitae of Key Personnel, and Attachment I - the response to apply for the Veterans Directed Home and Community Based Service Program - are not counted as part of the Project Narrative for purposes of the 15-page limit, but all of the other sections noted below are included in the limit.

The components counted as part of the 15 page limit include:

- Summary/Abstract
- Current Status of State's Community Living Program Efforts
- Goal(s) and Objective(s)
- Proposed Approach
- Project Outcomes
- Project Management
- Organizational Capability

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether or not your project meets the minimum requirements for grants under Title IV of the Older Americans Act. The Project Narrative should provide a **clear and concise** description of your project. AoA recommends that your project narrative include the following components:

Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: the goal(s) and objectives, and a description of the specific types of changes that will be made to existing programs as a result of the proposed

project. Detailed instructions for completing the summary/abstract are included in Attachment E of this document.

Current Status of Aging Network’s Role in Community Living Program Efforts in the State. Applicants should provide a description of the current efforts, or planned activities, in the State (and in the PSA(s) where local project(s) will be implemented) to divert both Medicaid and non-Medicaid individuals from institutions, and the specific role that the SUA, AAAs, ADRC programs, and community-based aging services provider organizations, and other stakeholders currently play in these existing efforts. Explain how these existing or continued diversion activities fit into the state’s overall long-term care system, including current system reform efforts.

Goals and Objectives. This section should describe the proposed project’s goals and objectives.

Proposed Approach. Describe the overall approach you plan to use to make each of the system changes described in this Program Announcement (see Page 1), including how you plan to change the way services will be provided to the individuals targeted under this Announcement, and why you think your approach will be successful. This **must** include a description of how funds are currently being used statewide and in the geographic areas to be covered by the proposed project, and how their use will be changed as a result of the project.

Applicants are encouraged to provide as much detail – and to be as precise as possible - in describing both the “status quo” and the specific changes that will be made in the way existing programs, organizations and funds are being deployed in order to achieve the long term care program changes described in this grant Announcement (see Page 1). This includes identifying the specific federal and state funds to be used, exactly how their use will change to improve the way the Aging Network diverts individuals in the target group from unnecessary nursing home placement and Medicaid spend-down, as well as to provide flexible service models and consumer-directed models like Cash and Counseling. Applicants should provide a detailed description of the involvement of the State Medicaid Agency, Area Agencies on Aging, ADRC, FMS program, and community providers, including aging services provider organizations, agencies serving people with disabilities, and other key stakeholders in the process. Special attention should be paid to the role of the ADRC as a key component of the project (see attachments F and G), and to the development of or choice of the FMS provider particularly with regard to known experience in the area or region (see Attachments G and L).

A successful application will include a description of how this project will actively engage aging services provider organizations in diversion activities. Such activities might include assisting providers in receiving referrals from an ADRC or ADRC-type program, developing the capacity to rapidly respond to the unique and changing needs and preferences of the individuals targeted under this program, and helping providers to set up models to deliver flexible services as well as helping them to participate in consumer-directed models such as Cash and Counseling.

Applicants must describe the elements of the targeting criteria they either already have in place, and/or plan to develop and implement. The description of the targeting criteria should also include the relationship of the targeting criteria to the State Medicaid Agency’s definition of

nursing home level of care. This section shall also include a detailed description of how the targeting criteria will be used through the ADRC, to effectively and efficiently identify individuals who are in fact at imminent risk of nursing home placement and spend-down to Medicaid, consistent with the targeting standards described in I.B. and I.D. contained in Attachment G.

Ideally, the ADRC will be performing nursing home preadmission screening and will be using its preadmission screening program to identify individuals to be served under this grant program. Applicants must document the manner in which the ADRC is integrated with, the process used by the state Medicaid long-term care program to determine a person's eligibility (both programmatic and financial) for Medicaid long-term care. Applicants should also include a description of the methods by which people who are found to be ineligible for Medicaid will be referred immediately and seamlessly to the diversion program supported under this Announcement.

Applicants should describe how and what client-level data will be used to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and any associated cost avoidance for the Medicaid program. See Attachment J for minimum data requirements.

Applicants should specify and provide a rationale for selecting the geographic location(s) where grant efforts will be carried-out in their state. State Units on Aging, at a minimum, may implement program elements in one or more Planning and Service Areas (PSAs) of their state (or one or more counties or regions in a state with a single PSA).

Applicants must specify the names and role of, and provide a rationale for selecting, the various key partners who will be involved in the project, including Area Agencies on Aging, community-based aging services provider organizations, the ADRC, the Single State Medicaid Agency, the FMS provider, and other key partners. The role and makeup of any strategic partnerships to be involved in implementing the intervention, including other organizations, funders, and/or consumers should also be described.

Applications should also include a projection of the total amount of OAA and other funds, including not more than 20% of grant funds, which will be used to provide home and community-based services and supports to consumers by the end of the grant. Applicants who are applying for the VDHCBS Option are encouraged to describe how they will use grant or other funds to cover the necessary upfront monthly costs for services for Veterans.

Proposals should include a description of the Information Technology (IT) that will be used to support a Community Living Program Modernization Grant project.

Applicants should demonstrate how their proposal fits with other state Community Living Program activities, including any earlier CLP grants, and those targeted at Medicaid eligible individuals including Hospital Discharge Planning models.

Proposals should include any major barriers anticipated in trying to achieve the systems changes called for in the Announcement (see Page 1), and how the project will be able to overcome those barriers. Applicants may wish to refer to the *State Readiness Assessment & Gap Analysis for a Community Living Program Program* located on the [Community Living Program Modernization Grant Announcement Resource Page](#) for assistance in preparing for this funding opportunity.

Project Outcomes. This section of the project narrative must clearly identify the project outcomes to be accomplished by the end of the 24-month project period, based on the priority activities outlined in Section I.5, ‘Description of Funding Opportunity’ and the standards described in Attachment G. The state’s project must at a minimum:

- No later than the end of the 12th month of the project period, have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:
 - 1.) Uses an Aging and Disability Resources Center (ADRC) program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,
 - 2.) Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., ADRC, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the ADRC program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.
 - 3.) Has the ability to provide Financial Management Services (FMS) to facilitate the delivery of consumer-directed services that provide necessary support functions including bill payment, payroll and tax payment.
 - 4.) Be providing a full range of service options to individuals who are targeted under this Announcement, including giving them the option to use consumer-directed models that give people control over the types of services they receive and the manner in which they are provided.
- Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being provided, that client and family needs are met, and that adjustments in services are made as necessary. At the discretion of the state, this “on-gong monitoring and follow-up” function can be performed by either the ADRC or by another entity.
- Projects must be able to report on client-level data and be able to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and any associated cost avoidance

for the Medicaid program. Projects must be able to report unduplicated and aggregated data on the number of clients receiving home and community-based services under this project, including the numbers of those receiving consumer directed services, and also be able to report on the total and per capita amounts expended from all public sources on home and community based services and supports provided to the clients being served under this program, as well as the total amounts being expended on home and community-based services and supports from each public source, including the grant funds under this project. **At a minimum, projects must be able to collect all the data elements listed in Attachment J.**

- This section should include a projected number of clients that will be served, the proportion of the estimated state eligible population that will be served, and a projected enrollment strategy that reflects the projected ramp up of the program. Consider the information provided in Attachment K which includes the estimated number of people throughout the state likely to be at risk of nursing home placement and spend down to Medicaid.

This section should also describe how, and to what extent, the system changes brought about by the project will be sustained beyond the grant period, as well as the extent to which the changes will be incorporated into the state's overall system of long-term care.

Project Management. This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes, including the systems changes described in this Announcement (see Page 1). It should specify who will have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; communications with SUA, AAA and other partners, and AoA. It should describe the approach that will be used to monitor and track progress on the project's tasks and objectives, and how the state plans to measure, monitor, and report success in diverting individuals from institutionalization and spend-down to Medicaid.

Organizational Capability Statement. Each application should include an organizational capability statement, organizational charts, and vitae for key project personnel. The organizational capability statement should describe the organization and capacity of the SUA, AAA (if applicable), community-based services providers, the ADRC or ADRC-type program, FMS provider, and other key participants, and how they will collaborate in this project. Neither vitas nor an organizational chart will count towards the narrative page limit. Also include information about any service provider or contractual organization(s) that will have a significant role(s) in implementing the program and achieving project goals.

D. Work Plan. Applicants should provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity within the 24 month project period as well as a description of how each activity will contribute to the overall goals and objectives of the program and to the system changes described in the Announcement.

The Project Work Plan should reflect and be consistent with the Project Narrative and Budget. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify the timeframes involved (including start- and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in the Attachments.

E. Letters of Commitment from Key Participating Organizations and Agencies. Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies. This should include at a minimum letters of commitment from: 1) the State Medicaid Agency; 2) the collaborating AAA(s); 3) community provider partners; 4) the Aging and Disability Resource Center; Financial Management Services provider and, any other organization that is specifically named to have a significant role in carrying out the project. For applications submitted electronically via www.grants.gov, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3466 no later than the application submission deadline.

F. Budget Narrative/Justification

The Budget Narrative/Justification should be provided using the format included as Attachment C of this Program Announcement. **Applicants are encouraged to pay particular attention to Attachment B, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required. PLEASE NOTE THAT WHEN MORE THAN 33% OF A PROJECT'S TOTAL BUDGET IS LISTED IN THE CONTRACTUAL LINE ITEM, DETAILED BUDGET NARRATIVES/JUSTIFICATIONS MUST BE PROVIDED FOR EACH SUB-CONTRACTOR OR SUB-GRANT FOR EACH YEAR OF POTENTIAL GRANT FUNDING.**

3. Submission Dates and Times

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity. The letter of intent assists AoA in planning for the independent review process of the applications. The deadline for submission of letters of intent is July 1, 2009.

The deadline for the submission of completed applications under this program announcement is August 3, 2009. Applications must be submitted electronically at www.grants.gov. Applications that fail to meet the application due date will **not** be reviewed and will receive **no** further consideration.

Grants.gov will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in Grants.gov. After the Administration on Aging retrieves your application form from Grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by Grants.gov

An open information teleconference for applicants of this solicitation will be held June 24, 2009 at 2:00 p.m., EST. The toll-free teleconference phone number will be 888-396-9185, pass code: 2043392.

4. Intergovernmental Review

This funding opportunity announcement is not subject to the requirements of Executive Order 12372, “Intergovernmental Review of Federal Programs.”

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings;
- Basic research (e.g. scientific or medical experiments); and,
- Continuation of existing projects without expansion or new and innovative approaches.

SECTION V. APPLICATION REVIEW INFORMATION

The Review Criteria listed below will be used by an Independent Review Panel to score each application for this funding opportunity. In applying for this opportunity, applicants should therefore be sure to adequately address all of the elements noted below.

1. Application Review Criteria

Applications are scored by assigning a maximum of 100 points across five criteria:

1. Current Status of Aging Network’s Role in Community Living Program Efforts in the State (Weight – 5 Points)

Does the applicant provide a description of the “status quo” including current efforts including earlier CLP and ADRC grants, planned activities, statewide and in the PSA where the projects supported under this Announcement will be implemented, related to diverting people, including non-Medicaid individuals, away from nursing home placement and spend-down, and the specific role that the SUA, AAAs, ADRCs and community-based aging services provider organizations play in those efforts? Does the applicant explain how these existing diversion activities fit into the state’s overall long-term care system, including current system rebalancing/reform efforts? Does the applicant describe the “status quo” statewide and in the relevant PSA(s) on the use of models to deliver flexible services and consumer-directed models like Cash and Counseling? (5 points)

2. Goals and Objectives, Proposed Approach, Project Outcomes (Weight – 65 Points)
 - a. Does the applicant describe activities, resources, partners and/or the infrastructure which are currently in place, and those that are being planned under the proposed project, that would suggest the project is going to be able to, no later than the end of the twelfth (12th)

month of the Project Period, be identifying, through an ADRC, individuals in the target population and then using formal protocols and tools to link those individuals with provider organizations that can rapidly provide them the home and community-based services they need to avoid nursing home placement and spend-down? Does the applicant describe the specific SUA, AAA, or other policies they need to revise or implement to support a change in the way existing federal and/or state program dollars are used so they can be deployed to serve the high-risk individuals who are targeted under this Announcement? Can these changes be in place no later than the 12th month of the project period? Does the applicant discuss any barriers and how these will be overcome? (10 points)

- b. Does the applicant propose in detail what consumer direction service model(s) it will use, what OAA and other funds will be used, and identify the Financial Management Service provider and a rationale for choosing this provider? Is it likely to succeed at implementing and providing a full range of service options and providing the option to use consumer-directed models to the targeted population by the end of the 12th month in the project period? For example, are there consumer directed programs and Financial Management Service providers currently being used in the state that it can adapt or build on (See Attachment L)? (10 points)
- c. Does the applicant either describe their criteria for identifying individuals who are ineligible for Medicaid but at imminent risk of nursing home placement and spend-down, or detail their plans to develop these criteria, in a way that is consistent with targeted standards I.B and I.D. described in Attachment G? Do they indicate how these criteria will be applied through the ADRC to identify at-risk individuals to be diverted? (10 points)
- d. Does the applicant provide evidence to document that they operate or have a relationship with an ADRC that, at a minimum, has the operational capacity, directly or through a seamless system, by the 12th month of the project period to:
- Assess the needs of individuals in the target group; provide them with options counseling; and, as needed, work with them to develop care plans or refer them to care management/support brokers for this task;
 - Coordinate with program case managers and community-based service providers, including aging services provider organizations, to assist the targeted individuals identified by the ADRC to rapidly arrange for and deliver the home and community-based services and supports that are needed to help these individuals avoid nursing home placement and spend-down;
 - Assess targeted individuals potential eligibility for publicly supported long-term care services and supports;
 - Be operationally integrated with – or so closely coordinated with –the Medicaid eligibility determination functions (both programmatic and financial) to ensure that individuals who are determined to be ineligible for Medicaid are immediately and seamlessly referred to the Community Living Program project supported under this grant Announcement.

- Be using formal protocols and other tools across and by key stakeholder organizations (e.g., aging services providers, AAA's, hospitals, nursing homes, Centers for Independent Living, VHA, etc.) for making client referrals; prioritizing clients; authorizing services, and following-up with clients?
(10 points)

e. Does the applicant describe a case management/care coordination program that is able to work with targeted individuals to help them develop and manage individual budgets and services based on the individuals' needs for both services and goods that support them in the home and community? Will this program be able to adapt to meet the full and changing needs of individuals served under this project?
(10 points)

f. Is the number of clients to be served by the end of the 24 month Project Period a significant number given the population of the state, population of the pilot area(s), the estimated number of people likely to be at risk of nursing home placement and spend down to Medicaid and other factors described in the application? Does the enrollment strategy and "ramp-up" plan demonstrate growth toward program sustainability? (5 points)

g. Is there a system proposed for tracking individual clients and for analyzing and reporting the data, including data that can be used to document the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down, and the cost avoidance being achieved for Medicaid? Projects must be able to report on, at a minimum the client-level data listed in Attachment J. Does the applicant commit to work with AoA and other successful applicants in the development and use of a common data set?
(10 points)

3. Organizational Capability Statement (Weight – 10 Points)

Did the applicant describe the organizational capacity of the SUA and its partners including the AAAs, community-based aging services providers, ADRC, FMS provider, and other stakeholders to implement and administer the CLP grant, and are these partners likely to coordinate as planned and succeed in achieving the project's goals and objectives and in advancing the systems changes called for in the Announcement (see Page 1)? (5 points)

Are project staff and their roles and responsibilities clearly described? Are the roles of any contract organizations clear and reasonable? (5 points)

4. Project Management, Work Plan and Budget (Weight – 10 Points)

- Did the applicants provide a realistic timetable and work plan that outlines the extent to which they will be able to complete each activity as required by the 12th month and within the 24 month project period? (5 points)

- Does the budget realistically reflect the goals, objectives and activities outlined in the work plan? (5 points)

5. Sustainability

(Weight – 10 Points)

Is there a plan for sustaining the system changes called for in the Announcement (see Page 1) and implemented by the project beyond the 24 month project period? Does the applicant describe key changes that will be made to the way existing federal and state programs are administered so they can be used consistent with the purposes of this Program Announcement and embedded into the fabric of the long term care delivery system in the state or pilot area? Does the applicant describe a plan for leveraging other resources to ensure the sustainability of the project? Are there letters of commitment from key partners? Does the applicant describe how this effort will coordinate with other long-term care programs and rebalancing efforts in the state? (10 points)

2. Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, State and local government, and federal government agencies. Based on the specific programmatic considerations as outlined under Section I.5, ‘Funding Opportunity Description’, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the criteria identified above.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; geographic distribution; program diversity; whether the state is receiving funding under the CMS Real Choice Systems Change grant program, and the likelihood that the proposed project will result in the benefits expected.

Applicants have the option of omitting from the application copies (not the original) specific salary rates or amounts for individuals specified in the application budget and Social Security Numbers. The copies may include summary salary information.

SECTION VI. AWARD ADMINISTRATION INFORMATION

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement, located at:

<http://www.hhs.gov/grantsnet/adminis/gpd/index.htm>.

3. Reporting

The SF-269 (Financial Status Report) is due annually and the AoA program progress report is due semi-annually. Final performance and SF-269 reports are due 90 days after the end of the project period.

SECTION VII. AGENCY CONTACTS

AoA CLP Project Officer:

U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Joseph Lugo
Telephone: (202) 357-3417, e-mail: joseph.lugo@aoa.hhs.gov

AoA Grants Management Officer:

U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Margaret Tolson
E-mail: margaret.tolson@aoa.hhs.gov

U.S. Veterans Health Administration Contacts

VA Central Office
Geriatrics & Extended Care
Washington, DC

- Attn: Daniel J. Schoeps
Director, Long-Term Care Purchasing
Telephone: (202) 461-6763, e-mail: daniel.schoeps@va.gov
- Attn: Patrick Brady
Coordinator, Purchased Long-Term Care Reimbursement
Telephone: (202)-461-6787, e-mail: patrick.brady@va.gov

VIII. OTHER INFORMATION

1. Application Elements

- A. SF 424 – Application for Federal Assistance.

B. SF 424A – Budget Information.

C. Separate Budget Narrative/Justification (See Attachments for Sample Format).

NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. Also, when more than 33% of a project’s total budget is listed in the contractual line item, detailed Budget Narratives/Justifications are REQUIRED for each sub-contractor or sub-grant for each year of potential grant funding.

D. SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

E. Lobbying Certification

F. Proof of non-profit status, if applicable

G. Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

H. Project Narrative with Work Plan (See Attachment D for Sample Work Plan Format).

I. Organizational Capability Statement and Vitae for Key Project Personnel.

J. Letters of Commitment from Key Partners.

K. “Survey on Ensuring Equal Opportunity for Applicants” (Optional non-profit applicants)

2. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

The project description and budget justification is approved under OMB control number 0985-0018 which expires on 05/31/2010.

Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

ATTACHMENTS:

**Attachment A:
Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative and Other
Required Forms**

**Attachment B:
Budget Justification Format – Sample Format with Examples**

**Attachment C:
Budget Justification – Sample Format**

**Attachment D:
Project Work Plan - Sample Format**

**Attachment E:
Instructions for Completing the Summary/Abstract**

**Attachment F:
Fully Functional Criteria for Aging and Disability Resource Centers**

**Attachment G:
Standards for a Community Living Program**

**Attachment H:
Grant Program Cooperative Agreements**

**Attachment I:
Special Opportunity To Serve Veterans: Veterans Directed Home and Community Based
Service Program Option**

**Attachment J:
Proposed Minimum Data Elements**

**Attachment K:
“Estimated Number of Eligible Individuals for Community Living Program by State”**

**Attachment L:
Financial Management Services: Models and Providers**

**Attachment M
Veteran Directed Home and Community Based Program Standards**

**Attachment N
Definitions**

Attachment A

Instructions for completing the SF 424, Budget (SF 424A), Budget Narrative/Justification, and Other Required Forms

This section provides step-by-step instructions for completing the four (4) standard Federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. AoA does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

a. Standard Form 424

1. **Type of Submission:** (Required): Select one type of submission in accordance with agency instructions.

• Pre-application • Application • Changed/Corrected Application – If AoA requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application:** (Required) Select one type of application in accordance with agency instructions.

• New • Continuation • Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier:** Leave this field blank

5a **Federal Entity Identifier:** Leave this field blank

5b. **Federal Award Identifier:** For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information:** Enter the following in accordance with agency instructions:

a. **Legal Name:** (Required): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website.

b. Employer/Taxpayer Number (EIN/TIN): (Required): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

c. Organizational DUNS: (Required) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website.

d. Address: (Required) Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable) that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. Type of Applicant: (Required) Select the applicant organization "type" from the following drop down list.

A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. Name of Federal Agency: (Required) Enter U.S. Administration on Aging

11. Catalog of Federal Domestic Assistance Number/Title: The CFDA number can be found on page one of the Program Announcement.

12. Funding Opportunity Number/Title: (Required) The Funding Opportunity Number and title of the opportunity can be found on page one of the Program Announcement.

13. Competition Identification Number/Title: Leave this field blank.

14. Areas Affected By Project: List the largest political entity affected (cities, counties, state etc).

15. Descriptive Title of Applicant’s Project: (Required) Enter a brief descriptive title of the project.

16. Congressional Districts of: (Required) 16a. Enter the applicant’s Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina’s 103rd district. • If all congressional districts in a state are affected, enter “all” for the district number, e.g., MD-all for all congressional districts in Maryland. • If nationwide, i.e. all districts within all states are affected, enter US-all.

17. Proposed Project Start and End Dates: (Required) Enter the proposed start date and final end date of the project. Therefore, if you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date.

18. Is Application Subject to Review by State Under Executive Order 12372 Process?
Check c. Program is not covered by E.O. 12372

19. Is the Applicant Delinquent on any Federal Debt? (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

20. Authorized Representative: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body’s authorization for you to sign this application as the official representative must be on file in the applicant’s office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this AoA program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a one year budget.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 3: Enter the breakdown of how you plan to use the Federal funds being requested by object class category (see instructions for each object class category below).

Column 4: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 3 and 4) by object class category.

Separate Budget Narrative/Justification Requirement

You must submit a separate Budget Narrative/Justification as part of your application. When more than 33% of a project's total budget falls under contractual, detailed Budget Narratives/Justifications must be provided for each sub-contractor or sub-grantee.

Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: Federal; non-Federal cash; and non-Federal in-kind. Cost breakdowns, or justifications, are required for any cost of \$1,000 or more. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-Federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification. The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: Personnel: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants; consultant costs should be included under 6h - other.

In the Budget Narrative/Justification: Identify the project director, if known. Specify the key staff, their titles, brief summary of project related duties, and the percent of their time commitments to the project in the Budget Narrative/Justification.

Line 6b: Fringe Benefits: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate. **In the Justification:** Provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement insurance, etc.

Line 6c: Travel: Enter total costs of **out-of-town travel** (travel requiring per diem) for staff of the project. Do not enter costs for consultant's travel - this should be included in line 6h. **In the Justification:** Include the total number of trips, destinations, purpose, length of stay and subsistence allowances and transportation costs (including mileage rates).

Line 6d: Equipment: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. If the item does not meet the \$5,000 threshold, include it in your budget under Supplies, line 6e. **In the Justification:** Equipment to be purchased with Federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions; the equipment, or a reasonable facsimile, must not be otherwise available to the applicant or its sub-grantees. The justification also must contain plans for the use or disposal of the equipment after the project ends.

Line 6e: Supplies: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d. **In the Justification:** Provide general description of types of items included.

Line 6f: Contractual: Enter the total costs of all contracts, including (1) procurement contracts (except those, which belong on other lines such as equipment, supplies, etc.). Also include any contracts with organizations for the provision of technical assistance. Do not include payments to individuals or consultants on this line. **In the Budget Narrative/Justification:** Attach a list of contractors indicating the name of the organization, the purpose of the contract, and the estimated dollar amount. If the name of the contractor, scope of work, and estimated costs are not available or have not been negotiated, indicate when this information will be available. **Whenever the applicant/grantee intends to delegate more than 33% of a project's total budget to the contractual line item, the applicant/grantee must provide a completed copy of Section B of the SF 424A Budget Categories for each sub-contractor or sub-grantee, and separate Budget Narrative/Justification for each sub-contractor or sub-grantee for each year of potential grant funding.**

Line 6g: Construction: Leave blank since construction is not an allowable cost under this AoA program.

Line 6h: Other: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits); non-contractual fees and travel paid directly to *individual* consultants; **local** transportation (all travel which does not require per diem is considered local travel); postage; space and equipment rentals/lease; printing and publication; computer use; training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs. **In the Justification:** Provide a reasonable explanation for items in this category. For individual consultants, explain the

nature of services provided and the relation to activities in the work plan. Describe the types of activities for staff development costs.

Line 6i: Total Direct Charges: Show the totals of Lines 6a through 6h.

Line 6j: Indirect Charges: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency; or (2) the applicant is a state or local government agency.

Budget Narrative/Justification: **State governments should enter the amount of indirect costs determined in accordance with DHHS requirements.** An applicant that will charge indirect costs to the grant **must enclose a copy of the current indirect cost rate agreement.** If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

If the applicant organization is in the process of initially developing or renegotiating a rate, it should immediately upon notification that an award will be made, develop a tentative indirect cost rate proposal based on its most recently completed fiscal year in accordance with the principles set forth in the cognizant agency's guidelines for establishing indirect cost rates, and submit it to the cognizant agency. Applicants awaiting approval of their indirect cost proposals may also request indirect costs. It should be noted that when an indirect cost rate is requested, those costs included in the indirect cost pool should not also be charged as direct costs to the grant. Also, if the applicant is requesting a rate which is less than what is allowed under the program, the authorized representative of the applicant organization must submit a signed acknowledgement that the applicant is accepting a lower rate than allowed.

Line 6k: Total: Enter the total amounts of Lines 6i and 6j.

Line 7: Program Income: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project. Program Income must be used as additional program costs and can not be used as match (non-Federal resource).

Section C - Non-Federal Resources

Line 12: Enter the amounts of non-Federal resources that will be used in carrying out the proposed project, by source (Applicant; State; Other) and enter the total amount in Column (e). Keep in mind that if the match requirement is not met, Federal dollars may be reduced.

Section D - Forecasted Cash Needs - Not applicable.

Section E - Budget Estimate of Federal Funds Needed for Balance of the Project

Line 20: Section E is relevant for multi-year grant applications, where the project period is 24 months or longer. This section does not apply to grant awards where the project period is less than 17 months.

Section F - Other Budget Information

Line 22: Indirect Charges: Enter the type of indirect rate (provisional, predetermined, final or fixed) to be in effect during the funding period, the base to which the rate is applied, and the total indirect costs. Include a copy of your current Indirect Cost Rate Agreement.

Line 23: Remarks: Provide any other comments deemed necessary.

c. Standard Form 424B - Assurances

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration on Aging. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

e. Other Application Components

Survey on Ensuring Equal Opportunity for Applicants

The Office of Management and Budget (OMB) has approved an HHS form to collect information on the number of faith-based groups applying for a HHS grant. Non-profit organizations, excluding private universities, are asked to include a completed survey with their grant application packet. Attached you will find the OMB approved HHS "Survey on Ensuring Equal Opportunity for Applicants" form (Attachment F). Your help in this data collection process is greatly appreciated.

Proof of Non-Profit Status

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.

- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment B: Budget Narrative/Justification, Page 1 – Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	\$40,000	\$5,000		\$45,000	Project Supervisor (name) = .3FTE @ \$50,000/yr = \$15,000 (\$10,000 = Federal; \$5,000 = Non-Federal cash) Project Director (name) = 1FTE @ \$30,000 (Federal) = \$30,000 TOTAL: = \$45,000
Fringe Benefits	\$12,600	0	0	\$12,600	Fringes on Supervisor and Director @ 28% of salary. (Federal) FICA (7.65%) = \$ 3,442 Health (12%) = \$ 5,400 Dental (5%) = \$ 2,250 Life (2%) = \$ 900 Workers Comp Insurance (.75%) = \$ 338 Unemployment Insurance (.6%) = \$ 270 TOTAL: = \$12,600
Travel	\$2,450	\$1,547		\$3,997	Travel to Annual Grantee Meeting: (Federal) Airfare: 1 RT x 2 people x \$750/RT = \$1,500 Lodging: 3 nights x 2 people x \$100/night = \$ 600 Per Diem: 4 days x 2 people x \$40/day = \$ 320 TOTAL: = \$2,420 Out-of-Town Project Site Visits (Non-Federal cash) Car mileage: 3 trips x 2 people x 350 miles/trip x \$.365/mile = \$ 767 Lodging: 3 trips x 2 people x 1 night/ trip x \$50/night = \$ 300 Per Diem: 3 trips x 2 people x 2days/trip x \$40/day = \$ 480 TOTAL: = \$1,547

NOTE: Applicants requesting funding for multi-year grant programs MUST provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required.

Attachment B: Budget Narrative/Justification, Page 2 - Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Equipment Equipment is non-expendable, tangible personal property having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. If the individual item does not cost more than \$5,000, include it in your budget under Supplies	0	0	0	0	No equipment requested
Supplies	\$1,340	\$2,160		\$3,500	Laptop computer for use in client intakes (Federal) = \$1,340 Consumable supplies (paper, pens, etc.) \$100/mo x 12 months = \$1,200 (Non-Federal cash) Copying \$80/mo x 12 months = \$ 960 (Non-Federal cash) TOTAL: = \$3,500

Attachment B: Budget Narrative/Justification, Page 3 – Sample Format with EXAMPLES

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Other Note: Items such as Video Production shown in this example, which are priced at a set fee, still require a cost breakdown.	\$10,000	\$8,000	\$19,800	\$37,800	Local conf registration fee (provide conference name) =\$ 200 (Non-Fed cash) Printing brochures (50,000 @ \$0.05 ea) = \$ 2,500 (Non-Fed cash) Video production (set fee) = \$19,800 (Non-Fed in-kind) Video Reproduction = \$ 3,500 (Non-Fed cash) NF Respite Training Manual reproduction \$3/manual x 2000 manuals = \$ 6,000 (Federal) Postage: \$150/mo x 12 months = \$ 1,800 (Non-Fed cash) Caregiver Forum meeting room rentals \$200/day x 12 forums = \$ 2,400 (Federal) Respite Training Scholarships = \$ <u>1,600</u> (Federal) - (16 scholarships @ \$100 each) TOTAL \$37,800

TOTAL	\$266,390 75% or less of Total Cost (Federal \$)	\$16,707* (Non- Federal Cash Match)	\$72,300* (Non- Federal In-Kind Match)	\$355,397	
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***Be sure Non-Federal Cash and Non-Federal In-Kind match equals the total program specific match requirements; 25% required match used for example purposes only**

Attachment C: Budget Narrative/Justification — Sample Template

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL					

Attachment D: Project Work Plan, Page 1 – Sample Template

Goal:

Measurable Outcome(s):

Major Objectives

Key Tasks

Lead Person

TimeFrame
(Start/End Dates by Month in

Project Cycle)

			1	2	3	4	5	6	7	8	9	10	11	12
1.														
2.														
3.														

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Attachment D: Project Work Plan, Page 2 – Sample Format

Goal:

Measurable Outcome(s):

Major Objectives

Key Tasks

Lead Person

TimeFrame
(Start/End Dates by Month in

Project Cycle)

			1	2	3	4	5	6	7	8	9	10	11	12
4.														
5.														
6.														

NOTE: Please do not infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Attachment E

Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, please limit the length to no more than 265 words on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

Goal(s) – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be

Objective(s) – narrow, more specific, identifiable or measurable steps toward a goal; part of the planning process or sequence (the “how”); specific performances which will result in the attainment of a goal.

Outcomes - measurable results of a project; positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities; (outcomes are the end-point).

Products – materials, deliverables.

- A model abstract/summary is provided below:

The grantee, Okoboji University, supports this three year Dementia Disease demonstration (DD) project in collaboration with the local Alzheimer's Association and related Dementias groups. The **goal** of the project is to provide comprehensive, coordinated care to individuals with memory concerns and to their caregivers. The approach is to expand the services and to integrate the bio-psycho-social aspects of care. The **objectives** are: 1) to provide dementia specific care, i.e., care management fully integrated into the services provided; 2) to train staff, students and volunteers; 3) to establish a system infrastructure to support services to individuals with early stage dementia and to their caregivers; 4) to develop linkages with community agencies; 5) to expand the assessment and intervention services; 6) to evaluate the impact of the added services; 7) to disseminate project information. The expected **outcomes** of this DD project are: patients will maintain as high a level of mental function and physical functions (thru Yoga) as possible; caregivers will increase ability to cope with changes; and pre and post – project patient evaluation will reflect positive results from expanded and integrated services. The **products** from this project are: a final report, including evaluation results; a website; articles for publication; data on driver assessment and in-home cognitive retraining; abstracts for national conferences.

Attachment F

Fully Functioning ADRC/ADRC Type Program

These criteria were developed to assist states measure and assess their progress toward developing fully functioning ADRCs. These criteria and recommended metrics are intended to be applicable across different types of ADRC models. Depending on the model of ADRC a state is implementing, the term may be interpreted to represent one operating organization in each community at the local level, a network of organizations serving as operating partners in each community at the local level, or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted or applied differently to systems with a “single entry point” than to systems where there are “multiple entry points” are noted.

Program Component	Criteria/ Description	Recommended Metrics
Awareness and Information	<p><i>Public education; information on long-term support options.</i></p> <ul style="list-style-type: none"> • ADRCs serve as highly visible and trusted places where people can turn for the full range of long-term support options. • Actively promote public awareness of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations. 	<ul style="list-style-type: none"> • The ADRC has a proven outreach and marketing plan in place that takes into consideration: (a) culturally diverse, underserved and unserved populations, their family caregivers, and the professionals who serve them through focused outreach and community education; (b) the identification of unique needs of the different populations being served; (c) a strategy to assess the effectiveness of the outreach and marketing activities; and (d) a feedback loop to modify activities as needed. • The ADRC has a comprehensive resource database which includes information about the range of long term support options in the ADRC service area. Information regarding providers, programs, and services available in the SEP/ADRC service area (including for private-payment) is collected into a central database. <ul style="list-style-type: none"> - Resources included in the database conform to established Inclusion/Exclusion policies. - A system is in place for updating and ensuring the accuracy of the information provided. - The database is accessible to the public via a comprehensive website and is user friendly, searchable and accessible to persons with disabilities. - Statewide coverage for the database is preferable. • The ADRC may have a single or multiple entry points within the service area. All agencies operating entry points (operating partners) have access to the same comprehensive resource database and provide consistent and uniform information. • The ADRC actively markets to and serves private pay consumers in addition to those that require public assistance.

Program Component	Criteria/ Description	Recommended Metrics
<p>Options Counseling</p>	<p><i>Long-term support options counseling; benefits counseling; employment options counseling; referral to other programs and benefits; crisis intervention; helping people to plan for their future long-term support needs.</i></p> <ul style="list-style-type: none"> The ADRC will provide information and counseling to help people assess their potential need and eligibility for all available long-term support options, both public and private. ADRC has the capacity to link consumers with needed support through appropriate referrals to other programs and benefits and has the ability to track client intake, needs assessment, and care plans. ADRC has established collaborative relationships with programs that provide home and community-based services including SHIP, NFCSP, Alzheimer’s Disease services, health promotion and disease prevention programs, transportation, employment, housing, adult education and others. ADRC consistently conducts follow-up when needed to determine outcome of options counseling. ADRC enables people to make informed, cost-effective decisions about long term care. ADRC has process to ensure that people are connected to the appropriate crisis intervention services. ADRC assists individuals to plan for future long-term care needs. 	<p><u>Options Counseling</u></p> <ul style="list-style-type: none"> ADRC has the capability, either through a single operating organization or through close coordination among operating partners, to provide accurate and comprehensive long term support options counseling to any consumer who requests it. All ADRC entry point agencies use standard intake and screening instruments. Protocols are in place to identify consumers who will be offered options counseling. At a minimum, this will include consumers who have gone through a comprehensive assessment process. Options counseling sessions: (a) entail individualized assistance; (b) are provided in a uniform manner to all SEP/ADRC consumers with the use of protocols or standard operating procedures; and (c) are conducted by staff qualified to provide objective assistance to consumers in the process of making informed decisions, as evidenced by certification requirements and/or training/cross-training practices. SEP/ADRC can demonstrate evidence that options counseling provided enables people to make informed, cost-effective decisions about long-term care services. <p><u>Information and Referral</u></p> <ul style="list-style-type: none"> ADRC uses systematic processes across all entry points to provide information, referral and access to services. These services include, at a minimum: <ul style="list-style-type: none"> Public benefits (OAA, Medicaid, Medicare including new Medicare Modernization Act benefits, state revenue programs and others) Employment Health promotion/disease prevention Transportation Crisis/Emergency services Services for family caregivers Residential care including assisted living <p><u>Referrals and Follow Up</u></p> <ul style="list-style-type: none"> SEP/ADRC has the ability to track referrals made. SEP/ADRC consistently conducts follow-up to determine outcome of options counseling. <p><u>Crisis Intervention</u></p> <ul style="list-style-type: none"> ADRC responds to situations requiring short-term assistance to support an individual until a plan for long-term support services is in place. Short-term case management is available as needed for all target populations and provided directly by SEP/ADRC (by at least one operating partner in multiple entry point systems), or is contracted out. <p><u>Future Long Term Support Needs Planning</u></p> <ul style="list-style-type: none"> Evidence of one of the following: (1) SEP/ADRC is involved with Own Your Future Campaign; (2) SEP/ADRC is a pilot Home Equity Conversion Mortgage counseling site; or (3) SEP/ADRC provides futures planning directly or contractually by staff who possess specific skills related to LTC needs planning and financial counseling.

Program Component	Criteria/ Description	Recommended Metrics
Access	<p><i>Eligibility screening; assistance in gaining access to private-pay long-term support services; comprehensive assessment; programmatic eligibility determination; Medicaid financial eligibility determination that is integrated or closely coordinated with the Resource Center services; one-stop access to all public programs for community and institutional long-term support services.</i></p> <ul style="list-style-type: none"> ADRC serves as the entry point to publicly funded long term care. The ADRC has in place necessary protocols and procedures to facilitate access (intake, eligibility, assessment) to public programs that is integrated or so closely coordinated that the process is seamless for consumers. ADRC support helps to reduce the cost of long term care by delaying or preventing the need for more expensive public long term care services. 	<ul style="list-style-type: none"> ADRC has a single, standardized entry process for accessing public and private services. In multiple entry point systems, the entry process is coordinated and standardized so that consumers experience the same process wherever they enter the system. For ADRCs with multiple entry points, the entry processes are overseen by a coordinating entity. Financial and functional eligibility determination processes are highly coordinated. ADRC uses uniform criteria across sites to assess risk of institutional placement in order to target support to individuals at high-risk. ADRC staff conducts level of care assessments that are used for determining functional eligibility, or SEP/ADRC has a formal process in place for seamlessly referring consumers to the agency that conducts level of care assessments. ADRC staff assists consumers as needed with initial processing functions (e.g., taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews. 42 CFR 435.904). Staff located on-site within the ADRC/SEP can determine financial eligibility (staff co-located from or delegated by the Single State Medicaid Agency), or ADRC/SEP staff can submit completed applications to the agency authorized to determine financial eligibility directly on behalf of consumers. ADRC is able to track individual consumers' eligibility status throughout the process of eligibility determination and re-determination. In localities where waiting lists for public LTC programs or services exist, there is a process by which the SEP/ADRC is informed of consumers who are on the waiting list and the SEP/ADRC conducts follow-up with those individuals. There is a process by which the SEP/ADRC is informed of consumers who are determined ineligible for public LTC programs or services and the SEP/ADRC conducts follow-up with those individuals. ADRC has a plan for reducing the average time from first contact to eligibility determination and the average time is below current time requirement. There is a reduction in the rate of institutional placement in the ADRC service area. ADRC tracks diversions and transitions (i.e., # Community Living Programs attempted and # of successful diversions; # nursing home relocations to community completed). ADRC can report the proportion of consumers requesting services that actually receive them. ADRC has a plan for streamlining access to long-term care signed by the State Medicaid Agency, State Unit on Aging and the State agency(s) representing target population(s) of people with disabilities. (Streamlining Access Plan).

Program Component	Criteria/ Description	Recommended Metrics
Target Populations	<p>ADRCs must serve the elderly and at least one target population of people with disabilities (e.g. physical; developmental/mental retardation; mental illness). ADRC projects should move towards the goal of serving persons with disabilities of all ages and types.</p>	<ul style="list-style-type: none"> The ADRC tracks the number of actual individuals served against the resident population estimate, by target population. ADRC demonstrates competencies relating to serving all of its target populations. ADRC is accessible to all of the populations it serves. There is evidence that the SEP/ADRC is moving towards the goal of serving all persons with disabilities, either through a single operating organization or through close coordination among operating partners.
Critical Pathways to Long Term Support	<p>ADRCs will create formal linkages between and among the critical pathways to long-term support.</p>	<ul style="list-style-type: none"> ADRC has "formal linkages" that involve all three of the following components that are updated on an ongoing basis: <ol style="list-style-type: none"> providing training and education about the SEP/ADRC to critical pathway providers (CPPs); involving CPPs in advisory board representation; and establishing protocols for referrals, particularly with hospitals and LTC facilities.
Partnerships & Stakeholder Involvement	<p>ADRCs must have the documented support and active participation of the Single State Agency on Aging, the Single State Medicaid Agency and the State Agency(s) serving the target populations(s) of people with disabilities.</p> <p>ADRCs must establish strong partnerships with the State Health Insurance Assistance Program (SHIP) and other programs instrumental to ADRC activities. Examples of other programs include Alzheimer's disease programs, Area Agencies on Aging, Centers for Independent Living, Developmental Disabilities Councils, Information and Referral/2-1-1 programs, Long-Term Care Ombudsman programs, housing agencies, transportation authorities, State Mental Health Planning Councils, One-Stop Employment Centers and other community-based organizations.</p> <p>ADRCs must meaningfully involve stakeholders, including consumers, in planning, implementation and evaluation activities.</p>	<p><u>Medicaid</u></p> <ul style="list-style-type: none"> ADRC has an agreement with Medicaid agency to ensure that access to Medicaid benefits is as streamlined as possible for consumers; MOU describes explicit role of each agency and information sharing policies. <p><u>Aging and Disability Partners</u></p> <ul style="list-style-type: none"> There is evidence of collaboration, including formal agreements, at the state and pilot level between aging and disability partners. ADRC has protocols for information sharing and cross-training across entry point operating partners and with other critical aging and disability services partners in the community. <p><u>Stakeholders</u></p> <ul style="list-style-type: none"> If the ADRC and SHIP are operated by separate entities, there is a MOU or Interagency Agreement establishing, at a minimum, a protocol for mutual referrals. There is evidence of strong collaboration with programs and services instrumental to SEP/ADRC activities including home and community-based service providers, residential care alternatives including assisted living, institutional care providers, hospitals and other critical pathways and others. <p><u>Consumers</u></p> <ul style="list-style-type: none"> Formal mechanisms for consumer involvement have been established, including consumer representation on the state/local SEP/ADRC advisory board or governing committee and there is evidence that consumers have been involved in planning, implementation and evaluation activities.

Program Component	Criteria/ Description	Recommended Metrics
IT/MIS	<p><i>The ADRC program must have a management information system that supports the functions of the program including tracking client intake, needs assessment, care plans, utilization and costs.</i></p>	<ul style="list-style-type: none"> • ADRC uses a management information system that can support the program functions. • ADRC can submit evidence of reports on the following: <ul style="list-style-type: none"> - # of unduplicated consumers YTD - Referrals for current month, referring agency/entity, # referrals under age 60; # referrals age 60 and older. <ul style="list-style-type: none"> ○ Types of assistance provided ○ Timing of eligibility determinations ○ Information regarding level of impairment and preferred support need ○ Disposition/placements (ex. waiver, institution) • ADRC has established an efficient process for sharing information electronically with external entities, as needed, from intake to service delivery. In multiple entry point systems, all entry points use MIS that allows for electronic exchange of resource and client data across entry points and with other partners, as appropriate.
Evaluation Activities	<p><i>At a minimum, ADRCs must have performance goals and indicators related to visibility, trust, ease of access, responsiveness, efficiency and effectiveness.</i></p>	<ul style="list-style-type: none"> • ADRC is measuring performance related to the established indicators. • ADRC can demonstrate ability to develop reports summarizing issues and making recommendations for corrective action or quality improvement based on performance indicators. • ADRC has used information obtained from consumer satisfaction evaluations to improve performance. • ADRC can demonstrate ability to document the impact on nursing home use • ADRC can demonstrate the ability to document the impact on the use of home and community based services. • ADRC can demonstrate a reduction in the average time from first contact to eligibility determination for publicly funded home and community-based services. • ADRC informs consumers of complaint and grievance policies and has the ability to track and address complaints and grievances. • ADRC has a plan in place to monitor program quality and a process to ensure continuous program improvement through the use of the data gathered.
Staffing and Resources	<ul style="list-style-type: none"> • Capacity • Quality • Any conflicts of interest have been addressed • Specialized training/gaps identified • Private and public funding opportunities are pursued to create sustainable programs 	<ul style="list-style-type: none"> • ADRC has adequate capacity to assist consumers in a timely manner with long term support requests and referrals, including referrals from critical pathway providers. • ADRC has an individual assigned to be the overall director/manager/coordinator of all ADRC operations. It is particularly important to have an overall coordinator or manager with sufficient authority to maintain quality processes when ADRC functions occur in more than one location or agency. • ADRC has conducted an assessment of potential funding sources such as Medicaid Federal Financial Participation, foundations and community organizations.

Attachment G:

Standards for Community Living Programs (formerly Nursing Home Diversion Programs)

Consistent with the new long-term care provisions in the OAA and the latest research and best practices from the field, AoA has identified standards for a Community Living Program. These standards include nine key elements. These elements are described in this Attachment and include both service elements and systems elements.

The **service elements** are designed to ensure that the program reaches its intended target population, and that the needs and preferences of consumers are fully considered in the design and implementation of the program. The **systems elements** of a Community Living Program are designed to ensure the effective and efficient administration of the program.

Consistent with the principle of local flexibility that has been a hallmark of the Older Americans Act, AoA will allow states to exercise considerable freedom in designing and implementing the service and system elements of a Community Living Program, including how to best phase in the implementation of the various elements over time. We expect and encourage states to demonstrate creativity and ingenuity in using the latest research and best practices to design their diversion programs. We believe this approach will help to advance the state-of-the-art by providing states with an opportunity to learn from one another as they develop and/or refine and implement their Community Living Programs.

The following standards describe the key design elements of a state-of-the-art Community Living Program targeted at individuals who are not eligible for Medicaid.

I. Service Elements:

A. Flexible Service Dollars that Follow the Needs of Individuals

Community Living Programs that support the needs of individuals at risk of nursing home placement and spend down to Medicaid need to be responsive to the needs of the consumer. A fully flexible, consumer-responsive program means that the funding is not tied to any particular service, or package of services, nor to any particular type, or types, of providers. Additionally, certain fiscal management techniques, such as per-capita and unit rate budgeting, help support the delivery of flexible service models and consumer-directed approaches. Within the statutory structure of the current Older American's Act which contains separate Title's or funding streams, State Units on Aging (SUAs) and/or Area Agencies on Aging (AAAs) can base client funding decisions on the needs of consumers rather than the source of the funding.

The funding used to support a Community Living Program should be flexible, so that it can be fully responsive to the individualized needs and preferences of consumers. This includes the capacity to respond rapidly to the often changing needs and circumstances facing at risk consumers.

Research on systems change efforts, such as those undertaken by CMS Real Choice Systems Change grantees, suggests that the most effective systems change efforts undertaken to-date by states include mechanisms to change long-term service systems from being provider- and service-driven to systems that are consumer-driven, and that it is critical that states concentrate on efforts and best practices that focus on consumer's needs. (See *Unlocking the Code of Effective Systems Change* located on the Technical Assistance Website at www.adrc-tae.org)

B. Targeting Individuals at High Risk of Nursing Home Placement

Targeting individuals at high risk of nursing home placement is an essential element of any Community Living Program. The earliest Community Living Programs used targeting criteria that focused on a person's functional status, such as the number of impairments in activities of daily living. Since these early efforts, the state-of-the-art has advanced considerably. Today, the more advanced Community Living Programs use multiple targeting criteria that go beyond functional status to include factors that relate to the individual's health and cognitive status and the status of their informal support system.

In addition to the state's functional definition of nursing home level of care, a Community Living Program should use multiple risk factors in its targeting criteria to ensure that the program has a high likelihood of reaching individuals who are, in fact, at high-risk of institutionalization. At a minimum, at least four domains must be addressed by these risk factors:

- ***Functional status*** which includes ability to perform activities of daily living and instrumental activities of daily living.
- ***Health status*** which includes diagnoses (e.g., diabetes, fall-related fractures) and medical/skilled care needs (e.g., nursing, therapies) and can be evidenced by a hospitalization or a prior nursing facility stay and the use of medications.
- ***Cognitive/emotional status***, which includes cognitive impairments, impairments in decision-making ability, inability to make decisions to avoid injury in emergency situations, etc.
- ***Informal support system status***, which may include the existing capacity of caregivers to assist in the provision of support, as well as the lack of informal support.

Many States are already using some of these risk factors in their existing eligibility criteria for public programs. Additional information is located on the Technical Assistance Website at www.adrc-tae.org.

C. Giving Consumers the Option to Use a Consumer-directed Model

A Community Living Program should give consumers the maximum degree of control possible, or desired, over decisions affecting the types of services and supports they receive, as well as the manner in which the services and supports are provided. AoA believes all consumers receiving long-term care from public programs should be offered – as a matter of choice - the option of controlling their own services through a consumer direction. If the consumer does not want, or is

not able to participate in, a consumer direction model, then a traditional form of care would be provided. For example under Cash and Counseling, individuals, or their representatives, manage a flexible budget, employ and pay workers, including family and friends, and purchase needed goods and services based on their specific needs and preferences. This model is reflected in the definition of “self-directed care” that was added to Title I of the OAA as a result of the 2006 Amendments.

The Cash and Counseling Demonstration provides clear evidence on the importance of using consumer-directed models of care. The evaluation of this three state demonstration, which was targeted at Medicaid clients who were at high-risk of nursing home placement, found that consumers who self-directed their services had better quality care, greatly improved quality of life, better health outcomes, and decreased utilization of more expensive services such as nursing home care. Additional information can be found at <http://www.cashandcounseling.org/index.html> and is included on the Technical Assistance Website at www.adrc-tae.org.

D. Targeting Individuals at High Risk of Medicaid Spend-down

In order to effectively target individuals who are at risk of Medicaid spend-down, states will have to develop an approach to understand how an individual’s income and assets relate to the state’s Medicaid financial eligibility criteria, and then use that information to determine the person’s risk of spending down. A number of states have developed different approaches to assess the risk of Medicaid spend-down. Minnesota, for example, in its Alternative Care Program, determines how long it may take an individual to spend-down if he/she were to enter a nursing facility, taking into account the combination of income and assets.

Additional information is located on the Technical Assistance Website at www.adrc-tae.org.

E. Complementing Caregiving and Individual Resources

Since its inception, Older Americans Act funding has been designed to fill gaps in services, not to fully fund the cost of all the services and supports needed by older individuals. Consistent with this philosophy and approach, a Community Living Program should complement other resources being deployed to support the consumer’s desire to remain at home. Of particular importance here are the personal and financial resources of the individual.

Variations in the amount of publicly supported services and/or supports that an individual receives should in no way preclude states from developing and operating Community Living Programs that serve individuals who are able to pay for their care. AoA strongly encourages states to develop Community Living Programs that not only serve individuals who need some form of public support to cover the cost of their care, but that also serve the growing number of individuals who are able to pay. For example, many states already have programs that can assist such individuals by helping them to assess their needs and then locate and/or help them to arrange for services that they directly purchase with their own resources.

Additional information is located on the Technical Assistance Website at www.adrc-tae.org.

II. System Elements

A. Using Single-Entry-Point Programs to Ensure Streamlined Access for Consumers

Single-Entry-Point systems perform functions that are essential to Community Living Program activities. For example, integrating access with Medicaid through a Single-Entry-Point system can ensure that those individuals who are screened by the entry point and found not eligible for Medicaid are seamlessly linked to the Community Living Program for non-Medicaid eligible individuals. Accordingly, to be effective, a “Single-Entry-Point” system needs to be integrated, in some manner, with the process that is used by the state to determine a person’s eligibility for Medicaid long-term care, and perform, at a minimum, the following functions for all those programs:

- Screening individuals to identify those most likely to benefit from the program, including performing preadmission nursing home screening which is a key component of any well-developed system of long-term care;
- Assessing the needs of the targeted individuals;
- Working with the individual and their caregivers to develop service plans;
- Linking consumers to needed services.
- Monitor and follow-up with the individuals being served to ensure services are provided and needs are being met.

Single-Entry-Point systems that are integrated, in some manner, with the process to provide streamlined access to all publicly funded long-term care programs can enable policy makers and program administrators to more effectively respond to individual needs, address system problems, and limit the unnecessary use of high-cost services, including institutional care.¹ The AoA/CMS funded Aging and Disability Resource Centers (ADRC) Program includes a “single point of entry” component that covers all publicly supported long-term care programs. For more detailed information on the components of a fully functional single point of entry system, additional information is located on the Technical Assistance Website at www.adrc-tae.org.

B. Infrastructure to Support Consumer-directed Service Approaches

The reauthorized OAA supports the use of consumer-directed models as an important element of a Community Living Program. For example, the Cash & Counseling model requires state and local programs to have the capacity to offer consumers the option of managing their own budgets, hiring their own workers, and purchasing necessary goods and services. This includes Financial Management Services and specialized care managers or support brokers. Financial Management Services involve payroll functions including paying taxes and insurance for the workers hired by consumers participating in the program. Support brokers are specially trained to counsel and assist consumers in directing their own care. Some of the functions of the support broker and/or Financial Management Services include:

¹ The Lewin Group (2006), The Aging and Disability Resource Center (ADRC) Initiative Interim Outcomes Report. www.adrc-tae.org.

- Training and assisting participants/representatives on recruiting, hiring, training, managing, evaluating and dismissing workers;
- Assisting participant/representative in developing an individual back-up plan;
- Processing payroll for directly hired workers in accordance with Federal, State and local tax, labor and worker compensation laws for domestic service employees and government or vendor fiscal/employer agents operating under Section 3504 of the IRS code²; and,
- Processing and making payments for goods and services in accordance with the participant's approved spending plan.

A full description of the operational systems and supports that a state needs to offer Cash and Counseling can be found on the website of the National Program Office for the Cash and Counseling Program at www.cashandcounseling.org. To the extent possible, a Community Living Program that chooses to use a Cash and Counseling program, should build on any existing Cash and Counseling program, including the infrastructures they developed for carrying out the necessary fiscal management and support broker functions.

More information on consumer direction can be found on <http://www.hcbs.org> and on the CLP Technical Assistance website at www.adrc-tae.org.

C. Quality Assurance

Any effective long-term care program must have a well-defined quality assurance program. Community Living Programs should adopt the CMS Quality Framework, or a similar quality assurance program, as the basis for development of the quality assurance component of their Programs. A well-developed quality assurance program enhances a state's capacity to determine if its long-term programs are operating as they were designed, and that the critical quality assurance processes of discovery, remediation, and systems improvement occur in a structured and routine manner.

Quality can assume several dimensions in community-based systems. The basic measures included in the CMS Quality Framework are:

- Participant access to services;
- Participant-centered service planning and delivery;
- Provider capacity and capabilities;
- Participant safeguards;
- Participant rights and responsibilities;
- Participant outcomes and satisfaction; and
- Systems performance.

² Oregon is the exception to this, for historical reasons.

A system of continuous quality improvement - remediation and systems improvement - results from examining and analyzing data to determine the meaning and significance for the program's operation. This includes sharing information with program administrators with responsibility and authority for program quality and interventions necessary to affect program improvements, using the information as a management tool to identify issues that need attention and remediation, and using subsequent measurements to gauge whether their interventions were successful or whether additional changes are necessary.

Quality monitoring, assessment and improvement activities in consumer-directed systems must involve consumer evaluation and must be focused on using data to enhance program quality. Quality monitoring systems might include complaint hotlines and program performance indicators. Quality assessment and improvement activities should involve mechanisms for stakeholder input and program self-assessment.

Information on the CMS Quality Framework can be found at: <http://www.cms.hhs.gov/HCBS/downloads/qualityframework.pdf>. In addition, "A Guide to Quality in Consumer-directed Services" and other information on quality in consumer-directed systems can be found at <http://www.cashandcounseling.org/index.html> and on the Technical Assistance Website at www.adrc-tae.org.

D. Performance Measurement and Evaluation

A state's Community Living Program must include a performance measurement program that can be used to continually track and evaluate the program's performance in achieving its goals and objectives. States must identify the relevant outcome and process evaluation factors they plan to use for their Community Living Program. At a minimum, states must plan for performance measurement and evaluation that includes the following factors:

- Change in consumer well being and quality of life;
- Numbers of consumers diverted from nursing home care;
- Numbers of consumers diverted from spending down to Medicaid;
- Documentation of cost-savings (or cost-neutrality) to public programs, including Medicaid, as compared to institutional care; and
- Decrease in State's Medicaid nursing home utilization.

The Performance Indicators being used in the Cash and Counseling replication offer a good model for developing a performance measurement and evaluation program. This can be accessed at www.cashandcounseling.org or on the Technical Assistance Website at www.adrc-tae.org.

Attachment H:
COMMUNITY LIVING PROGRAM GRANT
(HHS-2009-AoA-DR-0915)
COOPERATIVE AGREEMENT

Consistent with the Federal Grant and Cooperative Agreement Act of 1977 (P.L. 95-224), the **Grantee Name**, also herein referred to as the **grantee**, has received a Notice of Award to establish a Cooperative Agreement between the Administration on Aging (AoA) and the **grantee**. This Cooperative Agreement, whose terms are described below, provides for the substantial involvement and collaboration of AoA in activities the recipient organization will complete in accordance with the provisions of the approved grant award.

Grantee Responsibilities

As proposed in its approved application, the **grantee** agrees to carry out the objectives and activities of the project announced as the Community Living Program Grant. The **grantee** will design and implement a Community Living Program in accordance with the following conditions described in the *Promoting Community Living Through Community Living Program Cooperative Agreements* Announcement:

The **grantee** will partner with one or more Area Agencies on Aging (AAA), and work in collaboration with aging service provider organizations and other long-term care stakeholders, to modernize existing efforts to help individuals who are not eligible for Medicaid to avoid unnecessary nursing home placement and spend down to Medicaid.

Projects to be funded under this Announcement must:

1. No later than the end of the 12th month of the project period, have at least one local project up and running and delivering services to the high-risk individuals targeted under this Announcement in a way that:
 - A. Uses an ADRC program to identify individuals who are not eligible for Medicaid but are at imminent risk of nursing home placement and spend-down to Medicaid,
 - B. Uses formal protocols and other tools across, and by, key stakeholder organizations (e.g., ADRC, aging services providers, AAAs, hospitals, nursing homes, Centers for Independent Living, Veterans Health Administration, etc.) for making client referrals, prioritizing clients, authorizing services, and following-up with clients to ensure that the local project can rapidly provide home and community-based services and supports to the high –risk individuals who are identified by the ADRC program, and that the services for these individuals can be quickly adjusted as necessary as their needs change.

- C. Is able to provide Financial Management Services (FMS) to facilitate delivery of consumer directed services by providing necessary supports including payment for goods and services, payroll functions and reports.
 - D. Has in place formal SUA and AAA policies which are in effect—at least in the PSA(s) where the local project(s) are operating—that support the investment of some OAA dollars to serve the high-risk individuals who are targeted under this Announcement with flexible services and consumer directed options.
 - E. Be providing a full range of service options to the individuals who are targeted under this Announcement, as well as giving them the option to use consumer-directed models.
2. Projects funded under this Announcement must be able to monitor and follow-up with the individuals they are serving to ensure that the necessary services are being rapidly authorized and initiated, that client and family needs are being met, and that necessary adjustments in services are rapidly being made as the needs of the client and/or family caregiver change.
 3. Projects must also be able to track individual clients and be able to document and report on the effectiveness of the program in successfully diverting individuals away from long-term nursing home placement and Medicaid spend-down. At a minimum projects must be able to provide the data elements established by AoA.
 4. Agree to work with AoA, the CLP Technical Assistance Center, and the other CLP grantees to identify and collect common measures.
 5. Fully coordinate the project(s) with other state-administered long-term care programs and rebalancing efforts.
 6. Provide home and community-based services to significant numbers of clients in the target population in one or more geographic areas of the state over the 24 months of the grant period.

The **grantee** agrees that activities under this initiative will not duplicate activities funded under other resources.

AoA Responsibilities

The Administration on Aging agrees to work cooperatively in the development and execution of the activities of the project as follows:

- a. AoA Project Officer will perform the day-to-day Federal responsibilities of managing the Community Living Program Grants.
- b. AoA and the **grantee** will work cooperatively to clarify the programmatic and budgetary issues to be addressed by the project. Based on these negotiations, the **grantee** will revise

the project work plan detailing expectations for major activities and products during the 24 month grant. The work plan will include key tasks, timelines, and staff assignments. AoA or the **grantee** can propose a revision in the final work plan at any time. Any changes in the final work plan will require agreement of both parties.

- c. AoA will assist the **grantee** project leadership in understanding the policy concerns and/or priorities of AoA by conducting periodic briefings and by carrying out ongoing consultations.
- d. AoA will work with the **grantee** to ensure that the minimum requirements of the grant are met. Particular attention will be paid to the development of flexible service options and targeting criteria for identifying individuals at risk of institutionalization and spend down to Medicaid, and the use of Single Entry Point systems.
- e. AoA will work with the **grantee** on the development and implementation of evaluation and quality assurance systems in an effort to ensure consistency with program goals and the activities of other CLP grantees.
- f. AoA will designate technical assistance providers to design and implement, in cooperation with AoA, technical assistance to support grantee activities.

The grant period for this project is up to 24 months beginning no later than **September 30, 2009**.

Requests to modify or amend this Cooperative Agreement may be made at any time by AoA or the grantee. Any modifications and/or amendments shall be effective upon the mutual agreement of both parties.

Draw down of funding for this grant through the Federal Payment Management System serves as official acceptance of this Cooperative Agreement. If you do not plan to accept the grant award, please send a letter of declination to the AoA Grants Management Officer with a copy to the AoA Project Officer within 30 days of receipt of the Notice of Award.

Attachment I:
Special Opportunity to Serve Veterans
Veteran Directed Home and Community Based Service
Program Option

The Veterans Health Administration Intent

As a special component of the AoA CLP Grant Announcement, the Veterans Health Administration (VHA) is providing an additional opportunity to State Units on Aging (SUAs) and their Area Agency on Aging (AAAs) program sites to serve Veterans of any age at risk of nursing home placement through the Veteran Directed Home and Community Based Services Program (VDHCBS).

In FY2009, VHA provided over \$11 million to 15 VA Medical Centers (in 10 states) to work with SUAs and/or AAAs in developing VDHCBS programs in collaboration with AoA's Community Living Program. For FY2010 in collaboration with AoA and the CLP grants, VHA is seeking to expand the VDHCBS program to additional VAMCs and states and plans to invest \$4 million to serve Veterans at risk of nursing home placement.

For more information on the VDHCBS program, please refer to Attachment M of the Grant Announcement.

SUAs interested in this special opportunity should submit an additional application titled, “Attachment I: VDHCBS Program Option Application” along with their CLP grant application. Additional details regarding the application requirements are listed in “VDHCBS Program Option Application Process”.

Collaboration Between U.S. Veterans Health Administration and U.S. Administration on Aging

As directed by the President and Congress, through the reauthorization of the Older American's Act in 2006, the U.S. Administration on Aging (AoA), State Units on Aging, Area Agencies on Aging, ADRCs and aging service providers collectively known as “the Aging Network” are building an integrated home and community based long term care delivery system to serve the nation. The collaboration between AoA and VHA builds upon the similar missions of the administrations with regards to caring for the populations they serve and the drive for expanded home and community based long-term care options. Instead of duplicating efforts and resources, this initiative combines the commitment and resources of VHA with the experience of the Aging Network in providing more people, including Veterans, with additional opportunities to receive services that will allow them to remain in their homes and communities.

Who is Eligible to Apply for the VDHCBS Opportunity?

State Units on Aging that apply for the CLP grant are eligible to also apply to deliver the Veteran Directed Home and Community Based Service Program Option. **The VDHCBS Program Option application shall be submitted along with the CLP grant application.**

Who May Receive VDHCBS Awards?

State Units on Aging that submit a Veteran Directed Home and Community Based Service Program Option application along with their CLP grant application, and are selected by the VA.

VDHCBS Program Option Application Process:

To apply, the CLP grant application must contain an “Attachment I: VDHCBS Program Option Application”. The application shall include a brief narrative, a letter of commitment from the local VA Medical Center and letters of commitment from the State Unit on Aging and Area Agencies on Aging involved in the delivery of the VDHCBS program.

The proposal will include a brief narrative of the planned intervention and partnership that the State Unit on Aging, selected AAA program site(s), and VA Medical Center(s) will employ.

The narrative at a minimum is to include:

- a. Definition of service area
- b. Description of the system that will be used to serve veterans and their family caregivers including targeting, assessment, service planning, services that will be provided,
- c. A statement that the same functional targeting criteria used in the CLP grant will be used to conduct assessments to determine veterans’ risk of nursing home placement.
- d. Description of consumer-directed service model to be used (e.g. Cash and Counseling)
- e. Proposed range for monthly client budgets, including a “not-to-exceed” threshold (e.g.. the threshold could be based on local data or the state’s TBI waiver or aged/disability waiver cost maximum).
- f. Number of estimated veterans to be served over 24 month CLP grant period
- g. Estimated administrative costs to deliver the program.

The letter of commitment from the local VA Medical Center at a minimum should include:

- a. General Statement reflecting a positive sense of government agencies working with SUAs and or AAAs in developing a VDHCBS program.
- b. Specific statement reflecting on the potential benefits that a VDHCBS program will have on the VAMCs long-term care programs and its targeted Veteran population.
- c. The projected number of Veterans that will be served through the VDHCBS program throughout the 24 month CLP grant period.

The letter(s) of commitment from the State Unit on Aging and/or selected AAA pilot site(s), at a minimum is to include:

- a. The projected number of Veterans that will be served through the VDHCBS program throughout the 24 month CLP grant period.
- b. The “not to exceed” estimated monthly budget(s) for services for each enrolled Veteran.
- c. The projected timeframe from the point of a finalized Arrangement to enrollment of Veterans into the VDHCBS and initiation of services.

- d. Definition of the service area.
- e. The method by which the VA Medical Center and the Aging Network will regularly communicate regarding the status of the program.

The “Attachment I: VDHCBS Program Option Application” required to apply for this option will not be counted as part of the CLP grant Project Narrative for purposes of the 15-page limit.

VDHCBS Option Award:

Applicant’s eligibility and receipt of an award from the VHA for this option is dependent upon submitting an AoA CLP grant application. The VDHCBS Option awards will be made no later than September 30, 2009. At the time a Notice of Award is made by AoA to CLP grantees, the VHA in partnership with AoA will make contact with all accepted VDHCBS Option awardees and committed parties as demonstrated by the letters of support, to discuss and establish the details of their proposal for partnership and to enable them to finalize arrangements between the local VA Medical Center(s) and the State Unit on Aging or local AAA pilot site(s).

Attachment J

Proposed Semi-Annual Reporting Requirements for CLP

AoA has developed the following Basic CLP Data Elements that are expected to be the minimum data elements collected and reported on by all CLP grantees.

Demographics and Clinical Functional Status of New Enrollees

- 1 Number Of Participants Newly Enrolled Between Last And Current Report (Unduplicated Count)
- a) Veteran Care Recipients (assume all are Self-Directed)
 - b) Non-Veteran Care Recipients
 - o # in Traditional Services Only
 - o # in Self-directed Services
 - c) Caregivers
 - o # in Traditional Services Only
 - o # in Self-directed Services
- 3 Number Of New Enrollees By Referral Source Between Last and Current Report
- a) VAMC, Hospitals, Nursing or Rehab Facilities, ADRCs, AAAs, CILs, other
- 5 Number of New Enrollees Served by Demographics:
- a) Age (DOB or category)
 - b) Gender
 - c) Race/Ethnicity
 - a. Hispanic Origin/Not Hispanic Origin
 - b. White Alone, Black Alone, American Indian and Alaska Native Alone, Asian Alone, Native Hawaiian and Other Pacific Islander Alone, Two or more races
 - d) Marital status
 - e) Living arrangement (alone, with spouse, with children, with other relatives, with non-relatives)
- 6 Number of New Enrollees Served by Functional Status of Care Recipient:
- a) # with 0 ADL Impairments
 - b) # with 1 ADL Impairment
 - c) # with 2 ADL Impairments
 - d) # with 3 ADL Impairments
 - e) # with 4 ADL Impairments
 - f) # with 5 or more ADL Impairments
- 7 Number of New Enrollees Served by Financial Status:

- a) Number with annual household incomes between: \$0-20,000, \$20,001-40,000, \$40,001 - 60,000, above \$60,000
- b) Number with assets between: \$0-\$5,000; \$5,001-\$10,000; \$10,001-\$20,000, \$20,001-\$30,000; over \$30,000

Number of New Enrollees Using Different Types of Services:

- a) # receiving nursing care at home
- b) # receiving personal care/person assistance
- c) # receiving homemaker/choremaker services
- 8 d) # receiving respite care
- e) # receiving home-delivered meals
- f) # making home modifications
- g) # receiving occupational or recreational therapy
- h) Other (please provide examples)

Administrative Data and Program Financing of All Current Participants

- 1 Number of Active Participants Served in Program Between Last and Current Report
- Number of Participants Who Discontinued Program Between Last and Current Report by Reason for Discontinuation:
 - a) # who no longer needs CLP services but are remaining in community
 - b) # who are no longer eligible for CLP services but are remaining in the community
 - 2 c) # who entered Hospital
 - d) # who entered Nursing Home for temporary stay
 - e) # who entered Nursing Home on permanent basis
 - f) # who enrolled in Medicaid
 - g) # who moved out of service area
 - h) # deceased

Community Living Program and Medicaid Diversion

- Number of Participants Entering Nursing Home/Institution Between Last and Current Report For Each Individual:
 - a) How long was participant enrolled in CLP program?
 - 1 b) Is Nursing Home Placement expected to be temporary or permanent?
 - c) Why did participant enter the Nursing Home (e.g. post-acute stay, caregiver burden, change in family or caregiver situation, change in functional status)
- 2 From Client Survey:

How likely is it that you would have gone into a nursing home without these services?

(Not at all likely, Somewhat likely, Very likely, Almost certain)

3

Number of Participants Enrolling in Medicaid Between Last and Current Report

Client Satisfaction (to be collected through client surveys)

To what extent do the services that you receive help you? Would you say....

3

(They help a lot, They help a little, They do not help, They make things worse)

Attachment K:

Estimated Number of Eligible Individuals for Community Living Program by State³

Alabama	3,846	Montana	1,020
Alaska	219	Nebraska	1,744
Arizona	5,850	Nevada	1,849
Arkansas	2,576	New Hampshire	1,124
California	25,829	New Jersey	7,971
Colorado	3,378	New Mexico	1,627
Connecticut	3,637	New York	16,583
Delaware	854	North Carolina	7,101
District of Columbia	289	North Dakota	661
Florida	22,425	Ohio	12,108
Georgia	5,218	Oklahoma	3,256
Hawaii	1,069	Oregon	3,330
Idaho	1,166	Pennsylvania	14,844
Illinois	11,121	Rhode Island	1,102
Indiana	6,160	South Carolina	3,432
Iowa	3,606	South Dakota	759
Kansas	2,836	Tennessee	4,911
Kentucky	3,456	Texas	15,080
Louisiana	3,350	Utah	1,623
Maine	1,467	Vermont	566
Maryland	3,949	Virginia	5,258
Massachusetts	6,219	Washington	5,005
Michigan	9,904	West Virginia	2,119
Minnesota	4,580	Wisconsin	5,741
Mississippi	2,032	Wyoming	500
Missouri	5,651		

There will be an estimated 260,000 total potential eligible individuals in 2010. Individuals with two or more impairments with activities of daily living and income less than 300% supplemental security income (SSI) level (\$22,932 for a single individual and \$34,416 for a married individual in 2008) and financial assets above \$2,000 and below \$25,000.⁴

³ Source: The Lewin Group, Inc. estimates based on the 1996 Panel of the Survey of Income and Program Participation, Wave 11 and 12 Topical modules. Due to a lack of state specific data, the potential eligible individuals in each state are allocated based on the state's relative share of the total US population age 75+ between 1.5 to 3.0 times poverty.

⁴ Source: The Lewin Group, Inc. estimates based on the 1996 Panel of the Survey of Income and Program Participation, Wave 11 and 12 Topical modules.

Attachment L

Financial Management Services

Financial Management Services (FMS) are an essential support service for providing consumer directed services, but can be difficult to understand and implement because of the various models and types of programs. Deciding what FMS model and provider will work best with your program is critical. The following 3 pieces of information on FMS supplement information in Attachment G: Standards for Community Living Programs. These 3 pieces are: 1) a definition of FMS, 2) a summary of models and key characteristics of FMS programs, and, 3) a list of FMS providers across the country.

The definition and chart of FMS models and key characteristics is taken from “Developing and Implementing Self Direction Programs and Policies: A Handbook” a resource that can be found on the Cash and Counseling website: <http://cashandcounseling.org>, as well as on the website of the National Resource Center for Participant Directed Services: <http://www.participantdirection.org>.

The list of FMS providers was compiled in May, 2008. This list may help you quickly identify and contact an established FMS program in your state or area. However, grantees may need technical assistance in selecting an FMS provider, technical will be made available as needed and requested.

Please note: While every effort was made to make this a comprehensive list of all FMS programs nationally, it is possible that not every program was identified. Also, AoA is sharing this list for information for grantees, and does not endorse or promote any specific FMS program.

1. Definition of FMS

A service/function that assists the family or participant to: (a) manage and direct the distribution of funds contained in the participant-directed budget; (b) facilitate the employment of staff by the family or participant by performing as the participant’s agent such employer responsibilities as processing payroll, withholding and filing federal, state, and local taxes, and making tax payments to appropriate tax authorities; and (c) performing fiscal accounting and making expenditure reports to the participant and/or family and state authorities.²

2. Financial Management Services Models and Key Characteristics

FMS Model: Government Fiscal/Employer Agent

Operating Entity: Vendor Fiscal/Employer Agent State or County government agency (In accordance with §3504 of the IRS Code and IRS Rev. Proc. 80-4, 1980-1 C.B. 581 and as modified by IRS Proposed Notice 2003-70)

Worker’s Employer: Participants, unless agency services are used

Responsibilities: Under IRS rules, a state or local government entity acts as an “employer agent” for participants—performing all that is required of an employer for wages paid on the employer’s behalf and all that is required of the payer for requirements of backup withholding, as applicable.¹⁰

It receives, disburses, and tracks public funds based on participants' approved service plans and budgets; assists participants with completing participant enrollment and worker employment forms; conducts criminal background checks of prospective workers; and verifies workers' information (i.e., social security numbers, citizenship or legal alien verification documentation).

It also prepares and distributes payroll including the withholding, filing, and depositing of federal and state income tax withholding and employment taxes and locality taxes;¹¹ processes and pays vendor invoices for approved goods and services, as applicable; generates reports for state program agencies, counselors (also called support brokers, support coordinators, and other names), and participants; and may arrange and process payment for workers' compensation and health insurance, when appropriate.

The Government F/EA may choose to delegate employer agent tasks to a reporting or subagent per IRS Proposed Notice 2003-70.

Performs similar tasks to Government F/EA described above except as a vendor in accordance with IRS Rev. Proc. 70-6, 1970-1 C.B. 420 as modified by IRS Proposed Notice 2003-70. The Vendor F/EA may delegate agent tasks to a reporting agent per IRS Forms 2678 instructions.

FMS Model: Vendor Fiscal/Employer Agent

Operating Entity: Vendor (§3504 of the IRS Code and IRS Rev. Proc. 70-6, 1970-1 C.B. 420 and as modified by IRS Proposed Notice 2003-70)

Worker's Employer: Participants, unless agency services are used

Responsibilities: Performs similar tasks to Government F/EA described above except as a vendor in accordance with IRS Rev. Proc. 70-6, 1970-1 C.B. 420 as modified by IRS Proposed Notice 2003-70. The Vendor F/EA may delegate agent tasks to a reporting agent per IRS Forms 2678 instructions.

FMS Model: Agency with Choice

Operating Entity: Agency (e.g., Center for Independent Living [CIL], Home Health, Area Agency on Aging [AAA] or Social Service)

Worker's Employer: Co-employer (also referred to as joint-employer) arrangement with participants and an agency or its subcontracting agency (e.g., CIL, Home Health, AAA, or Social Service)

Responsibilities: The agency and participants are co-employers of the workers whom participants recruit and refer to the agency for hire and assignment back to them.¹² The agency is the primary employer of the worker, for the purpose of human resources and payroll management and Medicaid provider requirements. Participants are the secondary employer of their workers and perform or actively participate in the recruitment, training, supervision, and discharge of their workers.

The agency also may provide a variety of supportive services to assist participants in recruiting workers and being a managing employer (if requested by participants), i.e., establish and maintain a worker registry, provide referrals and emergency backup staff, or provide training and supervision directly to participants' workers.

FMS Model: Public Authority/Workforce Council¹³

Operating Entity: Independent or quasi-governmental entity

Worker's Employer: Multiple-employer arrangement with participants and independent or quasi-governmental entity, state or local community-based service program, or human service department

Responsibilities: Participants serve as the employer of their workers for recruitment, training, supervision, and discharge purposes. State or county program agencies may serve as the employer of participants' workers for the purpose of managing payroll including withholding, filing and depositing federal and state income tax withholding and employment taxes and locality taxes.

The Public Authority (PA) or Workforce Council (WC) serves as the employer of participants' workers for collective bargaining purposes with the union that represents the workers and, in some cases, performs the payroll task. The PA/WC also may maintain a worker registry, and offer voluntary training for workers and participants and emergency backup services to participants.

3. Alphabetical List of FMS Providers with contact information

This list was compiled May 2009 and includes 72 verifiable providers. AoA is providing this list to assist states to identify providers in their state and local areas. It is not based on a national survey, so may not include every FMS provider operating at this time. As noted above, AoA does not endorse or promote any specific provider.

1. Abilities in Motion (AIM)

Fiscal/Employer Agent

Bill Hertzog

aimsa@abilitiesinmotion.org

610-288-0120

416 Blair Ave

Reading, PA 19601

- Pennsylvania

2. Acumen Fiscal Agent

Fiscal/Employer Agent

Agency with Choice

Greg Murphy

801-852-0661

4542 Inverness Ave

Suite 210

Mesa, AZ 85206

gregm@acumen.net

- California
- Colorado
- Georgia
- Louisiana
- Nevada
- New Mexico
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- South Carolina
- Utah
- Wyoming

3. Addus Health Care

Agency with Choice

Darby Anderson

312-663-4647

danderson@addus.com

14 E. Jackson

Suite 902
Chicago, IL 60604
• Illinois

4. Adfinium

Agency with Choice
• Ohio

5. Administrative Services, Inc.

Fiscal/Employer Agent
Helen Dortch, Sr. VP of Finance
Karen Williamson, VP of Development
Administrative Services, Inc. (ASI WORKS)
hdortch@asiworks.com
(301) 654-3903
7101 Wisconsin Ave
Bethesda, MD 20814
• Missouri

6. Alliance Health Care

FSE providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Teresa Brooks
(651) 895-8030
teresab@alliancehealthcare.com
6900 Wedgwood Road North
Maple Grove, MN
• Michigan
• Minnesota

7. Alliance Health Services Fiscal Support

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Shalon Fiala Noval
651-895-8030
2260 Cliff Road
Eagan, MN 55122
• Minnesota

8. Allied Community Services

Fiscal/Employer Agent
Carol Bohnet
860-748-8833
cbohnet@alliedgroup.org
East Windsor, CT 06088
• Alabama
• Connecticut

9. **Alpha One**
Agency with Choice
Dennis Fitzgibbons, Executive Director
127 Main Street
So Portland, ME 04106
207-767-2189
dfitzgibbons@alphaonenow.org
 - Maine

10. **Arc of the Greater Twin Cities**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Jacki McCormack
(952) 920-0855
jackimccormack@arcgreatertwincities.org
 - Minnesota

11. **ARI Independent Living Center**
Fiscal/Employer Agent
Linda Campbell
500 Prospect Street
Pawtucket, RI 02860
401-725-1966
info@ari-ilc.org
 - Rhode Island

12. **ARIS Solutions**
Agency with Choice
Jason Richardson
P.O. Box 4409
White River Junction, VT 05001
(802) 280-1991
 - Vermont

13. **CareLink**
Fiscal/Employer Agent (for AoA NH Diversion Modernization Grant and AAAVA program)
Joy Mills
P.O. Box 5988
North Little Rock, AR 72119
501-372-5300
JMills@care-link.org
 - Arkansas

14. **Community Access Unlimited**

Fiscal/Employer Agent
George Murray
(908)-354-2665 X278
gmurray@caunj.org
80 West Grand Street
Elizabeth, NJ 07202

- New Jersey

15. Community Bridges

Agency with Choice
Victoria Chapman
2 Whitney Street
Concord, NH 02201
(603) 226 - 3212
Vchapman@communitybridges.org

- New Hampshire

16. Community Involvement Programs

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Jane Lawrence
1600 Broadway Street NE
Minneapolis, MN 55412
612/362-4437

- Minnesota

17. Community Services Council of New Hampshire

Agency with Choice
Robert Carter
79 Sheep Davis Road
Pembroke, NH 03302
(603) 225-9694
rcarter@cscnh.org

- New Hampshire

18. Community Services for the Developmentally Disabled, Inc.

Agency with Choice
Kathie O'Brien
2180 Genesee Street
Buffalo, New York 14211
(716) 896-2180
komara@csdd.net

- New York

19. Concepts of Independence, Inc.

Agency with Choice

Jim Bitonti
120 Wall Street; Suite 1010
New York, New York 10005
212-293-9999
jimbitonti@aol.com

- New York

20. Connections FSE Services

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency

Kristin Ferrier
15676 Fish Point Road
Prior Lake, MN
kristin.connections@juno.com
(952) 393-2426

- Minnesota

21. Consumer Choice, Inc. (CFCACCRA)

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS

Cara Benson
952-935-3515
carabenson@cfaccra.org
1011 1st Street S #315
Hopkins, MN 55343

- Minnesota

22. Consumer Directions

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS

Shantel Jaszczak
22 Wilson Avenue, NE; #101
St Cloud, MN 56302
shantel@consumerdirections.info
320-420-3423

- Minnesota

23. Consumer Direct Personal Care

Fiscal/Employer Agent, Agency with Choice, I&A provider

Bruce Kramer
406-532-1938
brucek@homehealthnursing.com
1903 South Russell Street
Missoula, MT 59801-6603

- AZ (F/EA for MCOs for AHCCCS)
- AK (AWC)
- ID (F/EA)

- MT (AWC)
 - NV (F/EA Autism Pilot)
 - NM (I&A and possibly AWC)
 - WI (F/EA)
- 24. Cooperating Community Programs (CCP) Consumer Directed Services**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
 Eric Pederson
 1885 University Avenue; #185
 St Paul, MN 55104
- Minnesota
- 25. CRI**
Fiscal/Employer Agent
 Marty Pushchak
 3410 West 12th Street
 Erie, PA 16505
 800-530-5541
mpushchak@crinet.org
- Pennsylvania
- 26. Cumberland County AAA**
Government Fiscal/Employer Agent
 Terry Barley
 16 W High St
 Carlisle, PA 17013
 717-240-6110
tbarley@ccpa.net
- Pennsylvania
- 27. CP of Massachusetts**
Fiscal/Employer Agent
 Larry Spencer
 43 Old Colony Ave
 Quincy, MA 02170
 617-479-7443 x111
larry_spencer@masscp.org
- Massachusetts
- 28. Dakota County Minnesota**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
 Karen Conrath
 1 Mendota Road
 West St Paul, MN

651-209-3350

- Minnesota

29. Duluth Regional Care Center (DRCC) FSE

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS

Michelle Hoey
728 Garfield Avenue
Duluth, MN 55802-2634
218-722-8180 ext. 101
hoey@drccinfo.org

- Minnesota

30. Dungarvin Fiscal Services MN, Inc.

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS

Christina Demopoulos
1110 Centre Pointe Curve
Mendota Heights, MN 55120
651-699-6050

- Minnesota

31. Easter Seals New Hampshire

Agency with Choice

Pat Schoch
555 Auburn Street
Manchester, NH 03103
(603) 621-3558
pschoch@eastersealsnh.org

- New Hampshire

32. Elderberry Institute

Fiscal Support Entity (FSE) providing Fiscal/Employer Agent, and Agency with Choice FMS (no Fiscal Conduit Services)

Malcolm Mitchell, Executive Director
Eleni Messiou
(651) 649-0315
mpmitchell@elderberry.org
emessiou@elderberry.org

475 N. Cleveland Avenue
St. Paul, MN 55104

- Minnesota

33. Enable

Agency with Choice

Michael Wolfson

1603 Court Street
Syracuse, NY 13208
(315) 455-7591
mwolfson@enablecny.org
• New York

34. Familycapped, Inc.
Agency with Choice
Nicholas Cappoletti
228 Lafayette Street
Syracuse, NY 13205
(315) 469-9931
nick@familycapped.com
• New York

35. Gateway Community Services, Inc.
Agency with Choice
Sharon Stephens
144 Canal Street
Nashua, NH 03064
603-459-2739
lboggis@gatewayscs.org
• New Hampshire

36. GTI Financial Services
Fiscal/Employer Agent
Tim Carmicheal, CFO
113 North Monroe St.
Sturgis, MI 49091
877-659-4500
• Michigan

37. Granite State Independent Living'
Agency with Choice
Jill Burke
21 Chenell Drive
Concord, NH 03302
603-228-9680
Jill.burke@gsil.org
• New Hampshire

38. Jewish Employment and Vocational Service
Agency with Choice
Greg Manz
1845 Walnut Street, 7th FL

Philadelphia, PA 19103
215-854-1800
Gregory.manz@jevs.org

- Pennsylvania

39. Independent Support Services, Inc.

Agency with Choice
Alan Kulchinsky
95 Glen Wild Road, Suite 2
Rock Hill, NY 12775
(845) 794-5218
isupport@pronetisp.net

40. KATCO

Fiscal/Employer Agent
Basil Kessler, Executive Director
625 Merchant; Suite #206
Emporia, KS 66801
866-465-2826
basil@katco.net

- Kansas (for WORK Program – PCA services for Medicaid-Buy-in Program participants)

41. Lakes Region Community Services Council

Agency with Choice
Karen Welford
635 Main Street
Laconia, NH 03246
(603) 524-8811
• New Hampshire

42. LDA Life and Learning Resources

Agency with Choice
Pat Willis
339 East Avenue, Suite 420
Rochester, NY 14604
(585) 263-3323
pwillis@ldagvi.org

- New York

43. Liberty Resources, Inc.

Fiscal/Employer Agent
Murray Rosenman
714 Market Street; Suite 100
Philadelphia, PA 19106
215-634-2000
murrayrosenman@libertyresources.org

- Pennsylvania
- 44. Lifeworks Services, Inc.**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
 Vicki Gerrits
 1120 Centre Pointe Drive; Suite #100
 Mendota Heights, MN 55120
 651-365-3734
vgerrits@lifeworks.org
- Minnesota
- 45. Living Innovations**
Agency with Choice
 Terri Lyons
 P.O. Box 781
 Greenland, NH 03840
 (603) 422-7308
tlyons@livinginnovations.com
- New Hampshire
- 46. Lutheran Services of NE**
Agency with Choice
 Marlene French
 261 Sheep Davis Road
 Concord, NH 03301
 (603) 224-8111
mfrench@lssnorth.org
- New Hampshire
- 47. Mains'I Services, Inc.**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Subagent to Government Fiscal/Employer Agent
 Stacy Roe
 6900 Wedgewood Road, #250
 Maple Grove, MN 55311
 763-416-9146
sroe@mainsl.com
- Florida (subagent)
 - Minnesota (FSE)
- 48. Mankato Rehabilitation Center Inc**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
 Ellen Wendt

507-386-5667
ewendt@mrci.info
15 Map Drive
PO Box 328
Mankato, MN 56002-0328
507-386-5667

- Minnesota

49. Monadnock Developmental Services

Agency with Choice
Carol Brown
121 Railroad Street
Keene, NH 03440
(603) 352-1304 X 255
carolbrown@mds-nh.org

- New Hampshire

50. Neighbors, Inc.

Fiscal/Employer Agent
49 Woodbridge Ave
Highland Park, New Jersey
(856) 228-8767
mzandanel@comcast.net

- Pennsylvania (F/EA for PA ODP until 12/31/09 and working on implementing AWC services for PA ODP)

51. Northeast PA Center for Independent Living (dba ACES\$)

Fiscal/Employer Agent
Duane Seidel
431 Wyoming Ave
Scranton, PA 18503
570-207-7722 X2221
dseidel@nepacil.org

- Illinois
- Pennsylvania

52. North Shore ARC

Fiscal/Employer Agent
Vade Mohammed
6 Southside Road
Danvers, MA 01923
978-762-8307
vmohammed@nsarc.org

- Massachusetts

53. Northwest Arkansas AAA (under AoA NH Diversion Modernization Project)

Fiscal/Employer Agent
1510 Rock Spring Road
P.O. Box 1795
Harrison, AR 72602
870-741-1144
Jerry Mitchell
jmitchell@aanwar.org
• Arkansas

54. Ocean State Community Resources

Fiscal/Employer Agent
David Reiss
310 Maple Avenue; Suite 102
Barrington, RI 02806
401-245-7900
dreiss@oscr.org
• Rhode Island

55. Orion ISO

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Jennifer Van Rooy
94000 Golden Valley Road
Golden Valley, MN 55427
763-450-5040
jvanrooy@orionassoc.net
• Minnesota

56. Paladino & Company, P.A.

Fiscal/Employer Agent
Larry Paladino, CPA
2504 McCain Blvd; Suite #224
North Little Rock, AR 72116
(501) 758-9900
larrypaladino@sbcglobal.net
• Arkansas

**57. Palmieri Health Services, Inc
dba Comforcare Senior Services**

Agency with Choice
Ana Crandall
1 Tara Blvd, Suite LL4
Nashua, NH 03062
(603) 888-3800
• New Hampshire

- 58. Partners in Community Supports, Inc. (PICS)**
Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Beth Peterson
1701 American Blvd. East
Minneapolis, MN 55425
952-854-6364 X107
- Minnesota
- 59. PayChex**
Reporting Agent⁵
Jim McElwain
5450 Frantz Road; Suite #100
Dublin, OH 43016
- Reporting agent for an Ohio Area Agency on Aging implementing the Independent Choices Program
- 60. PayChoice**
Reporting Agent (see footnote 2)
Thomas Gannon
Chris Murray
153 Andover Street; Suite 102
Danvers, MA 01923
978-624-2125
chris.murray@paychoice.com
978-624-2182
Tom.gannon@paychoice.com
- Reporting agent for the three Massachusetts Vendor F/EA FMS providers processing payroll for 16,000 participant/representative employers and 22,000 HCBS workers and related union dues processing,
- 61. People, Inc.**
Agency with Choice
Linda Rinaldo
1219 North Forest Road

⁵ Note, reporting agents do not have any liability for any unfulfilled federal tax obligations including penalties and interest in the eyes of the IRS and most state taxation agencies feel the same way. Reporting agents need to work in conjunction with a Government or Vendor F/EA FMS provider (as they do in OH and MA) since they are not willing to obtain the required separate FEIN to perform as a solo Vendor F/EA FMS provider. Any unfulfilled federal or state tax obligations, including penalties and interest, incurred by a reporting agent rests with the Government or Vendor F/EA and the program participant or representative-employer. In general, the Government or Vendor F/EA would take on the responsibility to resolve any tax liability issues. The IRS Form 8655, *Reporting Agent Authorization* should only be executed between the Government or Vendor F/EA FMS provider and a reporting agent and never with the program participant or representative-employer. In addition, Government or Vendor F/EA FMS providers should execute effective performance-based contracts with reporting agents they use to hold them accountable for any unfulfilled federal and state tax obligations including penalties and interest.

Williamsville, NY 14221
(716) 817-7481
Irinaldo@people-inc.org
• New York

62. Personal Accounting Service PAS

Fiscal/Employer Agent
Patti Sielaff
734-287-8210
• Michigan

63. PossAbilities of Southern Minnesota, Inc.

Fiscal Support Entity (FSE) providing Fiscal Conduit, Fiscal/Employer Agent, and Agency with Choice FMS
Polly Owens
1808 3rd Avenue South East
Rochester, MN 55904
507-281-6116
powens@possabilities.org
• Minnesota

64. Public Partnerships, LLC

Fiscal/Employer Agent
Marc Fenton
148 State Street; 10th Floor
Boston, MA 02109
617-426-2026 X 1116
mfenton@pcqus.com

- Arizona (subagent for the Government F/EA)
- Georgia
- Indiana
- Massachusetts (AWC FMS for DMR program)
- Maine
- Maryland
- Massachusetts
- New Jersey
- New Mexico
- South Carolina
- Tennessee
- Virginia (also providing F/EA FMS for AAA/VA pilot in Virginia)
- West Virginia (subagent for the Government F/EA)

65. Resource Center for Independent Living (RCIL)

Agency with Choice

Tammi Capuana

P.O. Box 210

Utica, NY 13503-0210

(315) 797- 4642

Tammi.Capuana@rcil.com

66. Southern Tier Independence

Agency with Choice

135 East Fredrick Street

Binghamton, NJ 13904

607-724-2111

- New York

67. Springbrook

Agency with Choice

Melissa Mabie

2705 State Highway 28

Oneonta, NY 13820

(607) 286-7171

mabiem@springbrookny.org

68. Stavros

Fiscal/Employer Agent

Serin Derin

Diane Dempsey

Amherst, MA 01104

800-442-1185

sderin@stavros.org

- Massachusetts

69. Summit Fiscal Agency, Inc.

Fiscal/Employer Agent

Nicolas Thomley

6009 Wayzata Boulevard

St. Louis Park, MN 55416

952-544-2787

info@summitfiscalagency.net

- Minnesota

70. Sunrise

Reporting Agent

- Washington

71. Sunset Shores

Fiscal/Employer Agent
Carol Agria
720 Barnum Ave, Cutoff
Stratford, CT 06614
Carol.Agria@SunsetshoresFi.com
(203) 882-1225

- Connecticut

- 72. Veridian Credit Union**
Fiscal/Employer Agent (Credit Union)
Dawn McMahon
1827 Anborough Ave
Waterloo, IA 50704-6000
319-236-5696
DawnRM@veridiancu.org
- Iowa

Attachment M
Veterans Health Administration (VHA)
Administration on Aging (AoA)
Veteran Directed Home and Community Based Service Program
Standards

Key Operation Context: VA Medical Centers (VAMCs) will purchase a product from Area Agencies on Aging known as the VD-HCBS program.

Veteran Directed Home and Community Based Service (VDHCBS) Program: The VDHCBS program serves Veterans of any age who are at risk of nursing home placement and their family caregivers. The VD-HCBS program provides Veterans the opportunity to receive home and community based services that enable them to avoid institutionalization and continue to live in their homes and communities.

Standards: Aging Network Agencies offering VD-HCBS must have in place the basic elements of a community living program and meet the readiness criteria for consumer directed programs before Veteran enrollment into the VDHCBS program can begin.

The specific readiness criteria will demonstrate the agency's capacity to implement the program and begin facilitation of the services in a consumer directed fashion that enables enrolled Veterans to:

- Receive an assessment and care planning assistance
- Decide for themselves, or with a participant representative, what mix of goods and services will best meet their, and their family caregiver's care needs
- Manage a flexible, individual budget
- Hire and supervise their own workers, including family or friends
- Purchase items or services needed to live independently in the community
- Have fiscal management and support services which facilitate service delivery
- Utilize traditional service providers if desired

Provider Agreement: When a State Unit on Aging or local Area Agency on Aging (AAA) meets the readiness criteria and is ready to begin serving Veterans and their family caregivers in the VDHCBS program, the applicable VA Medical Center (VAMC) will form a Provider Agreement with the Aging Network Agency. The Provider Agreement will outline the terms and conditions between the VAMC and Aging Network Agency for the VD-HCBS Program (2-3 pages).

Services & Goods: Aging Network Agencies offering VD-HCBS must provide or assist in arranging consumer/self directed services based upon the needs and preferences of the participating Veterans and/or their representatives. Aging Network Agencies will provide the VD-HCBS program as a bundled package, which at a minimum will include the following services:

- Home and Community-Based Services (HCBS) - some examples include, but are not limited to:
 - *Personal Care (e.g. physical or verbal assistance with eating, bathing, dressing, grooming, transferring)*
 - *Homemaker (e.g. cleaning, laundry, meal planning & preparation, shopping)*
 - *Adult Day Care*
 - *Assistive Technology (e.g. emergency response system, electronic pill minder)*
 - *Home-Delivered Meals*
 - *Caregiver Support (e.g. counseling, training)*
 - *Respite Care*
 - *Environmental Support (e.g. yard care, snow removal, extensive cleaning)*
 - *Other goods and services needed to remain safely in the community (e.g. small appliances, grab bars, ramp, lift chair, etc.)*
- Assessment
- Options Counseling/Support Services including care management
- Fiscal Management Services

Note: HCBS services provided through the VD-HCBS program cannot duplicate any services that are already being provided to a Veteran or their family caregiver(s) by or through the Department of Veterans Affairs. Local coordination will be required between the VAMC and the Aging Network Agency to identify what existing VA services are currently provided.

Target Population: All Veterans enrolled in VA health care system are eligible to participate in the VD-HCBS program when the Veteran is “in need of nursing home care” and interested in consumer directed care. Veterans are determined “in need of nursing home care” when one or more of the following conditions is met:

- Three or more activities of daily living (ADL) dependencies
- Significant cognitive impairment
- Receiving hospice services
- Two ADL dependencies and two or more of the following:
 - 3 or more instrumental activities of daily living (IADL) dependencies
 - Recently discharged from a nursing facility
 - 75 years old or greater
 - 3 hospitalizations or 12 outpatient clinics or emergency evaluations
 - Clinically depressed
 - Lives alone
- Does not meet any criteria but still clinically determined by the local VAMC to need services

Referral Process: The VAMC will identify Veterans that are eligible for the VD-HCBS program and refer the veterans to the Aging Network Agency.

Note: Veteran referrals that come through other avenues, such as an Aging and Disability Resource Center or AAAs, must first be approved by the local VAMC. Each participating Agency and VA Medical Center will establish protocols for determining eligibility in a streamlined and expedited manner. Aging Network Agencies can refuse to accept Veteran

participants and their family caregivers when it is anticipated that the services required would exceed the scope of the Agency's ability to meet the Veteran's needs.

Follow-up Process: The Aging Network Agency will meet with the VAMC staff on a monthly basis to review Veteran utilization, service delivery and satisfaction. Periodically the Aging Network Agency and the VAMC will meet with Veterans and their families to assure services are being provided and the Veterans' needs are met.

Rate Determination: Rates for the VD-HCBS Program will be based on a tiered rate schedule corresponding to specific levels of care. Participating Veterans and/or their representatives will be given a monthly budget, based upon an average per diem. Rates will be established by the local VAMC and Aging Network Agency and agreed to in the Provider Agreement.

Rates will reflect the assessed level of need of the Veteran and family caregiver(s), the specific services and supports to be provided to the veteran and the family caregiver(s), including the cost of the veteran's individual budget and the cost of services such as counseling, assistance and support, and fiscal management services. Rates will not include costs for any services provided directly by the VA for the Veteran's care.

Contacts:

Administration on Aging

Joseph Lugo, joseph.lugo@aoa.hhs.gov, Telephone: (202) 357-0152

Veterans Health Administration

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Attachment N

Definitions

Definitions for this solicitation:

For purposes of this Announcement, an “aging services provider organization” is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

Aged (or Older adult Person): As defined in the Older Americans Act, “an individual who is 60 years of age or older.”

Broad definition of **Options Counseling** is an interactive decision-support process whereby consumers, family members and/or significant others are supported in their deliberations to determine appropriate long-term support choices in the context of the consumer’s needs, preferences, values, and individual circumstances.

Benefits Counseling: The provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medigap policies), Supplemental Security Income (SSI), Food Stamps, Medicare, Medicaid and private pension benefits. For purposes of this program, Benefits Counseling funded under the Older Americans Act that is provided to individuals who need help in order to remain in the community, is included in this definition.

Coordination with Medicaid Financial Eligibility Determination: The determination of financial eligibility for Medicaid may take place either at the Resource Center or off-site. Regardless of where it takes place, the Resource Center must assure that the process is coordinated or integrated with the functions of the Center so that it takes place in an expeditious manner that avoids duplication of effort for individuals, their families and agency workers. The result of this coordination should be a seamless system of long-term support as experienced by the individual.

Counseling and Referral to Help People Remain in the Community: The provision of comprehensive and accurate information on services and programs that can help people to remain at home and in the community. These include (a) direct services (such as home and community-based waiver programs, home health, personal care, case management), (b) generic community sources of help (such as nutrition programs, prescription drug programs, health promotion and disease prevention programs, transportation services, home repair programs, real property tax relief), and public or private insurance (such as long-term care insurance, Medicare, Social Security Disability Insurance (SSDI), and SSI). For purposes of this program, counseling and referral activities designed to help individuals to remain in the community that are funded under the Older Americans Act are included in this definition.

Eligibility Screening: Is a non-binding inquiry into an individual's income and assets, as necessary, and other circumstances in order to determine probable eligibility for programs, services, and benefits, including Medicaid. This screening should be provided to all individuals who may be eligible for publicly funded programs.

Crisis Intervention: Resource Center programs must be able to respond to situations where short-term assistance is needed to support an individual until a plan for long-term support services can be put in place. For example, an individual whose existing support system has fallen apart may need immediate support to assist them while a more comprehensive plan is developed and implemented. If an individual is in danger to self or others, Resource Centers will refer to, and coordinate with, existing supports such as Adult Protective Services, in accordance with state laws and agency procedures.

Information on Long-term Support Options: The information available must be comprehensive, objective, up-to-date, citizen-friendly, and cover the full range of available options, including in-home, community-based, and institutional services (including nursing home services). The information must cover options that people will use immediately (such as Medicaid services) to long-range options (such as private long-term care insurance). The information must also cover programs and services that support family caregivers, as well as any special options in the state to maintain independence or direct one's own long-term support services.

Long-term Support Services: Long-term support refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help individuals with disabilities or chronic conditions with activities of daily living or instrumental activities of daily living. Public long-term support services are those administered by a governmental entity. For purposes of this program, long-term support services under Medicaid include home health, personal care, targeted case management, home and community-based waivers under section 1915(c) of the Social Security Act, nursing facility services, and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). Long-term support services under the Older Americans Act include personal care and other in-home services similar to those provided under section 1915(c) of the Social Security Act. Long-term support services under state-only programs include home health and personal care. Finally, for purposes of this program, the state may include in the definition of long-term support services any other publicly-funded service which the state determines should be accessed through the assessment process of the Resource Center.

Long-term Support Options Counseling : Resource Centers will help people make informed decisions by assisting individuals and their families in understanding how their strengths, needs, preferences, and unique situations translate into possible support strategies, plans, and tactics, based on the options available in the community. The counseling includes helping individuals assess their needs and resources, the assessment of the needs of family caregivers, developing a plan, and assisting the individual/family in implementing their long-term support choices. Counseling links individuals to other counseling programs and services, including Web-based information and counseling programs. For purposes of this program, Long-term Support Options Counseling activities funded under the Older Americans Act are included in this definition.

One-Stop Access to Public Programs: The organizational ability and authority to provide intake, full access, and comprehensive point of entry to publicly supported long-term support services for individuals who are eligible for, or appear to be eligible for, publicly supported long-term support services, as those services are defined under Section II. A single program performs these functions, along with information and assistance, through a simple, convenient, single contact point. The program may involve more than one entry point (or “site) at the community level (e.g., different access points for different populations) so long as (a) each access point is authorized and performs all functions of a single point of entry, (b) the process of access experienced by individuals is uniform across all entry points, and (c) individuals do not access long-term support services through admission points that do not perform all functions of a single point of entry. One-stop access to public programs also ensures that individuals have the information they need to make informed decisions and that individuals reliant on public support are not admitted to service by alternate means or by direct admission through an individual provider of services.

Programmatic Eligibility Determination: A determination of the publicly supported benefits or services to which a person is eligible, based on non-financial criteria. This may require a formal assessment to determine the full scope of the individual’s needs. It may include a functional assessment of the individual’s current health conditions and provide a situational assessment of the client’s environment, available resources, and current support. For Medicaid services, this function includes the “Level of Care” determination process.

Public Education and Outreach: Activities related to ensuring that all potential users of long-term support (and their families) are aware of both public and private long-term support options, as well as awareness of the Resource Center, especially among underserved and hard-to-reach populations.

State: Refers to the definition provided under 45 CFR 74.2 any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments.

“Models to deliver flexible services” includes service authorization and service delivery. The service authorization process should include the authority to utilize funds that can support a wide variety of service options so that services can be tailored to the unique and changing needs of individual clients. Models should also include the capacity of many provider organizations to provide and coordinate a complete array of services for elderly individuals and foster greater utilization of these types of providers. This approach to flexible services will foster greater efficiency and reduce per capita costs of services. Models to deliver flexible services should recognize full service providers and foster utilization of their services. “Consumer-directed models” are methods of delivering services that give the individuals being served the option to determine the specific types of services they receive as well as the manner in which those services are provided. (See Standards I.A and I.C in Attachment G

A **consumer** is defined as a person of any age or disability who seeks to reside in the community with the support of public funding. Persons included are patients being discharged from hospitals to rehabilitation facilities, nursing homes ICF-MR and other types of institutional settings.

Informal Supports are defined as family members, neighbors or friends whose regular assistance helps the consumer reside in the community. The consumer chooses support from the family caregiver(s) as part of the PCP process for community living.

Person-centered Planning is defined as a plan that empowers people with disabilities by focusing on the desires and abilities of the individual. Person-centered Planning involves a team of family members, friends, professionals and most importantly, the individual. The individual chooses their team members. This team then identifies the skills and abilities of the individual that can help them achieve their goals of competitive employment, independent living, continuing education, and full inclusion in the community. They also identify areas in which the individual may need assistance and support and decide how the team can meet those needs. While it is recognized that not all of the elements of a complete person-centered plan can be achieved prior to discharge from the hospital, many elements can be addressed. Elements, such as working with the patient to develop the most independent living arrangement and providing assistance and supports that are desired by the patient are included. The patient with involvement of family members, professionals and others work toward the ultimate discharge plan goal of living as independently as possible with home and community-based services.

Informal Community Network is defined as the consumer's current and potential friends and other social connections that do not provide continual care to the person but provide social support and may help intermittently with tasks and chores.

Helpful information may be accessed at the following websites:

- *Caregiver Assessment: Principles, Guidelines & Strategies for Change. Vol. I.* April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v1_consensus.pdf
- *Caregiver Assessment: Voices and Views from the Field. Vol. II.* April 2006. http://www.caregiver.org/caregiver/jsp/content/pdfs/v2_consensus.pdf
- *Caregivers Count Too. An Online Toolkit to Help Practitioners Assess the Needs of Family Caregivers.* June 2006. http://www.caregiver.org/caregiver/jsp/content_node.jsp?nodeid=1695
- Feinberg, Lynn Friss. *The State of the Art: Caregiver Assessment in Practice Settings.* 11/02. http://www.caregiver.org/caregiver/jsp/content/pdfs/op_2002_state_of_the_art.pdf

“The term ‘**self-directed care**’ means an approach to providing services (including programs, benefits, supports, and technology) under this Act intended to assist an individual with activities of daily living, in which:

- (A) such services (including the amount, duration, scope, provider, and location of such services) are planned, budgeted, and purchased under the direction and control of such individual;
- (B) such individual is provided with such information and assistance as are necessary and appropriate to enable such individual to make informed decisions about the individual’s care options;

(C) the needs, capabilities, and preferences of such individual with respect to such services, and such individual's ability to direct and control the individual's receipt of such services, are assessed by the area agency on aging (or other agency designated by the area a agency on aging) involved;

(D) based on the assessment made under subparagraph (C), the area agency on aging (or other agency designated by the area agency on aging) develops together with such individual and the individual's family caregiver (as defined in paragraph (18)(B)), or legal representative:

(i) a plan of services for such individual that specifies which services such individual will be responsible for directing;

(ii) a determination of the role of family members (and others whose participation is sought by such individual) in providing services under such plan; and

(iii) a budget for such services; and

(E) the area agency on aging or State agency provides for oversight of such individual's self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under this Act.”

For purposes of this Announcement, an “Aging and Disability Resource Center” (ADRC) program must have the operational capacity to:

- A. Effectively and efficiently identify individuals who are at imminent risk of nursing home placement but not eligible for Medicaid and who, without some type of intervention, will in fact go into – or stay in – a nursing home facility and spend-down to Medicaid (consistent with Standards I.B and I.D in Attachment G);
- B. Assess the needs of such individuals; provide them with options counseling; and, as needed, work with them to develop care plans and arrange for services, including linking them to services provided by aging network provider organizations (consistent with Standard II. A in Attachment G);
- C. Provide streamlined processes for determining an individual's eligibility for publicly supported long-term care services and supports. This means the ADRC programs used for projects under this Announcement need to be integrated, in some manner, with the process that is used by the state to determine a person's eligibility for Medicaid long-term care (both their programmatic eligibility and their financial eligibility for Medicaid). To the extent feasible it would be beneficial that individuals who are deemed by Medicaid to be ineligible for Medicaid long-term care and who are at imminent risk of nursing home placement have the opportunity to be referred to the diversion program supported under this Announcement (consistent with Standard II.A. in Attachment G).

For purposes of this Announcement, an “aging services provider organization” is an organization that is currently operating a program that serves older adults and is funded (at least in part) through the Older Americans Act. A Native American Tribal Organization funded under Title VI of the Older Americans Act may be included as an aging services provider under this grant announcement.

For purposes of this Announcement, “Financial Management Services” (FMS) are services that provide fiscal accountability for state and local government agencies and safeguards for individuals enrolled in self-direction programs and their workers by ensuring that payroll, worker’s compensation insurance policy management, and vendor payment tasks are performed accurately and in accordance with federal, state, and local rules and regulations, and in a timely manner. There are various FMS provider models including government and vendor fiscal employer agent models with which a project can contract.

For purposes of this Announcement, “models to deliver flexible services” includes service authorization and service delivery. The service authorization process should include the authority to utilize funds that are not tied to any one provider and can support a wide variety of service options so that services can be tailored to the unique and changing needs of individual clients. Models should enable many provider organizations to provide and coordinate a complete array of services for elderly individuals and foster greater utilization of these types of providers. This approach to flexible services will foster greater efficiency and reduce per capita costs of services. “Consumer-directed models” are methods of delivering services that give the individuals being served the option to determine the specific types of services they receive, the manner in which those services are provided, and the ability to directly manage those services. (See Standards I.A and I.C in Attachment G)